A Portfolio of Study, Practice and Research

Academic Dossier

Clinical Dossier

Research Dossier

Submitted for the degree of Doctor of Psychology (Psych D) in Clinical Psychology

by

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including a research project entitled: “Vicarious trauma: A survey of clinical and counselling psychologists”
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Part one: Academic Dossier
"Discuss the role of the psychologist in a rehabilitation/continuing care multi-disciplinary team and which aspects of a person's care they would be involved in"
Introduction and Overview

It now seems to be acknowledged that the nature of psychiatric rehabilitation, and its relationship to clinical psychology is changing (e.g. Shepherd 1995; Murray & Muijen 1995; Gournay 1995; Conning 1991 & Pilling 1995). This appears to be due to both changes in the kind of services that are now being offered to people with long-term mental health problems, and due to developments in treatment and care.

The recognition that we needed to move away from the institutionalised model of hospital care to facilities based more in the community was formally recognised in 1975, with the Department of Health and Social Security’s document Better Services for the Mentally Ill (cited in Koch, 1986). To replace this came the “new ideal” (Gournay, 1995) of comprehensive services of care which could accommodate all those with severe mental health problems in the community. There is now a growing recognition that there are still individuals who will continue to require periods of time in hospital, and an awareness of the social aspects of care that an institution did provide which community based services were having difficulty providing.

Shepherd (1995) points to schizophrenia as still “one of the challenges for community based health services”. He argues that concepts of schizophrenia, and its underlying causes have changed from being viewed as primarily biologically determined with a set of symptoms that need to be controlled by medication. Contemporary beliefs are that schizophrenia is heterogeneous in its presentation and relatively unpredictable in outcome. However, though the focus for the management of schizophrenia is still on the control of positive symptoms via medication, there is a growing recognition that good social and occupational outcomes are affected by other psycho-social factors such as the role of social relationships (Brier & Strauss 1984), ‘positive coping’ (McGlashan, 1976, cited in Shepherd 1995) and work opportunities (Conning & Pilling, 1994).

There now seems to be a growing recognition that the services should be focusing on clients’ residual capacities. Bennett (1978, cited in O’Callaghan 1986, p163) described rehabilitation as “the process of helping a physically or psychiatrically
disabled person to make the best use of his residual disabilities in order to function at an optimum level in as normal a social context as possible”. O’Callaghan (1986) argues that clinical psychologists may find it difficult to accept that they there are not going to ‘cure’ people, and perhaps only prevent deterioration or improve quality of life.

Nearly twenty years later Shepherd et al. (1995, p404) argues the need to develop a “menu of key ingredients... and to combine these in a way that acknowledges individual differences” . This obviously embraces a range of needs which, Conning (1991, p83) argues “no member of staff, of whatever discipline, is adequately equipped to identify and meet”. Shepherd et al. (1995), Conning (1991) and Gournay (1995) all stress the need for a multi-disciplinary approach. Conning (1991) stresses the fluctuating needs of the individual and how multi-disciplinary teams, possessing a range of skills, should be able to offer an assessment of needs in response to this constant process. This raises the question of how and what clinical psychologists contribute to the multi-disciplinary team. A number of areas of work which psychologists are likely to be involved in are discussed below.

Assessment

It is acknowledged by Hall (1981), Shepherd et al. (1985), Conning, (1994) that assessment is an essential step in a rehabilitation programme. Hall (1981, cited in Wing & Morris, 1981) argues that the most common form of assessment is clinical opinion based on interview, usually undertaken because some decision has to be made. He highlights five likely reasons for why such decisions have to be made: determining the general level of disability, enabling a rehabilitation programme to be planned, monitoring progress, planning services and enabling research to be carried out. It is likely that clinical psychologists, identified as being well-trained in assessment procedures (Connings, 1991), are involved in these decisions.

Clinical psychologists have clearly been involved with the development and administration of systematic assessments. A number of measures have been developed, such as Hall and Bakers Rehab Scale (1983, cited in Hall, 1985) which
identifies ‘deviant behaviour’ and ‘general behaviour’ as categories, each consisting
of various items to be filled in by a nurse or other. The Social and Adjustment Scale
(Weissman & Paykel, 1974, cited in Hall, 1985) is another example, though aimed at
long-term patients in the community. More recently, research has directed people to
develop more specific scales. For example Chadwick (1996) has developed a 30-item
‘Beliefs about Voices’ questionnaire (BAVQ) to help establish reliability and validity
to their theory that the meaning psychotic individuals attached to their voices is linked
to their affect and coping behaviour. David (1990) has proposed a scheme for
assessing ‘insight’ in patients with psychosis. He identifies three components of
‘insight’, which he measures with a series of questions. Though he does acknowledge
that more research is needed to validate this scheme, it is a good example of how
psychologists may develop measures in the future.

Though standardised assessments are commonly used by clinical psychologists, there
can be problems with the reliability of these, especially when staff reports are used,
are highlighted by Conning (1991). Other techniques are open to the psychologist,
such as direct observation methods (e.g. functional analysis, which examines the
identifies the fluctuating needs of the client, and how this can make ‘one-off’
assessments of limited value. The psychologist may need to consult with staff teams
to establish consistency. ‘Main stream’ assessments should also not be discounted.
For example, assessments of cognitive skills can be useful though an awareness of the
likely interference of ‘symptoms’ (e.g., hearing voices) on their performance should
be borne in mind.

Therapeutic Interventions with the Individual
The literature reveals that the clinical psychologist working in rehabilitation may also
work therapeutically with the individual. Though psychological treatments for
individuals with long term mental health problems have been around for more than 30
years (Slade, 1996), it is only more recently that they have become more valued as
viable options. Most of the work has focused on the ‘positive’ symptoms (e.g.
delusions and hallucinations). This will be considered here.
Early psychological treatments for psychosis were based on both operant and classical conditioning principles based on the work of Skinner. Nydegger (1972, cited in Slade, 1996), for example, concluded that the auditory hallucinations of an individual patient occurred when that person was in conflict situations, and usually resolved these conflicts by listening to his voices' orders. This was resolved by the patient being encouraged to acknowledge these voices as thoughts, and thus accept responsibility for conflict resolution. Liberman (1973, cited in Slade, 1996) carried out a study with delusional patients in which periods of rational speed were reinforced with an 'evening chat' with a therapist. The limitations of such studies has now been discussed (e.g. Slade 1996) and acknowledged as crude, though they mark the beginnings of more recent psychological interventions. More recently, behavioural studies have used thought-stopping techniques (e.g. Audet and Elie, 1983, cited in Allen, 1985). Allen (1985) describes removal (by thought substitution) and diversion techniques to control auditory hallucinations.

Recent treatments for ‘positive symptoms’ have focused on cognitive-behavioural interventions for the modification of hallucinations and delusions. These seem to have developed pragmatically in response to individuals whose symptoms are resistant to treatment by medication. Kingdon, Turkington & John, (1994) review the literature on Cognitive Behaviour Therapy and the amenability of delusions and hallucinations to reasoning. They describes how it was first Beck (1952, cited in Kingdon et al.1994) who had introduced reality testing to a client who thought he was being followed by the FBI. Watts (1983, cited in Kingdon et al. 1994) and Perris (1988, cited in Kingdon et al. 1994) have also applied belief modification techniques to clients with delusions with some success. Hingly (1992) highlights the attributional style of the client as significant. Kaney and Bentall (1989, cited in Hingly, 1992) found that psychotic subjects made more external attributions to negative events, and more internal attributions for positive events compared to controls. More recently, Chadwick & Lowe (1994) provide experimental evidence to assert that delusions and auditory hallucinations can be modified by cognitive therapy.
Kingdon et al. (1994) concluded that recent studies have shown optimism for cognitive-behavioural techniques complementing drug treatment and other psychosocial interventions. Chadwick and Lowe (1994) argue that a cognitive approach can be effective in reducing auditory hallucinations in individuals who are resistant to drug treatment. Either way, for working with individual clients in this way, it seems that a multi-disciplinary approach will still be necessary. Conning (1991) is, again, keen to stress this. Pilling (1995) warns of the "burgeoning interest" (p41) in cognitive behavioural treatments, and how it may entice clinical psychologists into rehabilitation to work in this specific area. The danger of this, he warns, is that not enough attention will be paid by psychologists to the importance of the overall rehabilitation plan.

Cognitive Deficits
Psychologists have also contributed to the field in establishing evidence to suggest that people who suffer from schizophrenia also suffer from cognitive deficits. For example, Hemsley (1975, cited in Hemsley 1977) argues that these deficits could be viewed in terms of information processing deficits, and later (1977) argues that these deficits could be related to some of the characteristic 'symptoms' of schizophrenia. He draws out the implications for the application of operant procedures within this context. McGrath (1991) argues that in people that "certain features of thought disorder can be reinterpreted as being consistent with dysfunction of the frontal lobe", and therefore hypothesises that these patients will have impaired performance on tests which require frontal lobe function. Penn, Van der Does, Spalding, Garbin, Linzen & Dingemans (1993) demonstrates that there are information and social processing problems in individuals. Such discoveries have led Goldstein and Kern (1994, cited in Gournay, 1995), to argue that knowledge of cognitive deficits in this client group could justify a rehabilitation approach to that adopted for people with head injuries. Clinical psychologists, therefore, could be expected to generalise their knowledge from this field.
Therapeutic Interventions with the Family

Recent literature (e.g. Falloon, Boyd, McGill, Williamson, Razani, Moss, Gilderman & Simpson 1985; Kuipers & Bebbington 1985; Winefield & Harvey 1994; Wiedemann 1994) has also highlighted the benefits of family input for the management of schizophrenia. Kuipers and Bebbington (1979) research into Expressed Emotion (EE) in the relatives of discharged schizophrenics revealed the significance of social and family factors on the prognosis of schizophrenics living with their families i.e. those that are returning to families rated as high EE are more likely to relapse. Kuipers and Bebbington later (1985) argue that the family should be used as a resource, and raises the question of which member of the multi disciplinary team should have involvement with the family. They argue that this is best done by the team member who has an interest and aptitude for the work. It would appear that the clinical psychologist would be well-trained for such a role. Falloon et al. (1985), Winefield & Hervey (1994) and Weidemann (1994) also highlight the need for professional involvement for the family care-givers, particularly in terms of psycho-educational input. O'Callaghhan (1986) highlights the options of other forms of family therapies such as 'problem solving approaches' or systemic ways of working. Overall, the studies would suggest the likelihood of growing involvement of clinical psychologists in this work, whether in direct contact with the families, or in the supervising of other staff who are in contact with the families.

Therapeutic Interventions with Staff Teams

It could also be expected for clinical psychologist working in rehabilitation to be working with staff teams or members from other professional groups. This contact is likely to include training probably on generally relevant issues, but also possibly as a training resource for dealing with particularly difficult cases. The psychologist may also involve staff in the assessment and programme design for individual clients, often relying on the staff team to carry out interventions such as behavioural programmes and skills teaching programmes. They may also be involved in the development of a unit to meet a client’s needs, including the location and design (O’Callaghan, 1986). The token economy system, which is based on a system of rewards for appropriate behaviour, is one such example of how psychologists have
attempted to work with staff teams with common aims. O’Callaghan & Mark (1986) also highlights the relatively flexible role of the psychologist within a system, and across systems, in that not only can he/she use his or her experience across systems, but they can act as a ‘referee between services and encourage joint planning.

Related to this, and also highlighted in the literature, is the role the clinical psychologist may take in changing staff attitudes. Shepherd (1984), draws attention to this in his chapter ‘Creating organisational change’, emphasising the importance of defining clear goals, involving others in change and using existing organisation channels that are already in place. Conning (1991) highlights the debate in the literature on this. She points out that clinical psychologists’ are well-placed to initiate change as they have no distinct authority in the medical hierarchy (Lavender, 1985, cited in Conning, 1991).

Clinical audit and service delivery
Clinical Audit has been defined by Firth-Cozens (1993) as “a way of systematically reviewing the quality of care we give to patients”. Though some audit projects were funded in the 1980’s, the publication of the ‘White Paper’ (1989) ‘Working for Patients’ (cited in Firth Cozens, 1993) introduced a heavier emphasis on audit, particularly as auditing became part of the equation when contracts were being made between purchasers and providers. Firth-Cozens (1993) argues that a multi-disciplinary approach to audit in community health has been encouraged as it is viewed as important that care is represented as a ‘package’.

This new accountability raises new responsibilities, which the Government has suggested that clinical psychologists are well equipped to deal with (House of Commons Social Services Committee, 1985, cited in Conning, 1991). Conning highlights several reasons why evaluation may need to be carried out: to provide information to guide future practice, to discover value for money, and to find out whether a service is still serving the desired population and curiosity.

An example of such work has come out of this new awareness is Lavender’s study (1985), which attempted to identify staff practice which would be generally
considered as ‘high quality’. From this he devised a series of questionnaires to monitor standards and treatment of care in long-stay wards of a psychiatric hospital. Interestingly, Lavender points out that any assessment of quality should consider both the human and physical environment. This is also stressed by Conning 1991. There is a wealth of literature in this field, and though it will not be reviewed here, it should be noted that the assessment of environmental issues is significant and related to both assessment and audit issues discussed here.

Service philosophies developed by psychologists, have also played apart in the direction and focus of audit, and thus quality of care. For example, Wolfensberger’s theory of normalisation identified the impact of services on the lives of individuals, and the devalued status it carries with it. (e.g. Wolfensberger 1972, cited in Brown & Smith, 1992). Normalisation principles were first introduced in the 70’s by psychologists working in the field of learning disabilities These principles are now clearly influencing service philosophy in rehabilitation. As discussed earlier, it is argued that psychologists are ideally placed for being involved in the development of services, particularly when equipped with theories of service philosophy from colleagues in different fields in the profession.

Case Management
Clinical psychologists may also be involved in the ‘Case Management’ process when working in rehabilitation. Though case management has existed in various forms, it is now identified by Gournay (1995) as becoming the standard method of delivery of services. The basic principle is that one person is responsible for the co-ordination of the ‘care package’ for the client. In the UK this role has been primarily undertaken by a mental health nurse. However, Gournay (1995) now points to the role being taken by clinical psychologists and some ‘non-professionals’. He reviews the literature for various models of case management (which will not be reviewed here) and highlights that those services which employ “clinically focused” workers (Gournay, 1995) have better outcomes than those with case managers which have little clinical involvement. This certainly seems to suggest that clinical psychologists have a useful role to play in case management. However, Gournay (1995) argues that
it may not be cost effective for psychologists to take on the specific role of the case manager, and suggests that a consultative role may be more appropriate.

The ‘New Long Stay’ Patient
A recent audit (Lellliot, 1994, cited in Gournay, 1995) revealed the fact that there is an increasingly significant number of people who need periods of time in hospital, requiring 24 hour care. Gournay (1995) points out the ‘new-long stay’ are often cared for inappropriately on the acute admission wards. Interestingly, Koch identified the ‘New Long-stay’ patient back in 1986. He argued, back then, that ‘it is essential that steps are taken to ensure that patient who remain on acute wards for more than 6 weeks do not become the ‘old long stay’. At this time he put forward the model of admitting clients directly to a rehabilitation unit so that time on the ward is minimised, and ‘illness’ de-emphasised. He also accepted that people in this group may be very disturbed at times, and that access to appropriate help should be immediate - though preferably not hospital based. The identification of the ‘new long stay’ highlights the evolutionary nature of services in rehabilitation at the moment. Gournay (1995) argues that psychologists have a lot to offer in developing services for this group of clients.

Other Possible Future Roles
Other possible future roles for the psychologist in rehabilitation identified by Gornay (1995) are Substance Abuse and Offenders. Substance abuse, often a co-morbid condition with long-term mental illness (Smith and Hucker 1994, cited in Gournay, 1995), poses problems and Gournay (1995) argues that psychologists, with a background in therapies for addictions, have much to offer. He also identifies recent policy to rehabilitate offenders back into the community and newly established court schemes to divert offenders with mental health problems. Gournay (1995) predicts that psychologists should be able to generalise forensic experience to working with this client group in the community. Gournay (1995) also highlights recent research into predrome monitoring. Exploratory studies have looked at identifying early signs of relapse (Birchwood, 1994 cited in Gournay, 1995) and patterns of recovery from
schizophrenia (Harding 1994, cited in Gournay 1995) with the aim of providing early intervention. Again, he highlights the psychologist’s potential role in this field.

**Concluding Comments**

The great extent to which research has directed practice in this field is something which is hopefully obvious in the literature which has been reviewed in this essay. It seems incredibly varied, extending, for example, from service related evaluations (Lavender, 1985) to research into the ‘beliefs’ that people hold about their auditory hallucinations (Chadwick & Birchwood, 1994). It will be interesting, considering the varied demands on the clinical psychologist’s time, and the shortage of clinical psychologists in this field, to see how research continues develop.

It seems that the role of the clinical psychologist in rehabilitation is evolving in a range of varied areas. Throughout the literature, the importance of working within a multi-disciplinary team, and the benefits this can bring, has been stressed. However, the series of papers published in the 1995 Clinical Psychology Forum (including Pilling; Johnstone; Gournay) seems to highlight difficulties with this. Johnstone (1995) describes feeling “disillusioned with the multi-disciplinary approach” (p28). Pilling (1995) argues that “rehabilitation requires an effective team model....” and “if clinical psychologists cannot find themselves working in teams without feeling too oppressed, then (I feel) clinical psychology training is failing badly” (p41). It seems that the concept of the multi-disciplinary team has not been clearly established within the profession.

In 1986, O’Callaghan highlighted that there are “relatively few clinical psychologists available to address themselves to the many people with long-standing psychiatric problems” (p 179). This is also highlighted by the report of the clinical Standards Audit Group on Schizophrenia (DOH, 1995, cited in Gournay 1995). This clearly has implications for how existing psychologists choose to spend their time and O’Callaghan argues that psychologists get steered away from embracing ‘rehabilitation’ work by tempting individual therapies (e.g. Cognitive Behavioral Therapies). Considering the strong interest in developing individual therapies, at the
moment, it seems there is a difference in opinion within the profession on how the psychologist's time is best utilised.

It is also interesting that Conning (1991), amongst others, argues that the psychologist should be prepared to get involved with the practical aspects of an individual’s care. This seems far removed from the recognition of boundaries generally acknowledged in Adult Mental Health work and highlights the need for rehabilitation work to be clearly recognised as a speciality with its own training needs.


"Concern has been raised regarding a relationship between two clients of the same sex but of differing levels of ability living in staffed home. What are the areas that need to be considered when reflecting on this relationship, with specific reference to consent and policy issues?"
Introduction
This question will be taken to refer to staff concern regarding a sexual relationship between two adults (either both male, or both female). This would represent a typical referral to a psychologist working in a learning disability service, though most commonly such a referral would regard two male clients. The aim of this essay is to provide a discussion of the wider issues likely to influence the psychologist’s response to such an issue, and then relate these issues specifically to the referral in question. The complexity of such a referral is apparent; it encompasses a range of issues which will be discussed here.

Background issues
The background and contextual issues to this referral are worth considering. The referral itself can be seen as a reflection of concerns within a new era of service philosophies which, on the one hand, suggest that clients are entitled to develop their sexuality and relationships, yet on the other hand are bound by law to protect their clients from sexual abuse.

Attitudes towards the sexuality of people with learning disabilities have now changed over the years. It is worth briefly reflecting on the myths surrounding the sexuality of people with learning disabilities at the turn of the century. Craft (1987) highlights how they were seen as either menaces, having very strong sexual inclinations together with poor control, or as children who remain asexual. According to the latter, any ‘sign’ of sexuality would be deemed inappropriate.

In 1971 the United Nations stated that people with learning disabilities have the same basic rights as other people. There has also been a growth in the philosophy of normalisation since the 70’s, the principles of which can be described as the enabling of people to live culturally valued lives by giving them culturally valued roles (e.g. Wolfensberger, 1980, cited in Brown & Smith, 1992). Overall, this has led to a shift in how we consider the rights, including the sexual rights, of people with learning
disabilities. Yet sexual rights for people with learning disabilities is still an issue of controversy. Brown (1994) highlights that "within mainstream community living, service workers have balked at actively supporting people in 'ordinary' sexual roles, because beneath the rhetoric workers suspect that these 'ordinary' roles are off limits...part of the eugenic agenda is still alive and well in that services are supposed to act as a container and regulator of the sexual behavior of people with learning disabilities" (p130). Thus she emphasises how a change in philosophy has not necessarily led to real change at a practical level.

Parallel to the new recognition for sexual rights for people with learning disabilities, was the discovery of widespread sexual abuse within services (e.g. Turk and Brown, 1993). This had given rise to new fears regarding the safety of clients and the legal responsibility of services to ensure appropriate risk management. This demanded a reconsideration of what services should be offered.

It is useful for the psychologist to be able to question the meaning of "staff concern" (identified in this particular question) with an understanding of the myths surrounding the sexuality of people with learning disabilities, and an appreciation of the 'real' risk of abuse.

**Working with staff attitudes**

In the light of society's attitudes towards the sexuality of people with learning disabilities, it could be expected that staff attitudes will represent some of the myths described above. Back in 1967 Reiss, (cited in Bratlinger, 1987) found that those in a supervisory role tended to show a decrease in their permissive attitudes towards their clients' sexuality. Haavki and Menninger (cited in Bratlinger, 1987) found that even in the more 'progressive' homes, denial of sexuality and prohibition was still not uncommon. New staff were found to copy older staff behaviours and attitudes so that 'myths' were being perpetuated (Reiss, 1967, cited in Bratlinger, 1987).
Staff concerns, such as those highlighted in this question, should be explored and treated seriously. For example, with regards to this case of a ‘same-sex’ relationship, there may be a particularly wide-range of emotional and prejudicial responses. If concerns are rooted in a real difficulty regarding the consent and legal issues, then appropriate action will need be taken (see sections on legal and consent issues). However, if it becomes apparent that the concern stems from staff misconceptions about what is acceptable, then staff training may be more appropriate.

Craft (1987) highlights how “staff training is essential if professionals are to respond positively to the sexual needs of persons with mental handicap” p29. She describes how training sessions should take an objective look at the myths and fears surrounding the sexuality of people with learning disabilities. It should involve, she outlines, a consideration of how physical environments, living and working arrangements may shape sexual behaviour. Craft (1987) also highlights how training should aim to help staff to become more comfortable discussing sexuality with their clients, and take into account those with special needs. It should also incorporate an awareness of parental needs and common concerns.

Legal and consent issues
Although in general people with learning disabilities are usually treated the same as the general public under law, there are specific exceptions for those whose learning disability fulfills certain classifications under the Sexual Offensive Acts and Mental Health Acts. Gunn (1996) highlights these exemptions. Those described as ‘defective’ in the Sexual Offences Act 1956, and as having a ‘severe mental handicap’ by the Sexual Offences Act 1967 and also as having ‘severe mental impairment’ in the Mental Health Act 1983, cannot, in law, validly give consent. There seems to be no general agreement on how people are defined as ‘defective’, though severe impairment is often taken to mean those with an IQ below 50. However, this fails to take into account the client’s social functioning and assumes a limited definition of intelligence.
The crucial issue is consent. Consent can be described as the individual’s understanding and ability to voluntarily agree to engage in a given activity. This is difficult to establish, particularly with regard to sexual relationships where the issues are complex. For example, Gunn (1996) highlights, how when a woman or man with learning disabilities is assessed for their ability to consent to sex, they must be seen to understand the ‘nature of the act’. This can be taken to mean that s/he must be able to show an understanding of the sexual act itself, or that they require an appreciation of the significance of the sexual act, and the implications it may have for him or her. Gunn (1996) reports that the latter meaning of consent tends to be taken by the courts (R v Howard, 1965, cited in Gunn, 1996) in the cases of young women. Though this can mean protection for some, it can mean the denial of sexual rights for others, if they are not able to demonstrate their understanding to the satisfaction of the court. Professionals and staff may be wary of taking the responsibility of proving a client’s ability to consent. They may risk breaching their ‘duty of care’ if they fail to do so.

The relevant legislation is outlined (Gunn, 1996) below:

**Rape**

*Section 1 (2) of the Sexual Offences Act, 1956* states that sexual intercourse (vaginal or anal penetration) is illegal if the man or woman did not consent.

**Indecent assault**

*Section 15 of the Sexual Offences Act, 1956* states that the indecent assault has occurred if a sexual, or physical, act has taken place which is inherently indecent, was accompanied by an indecent motive or was capable of being indecent. The law states that a girl under 16, or a ‘defective’ woman, cannot give consent. The same applies to indecent assault on a man, while a man with a severe learning disability is deemed unable to give consent.
Anal intercourse

Section 12 (1) of the Sexual Offences Act, 1956, amended by Section 143 of the Criminal Justice and Public Order Act, 1994 states that anal sex is illegal if it occurred with a woman, male under 18, or child under 16. It is also illegal if it was not carried out in private. In this context, ‘not in private’ means in a public place (such as toilets), and can also include a private residence if more than two men are present. However, whether the person could be seen to consent would also be seen as relevant in sentencing.

Indecency between men

Section 13 of the Sexual Offenses Act, 1956 states that sex is illegal between two men (including masturbation) if it occurs in a public place (i.e. where the public are permitted to have access).

There are no laws referring to sex between women, arguably making lesbianism legally invisible. This includes the age of consent for sex between women. However, there are laws regarding consent in that prosecutions could be brought for indecent assault, or the corruption of a minor relating to the age of consent.

In this particular case, the concern is between two clients of the same sex. If this refers to two women in a sexual relationship, there are no laws referring specifically to this, though it could be argued that indecent assault was occurring if one of the clients was unable to give consent. With regard to a sexual relationship between two men, there are a number of considerations. First of all, both men must be deemed to able to consent to sex and sexual behaviour. As described earlier, this is a complex issue in itself. Furthermore, if it is decided that both clients are able to consent, the whereabouts of any sexual activity must be considered. If two men engage in sex or sexual activity (e.g. masturbation) in a public place or in private with more than two men present, then this is considered to be an offence. This may have implications for clients living in shared accommodation in that the privacy of any sexual activity would have to be ensured.
Risk management and police involvement

There is now evidence (Turk and Brown, 1993) to suggest that there are a substantial number of abusive incidents that occur between service users. If on collating the relevant information, the psychologist becomes aware that an incident has, or may have occurred, which according to law (outlined above) is deemed as an offence, then immediate action needs to be taken.

‘Victim’ safety needs to be ensured. This may mean that the alleged ‘perpetrator’ needs to be moved to another residential setting, though consideration should be given to the risk of others in the alternative setting. An appropriate level of supervision should be agreed to ensure safety of others and staff should have clear guidance as to what action is required of them. The ‘victim’ may also need support and counselling, and the psychologist may be involved with this input.

Police involvement should also be quickly addressed. This may seem an extreme measure if the perpetrator also seems vulnerable and has a learning disability. Determining the needs and rights of the ‘victim’ and ‘perpetrator’ is a complex task. The ‘needs’ of the perpetrator may be clear in terms of the therapeutic input they may require. However, the legal rights of the perpetrator remain unclear. The ‘alleged’ perpetrator should retain rights to a full service, However, the police may protect the rights of the ‘victim’ by limiting the freedom of the alleged perpetrator. For example, they may insist that the perpetrator be moved away from living with the ‘victim’. As part of the multi-disciplinary team, the psychologist would hope to be involved in the careful consideration of such issues. The team would be guided by legal experts.

Policy

The general aims of the law seem to be to prevent exploitation, discourage relationships with unequal power structures and to limit people with severe learning disabilities to having sexual relationships with someone of a similar intellectual ability. However, the ambiguity around these issues, discussed in the ‘legal and consent section’, highlights the
need for health trusts and care agencies to develop clear policies and procedures to address sexuality issues. For example, Sundrum & Stavis (1994) points out that in American law, if a ‘carer’ allows a client to have a sexual relationship when the client is not considered to be competent to consent, a ‘carer’ could be charged with the facilitation of ‘statutory rape’. Though this refers to American law, the same issues apply within British law. In the absence of a clear policy, staff are likely to be faced with situations which they may respond to according to their own personal judgments on issues of sexuality. This can lead to inconsistent management which can be confusing and unjust for the client, as well as leaving the ‘carer’ at risk of infringing the law.

Commissioners and providers of services tend to view sexuality and abuse issues as problems to be ‘managed’ (Cambridge and MCarthy, 1997), and policies are derived as a way of managing the problem on a day-to-day basis. Cambridge argues that it is more helpful to think of policy as a way of empowering people with learning disabilities to have more informed sexual choices and to learn from their experience. He argues that many sexually inappropriate and abusive behaviours are products of the social and physical environments constructed by services which treat clients’ sexuality in a negative way. If services were focused on helping to nurture clients’ sexuality in a safe way, inappropriate behaviours may be reduced.

Cambridge & MCarthy (1997) argue that a policy should incorporate clear guidelines which are the result of debate and discussion throughout the organisational hierarchy. It should contain positive statements of rights, within the context of the law, which should be regularly reviewed. His report on the development of a sexuality policy for a learning disability provider service describes a consultation process which involves parents, clients and staff. The policy reflects a variety of views and interests expressed and included the following areas:
• masturbation, including guidance on the teaching of masturbation
• sexual abuse and exploitation, including clear definitions of abuse and informed consent
• personal care and respect
• involving relatives
• people with severe learning disabilities; guidelines for determining consent
• same sex relationships and acceptance of equality
• pornography; clarity about the use of explicit materials
• contraception
• sex education
• privacy and confidentiality
• HIV and sexual health

This particular policy was implemented via staff training sessions, designed to give staff detailed input on the main areas covered by the policy.

With regards to the referral identified in the question, it would be important for the psychologist and ‘care’ staff to refer to policy for guidance. It may be necessary to arrange a multi-disciplinary meeting if there is any ambiguity with regards to policy.

Sexual health issues
Sexually transmitted diseases, including AIDS, is also a serious issue to consider. The question describes a ‘same sex’ relationship, which could be male or female. A lesbian relationship is considered low risk for sexually transmitted diseases. However, sexually active gay men have been found to be at greatest risk with regards to AIDS, and there is still some controversy surrounding the best approach for services to take regarding this ‘risk’. Cambridge (1997) argues for the ‘re-homosexualisation’ of AIDS for men in services for people with learning disabilities, meaning that the greater risk should be openly acknowledged. Particularly at risk, for example, are those who participate in
‘cottaging’ (‘casual’ sex in public places). This raises issues around safe sex, consent and risk management.

Cambridge (1997) argues not being able to appreciate HIV risk, or knowing how to carry out safe sex, is a barrier to them being able to consent to sex. He states that “in relation to HIV risk and safer sex, the person would need to know about HIV and AIDS, the health implications and social consequences of unsafe sex, how HIV is transmitted and what happens to someone infected with HIV. Such basic knowledge is a prerequisite to assessing informed consent for sex and safer sex” p 429.

The question of whether a HIV antibody test is appropriate is also an important issue. Cambridge (1997) again argues that informed consent would require a basic understanding of HIV infection, an appreciation of what the results would mean, and what it means to have an AIDS related illness. Furthermore, an understanding of the implications of a positive result for future lifestyle would also be required to be satisfied that consent was given.

With regards to this case, if the clients are male and it has been established that the clients are sexually active, individual assessments should be carried out to establish the clients’ sexual knowledge and understanding of safe sex. If it is a possibility that at least one of the clients concerned is unable to demonstrate an understanding of the issues outlined above, then the psychologist may be involved in multi-disciplinary risk management decisions. Various interventions may be appropriate. For example, it may be decided that the client should be given condoms regularly if they are able to use them appropriately, but would have difficulty purchasing them independently. Other sex education interventions may be appropriate, such as teaching the client how to use a condom (e.g. using pictures or a model penis).
Sex education

In the past, misconceptions about people with learning disabilities’ ‘asexuality’ has led to a lack of recognition of the need for sex education for this client group (e.g. Shaman, 1986, cited in Sundram and Stavis 1994). Craft and Craft (1981) argue that the majority of people with learning disabilities need help understanding their own sexual development. Lack of sex education, therefore, leaves clients vulnerable to sexual abuse and exploitation by others.

McCarthy (1996) recently found that the most common referrals for sex education were men in their 20s - particularly those who were at the milder range of the learning disability spectrum. In response to this need, there are now a number of resources and models for teaching people with learning disabilities for use in individual and group work e.g. ‘Sex and the 3 R’s’. (McCarthy & Thompson, 1992); ‘Living Your Life’, (Craft, 1991), ‘Picture Yourself’, Dixon & Craft, 1992). These resources typically include pictures and photographs to assist clients in their understanding, as well as exercises of a more practical nature for clients to work through with peers in groups. The psychologist may also be involved in couple therapy, or may advise staff how to work with clients who may confide in them over such issues. Again, this work can be assisted by materials available.

However Craft and Craft (1985) highlight that sexual education is also important for those with severe learning disabilities. Paying attention to the individual’s sexual development does not necessarily require verbal communication. For example, behaviour modification programmes can be used to teach specific self-care skills and to shape behaviours, such as masturbation, to occur in appropriate places. Consideration should also be given to the environment, for example, to ensure accessibility to private places for the individual.

With regard to question raised in this essay relating to concern regarding a relationship between two clients of the same sex, intervention would depend upon the level of
learning disability of the clients and any learning need identified. Urgent and specific needs may be identified (e.g. how to use a condom). It is noted that this is a relationship between two clients of the same-sex who may benefit from counselling which takes into account the social issues relating to gay and lesbian relationships. There are a lack of teaching and educational resources that address homosexual relationships, and the clients may need help gaining access to mainstream gay or lesbian resources.

Final Comments
A number of issues have been addressed here which highlight the complexity of such a referral. It seems that the law does not necessarily facilitate the role of staff and professionals when working on issues of sexuality for clients with learning disabilities. Such work demands a balanced consideration of the sexual rights of the individual, the duty of care of the service provider, as well as the legal implications of any decisions which are made.
A2: Bibliography


Consider the Utility of the Diagnostic Classification of Attention Deficit Disorder.

Child and adolescent Essay

Submitted January 1998 (Year II)
Introduction

The literature over the last fifteen years reflects much controversy over the concept and diagnosis of Attention Deficit Disorder (ADD) (e.g. Hinshaw, 1994; Golden, 1992; Campbell & Werry, 1986; Meents, 1989; Bloomingdale, 1984). Generally, Attention Deficit Disorder (ADD) refers to a cluster of behavioural symptoms focusing around overactivity, impulsiveness and inattentiveness. This specific label (ADD) was used in the third edition of the Diagnostic and Statistical Manual (DSM III, American Psychiatric Association, APA, 1980) in 1980, though the concept has evolved under various guises including, hyperkinesis, hyperactive child syndrome, and minimal brain dysfunction. The most recent classifications for this disorder are currently labeled as ‘Attention Deficit Hyperactive Disorder’ (DSM IV, 1994, appendix A3:1) and Hyperkinetic Disorder (ICD10, WHO 1992, appendix A3:2).

Establishing the utility of any diagnostic classification system is a complex issue. In the case of ADD it is perhaps more so as the notion of ADD is currently best understood as an evolving and heterogeneous concept (BPS, 1996). With regards to this essay, the question will be taken to relate to the empirical evidence which may exist in support of the diagnostic classification for ADD, and will not consider the ‘meaning’ that diagnosis may have for the parent and child. Firstly criteria for the evaluation of a classification system will be established. These criteria will then be discussed in relation to the evidence for ADD. Finally, recent attempts to validate the utility of the diagnostic classification of ADD will be reviewed. It is argued that in addressing this question it is relevant to consider the evolution of ADD across the various classifications that have been used. The notion of Attention Deficit Disorder will be referred to as ‘ADD’ throughout this essay unless referring to the specific ‘label’ used by a classification system.
Criteria for Evaluation of Classification Systems

Before considering the detail of evidence for and against the utility of the diagnostic classification of ADD, it is useful to establish the criteria required for a ‘useful’ classification system. Rutter (1978, cited in Schachar, 1991) described how “a diagnostic entity must differ in aetiology, course, characteristics, or treatment response from those of other child psychiatric entities as well as from normality” (p157). Quay (1986) also provides a useful introduction to the classification of disorders, outlining a criteria for evaluating a classification system. The main crucial points are outlined below:

i) A Clear and Operational Definition. The features of the classification must be clearly and operationally defined with features existing “as a cluster of covarying characteristics, observable with regularity in more or more situations by one or more methods of observation” (Quay, 1986, p2).

ii) Reliability. This is also a crucial issue. There should be a consistent assignment of an individual to a category, or place on a dimension, with that assignment being stable over time. There should also be inter-clinician agreement, and agreement between different ways of measuring the disorder.

iii) Validity. This is also a requisite. This should include construct validity (i.e. there should be a positive correlation between other measures of the same thing). Quay (1986) argues that “Validity determines the extent to which the system can adequately serve those functions of nomenclature, information retrieval, description, prediction and theory building” (p3).

Attempts to classify ADD as a distinct entity have reflected difficulties with all three of the points described above. Though it is recognised that these points are inter-related, the key issues apparent in the literature will now be discussed in relation to these three crucial criteria.
i) A Clear and Operational Definition

**Classification of ADD**

The features of ADD have proved difficult clearly and operationally to define. This is reflected in recent attempts to establish a classification system for ADD which have focused on describing the behavioural features of the disorder. The Americans developed the Diagnostic and Statistical Manual (DSM) with DSM-II (1968, APA. cited in Lahey, 1994) recognising those children with maladaptive levels of inattention, impulsivity and motor activity. However, DSM-III (APA, 1980) allowed the diagnosis of ADD for those *without* hyperactivity and introduced the label Attention Deficit Disorder. In other words, it allowed diagnosis for those with dysfunctional levels of inattention impulsivity and motor activity *and* for those with dysfunctional levels of inattention and impulsivity, but normal levels of activity. However, the introduction of DSM-IIIR (APA, 1987) changed the criteria again. Now under the title Attention Deficit Hyperactivity Disorder (ADHD), this combined the symptoms of impulsivity, inattention and hyperactivity into a single symptom list. Lahey (1994) argues that this "*effectively eliminated the DSM III subtype of attention deficit disorder without hyperactivity*" (p1673). This gave rise to new and growing controversy.

The recent field trials for DSM IV (e.g. Lahey, Applegate, McBumett et al, 1994) set out to try and resolve some of the controversy on the dimensional changes between DSM-III (1980) and DSM-IIIR (1987). Evidence suggested, which will be discussed below, that ADD was not a unitary dimension, as suggested by the single symptom list in DSM-III. Rather, there was evidence to support two dimensions of symptoms; that of inattention and hyperactivity-impulsivity. This allows for three subtypes: those who are predominantly inattentive, those who are predominantly hyperactive-impulsive, and a combined type for individuals who display both sets of symptoms.

To complicate matters further, in Europe and Britain, there has been a tendency to use the International Classification of Diseases system (ICD), the diagnostic classification
system published by the World Health Organisation (WHO). Their current diagnostic classification for ADD is known as Hyperkinetic Disorder, published in the ICD 10 manual (WHO, 1992). The main diagnostic difference between this and DSM-IV (1994, APA) seems to be in the greater pervasiveness and persistence of symptoms required for a diagnosis of Hyperkinetic Disorder. Symptoms are required on three axes including at least three hyperactivity symptoms, one impulsivity symptom and a minimum of at least six inattention symptoms. DSM-IV, in comparison, requires only that six inattention and/or six impulsiveness/hyperactivity symptoms are impaired. However, though there have been major differences between ICD and DSM classifications, the current DSM-IV reflects the systematic effort taken to make these systems more transferable (Barkley & Shelton, 1994). The onset and duration criteria for DSM-IV and ICD10 are nearly identical, with the symptom lists having many items in common. Both classifications now demand that the symptoms be observed across more than one setting, which has been a major difference in the past.

**Etiology**

Unfortunately, there is, as yet, no clearly supported hypotheses about the etiology of ADD. This adds to the difficulty in clearly describing and explaining the notion of ADD. There is increasing acknowledgment that ADD is not a homogenous syndrome and that there may be several etiologic routes (e.g. British Psychological Society (BPS), 1996; Hinshaw & Erdhardt, 1991). Treatment outcome studies, which will not be reviewed here, have also produced inconsistent results which have not helped resolve this debate (see Schachar, 1991, for a review).

Hypotheses in the past that have focused on neurological mechanisms, genetic, environmental and constitutional factors. Campbell & Werry (1986) give an overview of these theories. It seems that despite the early focus on neurological impairment in the 1950’s and 60’, there was little evidence to support this theory. Genetic-familial theories also had difficulties producing data which differentiated ADD from other disorders, with few studies looking at family pathology. It seems that most recent theorists have argued
for multiple etiologies (e.g. Barkley & Shelton 1994). The recent BPS working paper (1996) also warns that there may not be one single biological or psychological mechanism causing the difficulties associated with ADD, and to aim for such a unitary explanation may be unrealistic.

Furthermore, the core features of ADD (attention, impulsivity and hyperactivity) are not homogeneous, unitary constructs. There are a number of reviews which consider the data on the core features of ADD (e.g. Hinshaw, 1994, Hooper, Hynde, & Mattison 1992; Schachar 1991; Guevremont & Barkley, 1994; Sergeant & Scholten, 1985; Campbell & Werry, 1986), which will not be considered in detail here. However, it is now commonly acknowledged that 'attention' and 'impulsivity', are multidimensional constructs, which has made theories regarding these deficits in children particularly difficult to establish. There is also difficulty establishing attention and hyperactivity as independent dimensions, with factor analysis studies revealing overlap (e.g Milch & Kramer, 1985 cited in Guevremont & Barkley, 1994). This raises the question of whether it is helpful to consider attention and hyperactivity as separate dimensions, or whether it would be better to consider them as different facets of the same thing.

ii) Reliability

Prevalence

The inconsistency of prevalence rates for ADD between studies and nations poses significant problems for establishing the reliability of the diagnostic classification for ADD. The assignment of an individual to a diagnostic category should be consistent, and prevalence rates should therefore be expected to be similar between studies. It is noted, however, that Hyperkinetic Disorder (ICD 10) has the reputation of identifying those cases which are more severe, due to the more stringent criteria highlighted above, with prevalence rates of 0.5% to 1% in the child population (Hemsly, 1995, cited in BPS, 1996). In the USA and Canada, where the DSM-III criteria has been used, prevalence rates are greater - with reports rating from 2% to 19% (Costello, 1989; Szatmari, 1989,
cited in BPS, 1996). It is hoped that the current use of DSM-IV and ICD 10 will produce more consistent results

**Assessment**

Quay (1986) highlights how there should be agreement between different ways of measuring the disorder. Establishing valid and reliable assessment tools has proved to be one of the main challenges facing the research and practice within ADD. A diagnostic classification is not much use without reliable ways of measuring its components of the disorder. The assessment measures should have content (i.e. representative of the domains of impulsivity, attention and impulsivity), criterion, and construct validity. The BPS (1996) also highlight the need for assessment tools to take into account ethnic groups due to the recent recognition that there is a higher prevalence rate in children from minority and ethnic groups. This is possibly due to different cultural expectations of behaviour rather than due to genetic/neurological factors. Assessment generally has proved particularly difficult with regards to this disorder due to the heterogeneity of ADD and the often fluctuating presentation of inappropriate behaviour.

Standardised rating scales have commonly been used as assessment tools for ADD (see Guevremont & Barkley, 1994; BPS, 1996 for a review). They are attractive to researchers due to their ease of administration, the definition of the problem they give and the minimisation of subjectivity when administered to large numbers. However, the sole use of rating scales has now been criticised (e.g. BPS, 1996; Campbell & Werry, 1986) as they do not correspond to DSM/WHO criteria and used in isolation have proved invalid. It has now been acknowledged that the wide use of these scales has probably contributed to lack of consistency within the research literature (e.g. Schachar, 1991; BPS 1996). For example, Schacher (1991) argues that the use of rating scales has resulted in a high degree of correlation in those studies which attempt to distinguish patterns of correlates of ADD and conduct disorder. It is now recommended that assessment should include a variety of methods of assessment (possibly including rating scales as an initial screening tool and clinical observation) and a variety of assessors
across a range of the child’s normal settings (Campbell & Werry 1986; BPS 1996). The BPS (1996) now recommend that the assessment procedure should also involve questioning the children themselves.

**Inter-reliability**

The difficulty establishing assessment tools also seems to reflect in the low inter-reliability of diagnosis. Achenbach’s (1987) meta-analytic review (cited in Hooper et al. 1992), showed that there was only moderate correspondence between two equivalent assessors’ rating of emotional and behavioural difficulties (r =.6), with a low correlation between the child’s self report and the assessor (r =.22). This lack of inter-diagnosis reliability poses difficulties for the justification of the utility of this particular diagnostic classification, and casts doubt on the ‘type’ of children who have been selected for various studies. Hopefully, a shift in the way assessments are conducted will show an improvement with regards to this.

**iii) Validity**

Attempts to establish the validity of ADD has usually focused on attempts to clarify the distinction between ADD and other childhood psychopathology - particularly with that of Conduct Disorder (CD). It is worth pointing out that the design of studies effects the how much they can tell us about validity. Schacher (1991) highlights how most of the studies have been correlational or clinical comparison studies and these have been attempting to isolate specific behavioural characteristics of ADD. Comparison studies assume that ADD is a disorder, with extremes of behavioural symptoms of ADD defining it as a valid entity. These studies have usually compared ADD children with ‘normal’ children. Though these studies can be useful in defining likely characteristics, it is limited in determining validity because they can obviously not tell us anything about distinguishing characteristics of ADD from other disorders. Correlational studies, however, have more potential for providing partial tests of validity. They approach ADD as a dimension of disturbance, with studies attempting to identify the associates of the qualitative measures of ADD. Though studies which show a distinction between ADD
and CD can not prove the validity of ADD, validity can certainly not be established if mixed-comorbid cases were consistently spread across the populations of other psychopathology. It is, therefore, worth reviewing the results of these studies.

Again, the evidence seems to be inconclusive (e.g. Schachar, 1991; Sabatini & Vance, 1994). For example, Hinshaw (1987) reviews both factor analysis studies and subgroup studies (i.e. those which attempt to separate and validate subgroups of children) which are concerned with clarifying the distinctness between ADD and CD in an attempt to establish the external validity of these psychopathologies. Hinshaw (1987) selected 60 factor analyses studies between 1969 and 1984. There were mixed results - not surprising considering the time span over which the studies were carried out and the likelihood of them using different assessment tools and diagnostic criteria. However, he found that most studies (e.g. Clarfieds, 1974; Achenbach, 1978; McGee, 1985, cited in Hinshaw, 1987) have found orthogonal factors of hyperactivity/attentional deficits versus aggression/conduct problems. It is argued that those that those who did not find positive results (e.g. Eisenberg, 1975; Langner, 1976, cited in Hinshaw, 1987) did so due to restricted item pools.

Unfortunately, a consistently high level of association was found between factors across the two domains. This casts doubt on the independence of hyperactivity/attention deficits and conduct disorders aggression. This, again, raises the question of rating scales and the specificity of their worded items. The Conner’s Parent and Teacher and Rating Scale (1970, 73, cited in Hinshaw, 1987) was reported to demonstrate particularly high inter-correlations between conduct disorder factors and hyperactivity factors. However, Loney, 1978; 82, cited in Hinshaw, 1987) went on to revise the items selected, demonstrating that this lowered the correlations between factors. This work holds promise and highlights the need for measures that are sensitive and specific to ADD.

Hinshaw (1987) also reviews those studies dealing with the separation and validation of subgroups of children with ADD. This has usually been done by establishing ‘cutoff’
scores on relevant factors. The results of these studies are again ‘mixed’. It seems that there is a high overlap between conduct disorder and aggressive children (e.g. Sandberg, 1972; 1980, cited in Hinshaw, 1987). However, the subgroups of externalizing disorders displayed differential patterns of association with some key variables, showing promise. Yet, disconcertingly, Hinshaw (1987) reports no clear evidence for differential treatment outcome for these groups.

Hinshaw (1987) concludes that, according to strict medical criteria, ADD cannot be confirmed to be a valid syndrome/disorder. The strength of this review is the selection procedure used (e.g. studies with at least 100 subjects) and the number of studies selected. However, factor analysis can only reveal factors to account for the correlations between variables that have been measured. As described earlier, the fact that attention and hyperactivity are not unitary constructs makes this difficult. In addition, the wide range of selection procedures, assessment measures and diagnostic criteria used in the studies between 1969 and 1984 would make it difficult to draw any firm conclusions.

**Recent Attempts to Validate the Diagnostic Classification of ADD**

It is worth considering recent attempts to validate the diagnostic classification of ADD as much of the recent work has emerged in response to the inconsistencies in the research described above. Unfortunately the ICD 10 (WHO, 1992) criteria is not empirically validated, but determined mainly by committee consensus (Barkely & Shelton, 1994). However, the intention of the DSM-IV was to develop a more stringent criteria based on the results of research over the years. Recent studies have been supportive of the DSM-IV (APA.1994) criteria (e.g. Lahey, 1994; Sabatino, 1994; Milberger, Biederman, Faraone, Murphy & Tsuang 1995). As the most recent ‘trial’ of the utility of the diagnostic classification of ADD, it is worth considering the current evidence and research methodology to support it.

Frick, Lahey, Applegate et al. (1994), tested the predictive utility of symptoms in the DSMIV trials for the 'Distruptive Behaviour Disorders', referring to Oppositional defiant
disorder, conduct disorder and ADHD. The aim was to improve reliability and validity of the diagnosis by analysing the diagnostic utility for each symptom using positive and negative predictive power. They found that both symptoms of inattention and hyperactivity and impulsivity had high predictive utility (highly predictive of reaching the threshold number of symptoms). There was little variance across age and gender for either the ‘inattention’ or hyperactivity-impulsivity symptoms.

The methodology of this study is rigorous. For example, the assessment procedures are clearly specified with the authors using the Diagnostic Scale for Children (DISC-2), (Shaffer, 1992, cited in Frick et al.1994), which relates to DSMIII-R and has reportedly been tested for its inter-rater reliability, and validity. The authors were clear to specify extra symptoms selected for possible DSM-IV criteria. It is also clearly specified that symptoms were classified as present if reported by either the teacher or parent. This is valuable information for further cross study research.

The results are clearly useful for the clinician and researcher. Frick et al. (1994) argues that it helps to conceptualise the predictive relationship between symptom and diagnosis and for clarifying any core features and their relevant weight in diagnosis. However, its utility should be considered in context. The study demonstrates the predictive utility of symptoms according to a certain criteria (i.e. DSM III-R), but does not prove its construct or external validity. The predictive value of a symptom is also dependent on how reliably it is assessed. For example, the identification of a symptom according to the DSM-IV (APA.1994) criteria depends on how one interprets the word “often” used in the manual. Again, this highlights the need for valid and reliable measures.

Lahey’s (et al) report (1994) on the field trials for DSM-IV also adds hope for a more consistent research in the future. He reports on the optimal diagnostic thresholds for the two new symptoms’ dimensions (i.e. inattention and hyperactive-impulsivity) and reports on the validity of the three new subtypes identified in DSM-IV.
The sample consists of 380 youths (aged 4-17) interviewed with the DISC-2 (as above) as well as a clinician’s validation diagnosis being obtained. Rigorous statistical methods (Kappa analysis) were used to determine to diagnostic thresholds for DSM-IV. It was on the basis of these analyses that the authors found support for the three subtypes of DSM-IV i.e. that an individual can be diagnosed with ADD by displaying six or more inattention symptoms, six or more hyperactivity-impulsivity symptoms or both. They report a clear improvement on the test-retest reliability of the DSM-IV ‘inattentive’ type over that identified by the DSM-III.

It is noted that neither age or onset is taken into account in these trials. However, these results offer a number of positive steps forwards. The new DSM-IV criteria will hopefully reduce the heterogeneity of the disorder, which has been apparent in the literature, by re-operationalising the ‘inattentive’ subtype. Furthermore, these criteria seem to be better at identifying girls - who seem to be emerging as predominantly the ‘inattentive’ type. Further research is needed to test other forms of validity such as any differences in etiology, clinical course and response to treatment between the three subtypes. Although this does not prove the validity of ADD as a separate entity, the rigorous approach used by these two recent trials do give promise for the increasing utility of the diagnostic classification.

Final Comments
It seems clear that the utility of the diagnostic classification of ADD cannot be established, as yet, according to the criteria outlined by Quay (1986) earlier in this essay. Yet efforts to categorise child psychopathology are relatively new. Early efforts to categorise ADD had little empirical evidence to support them, yet the DSM-IV classification for ADHD is based on rigorous methods and offers more hope for considering ADD as a homogeneous disorder. However, this hope needs to be taken with caution. It may be that research reveals further inconsistencies. Hinshaw (1987) asks whether we should expect behavioural categories to conform to the criteria that we expect of medical disorders. Oltmann (1980, cited in Hinshaw), for example, viewed
schizophrenia as a scientific construct rather than a disorder. It may be revealed that it is
more realistic to regard ADD as a scientifically testable construct which displays
important patterns of association, rather than a 'medical' disorder.
A3: Bibliography


Appendix A3:1

DSM-IV Criteria for Attention Deficit Hyperactive Disorder (ADHD)

A. EITHER (1) OR (2)

1) Six (or more) of the following symptoms of inattention have persisted for at least six months to a degree that it is maladaptive and inconsistent with developmental level.

INATTENTION

a) Often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities.
b) Often has difficulty sustaining attention in tasks or play activities.
c) Often does not seem to listen when spoken to directly.
d) Often does not seem to follow through on instructions and fails to finish school work, chores or duties in the workplace (not due to oppositional behaviour or failure to understand instructions).
e) Often has difficulty organizing tasks and activities
f) Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework).
g) Often loses things necessary to tasks or activities (e.g. toys, school assignments, pencils, books, or tools).
h) Is often distracted by extraneous stimuli.
i) Is often forgetful in daily activities.

A (2) Six, or more of the following symptoms of hyperactivity-impulsivity have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level.

HYPERACTIVITY

a) Often fidgets with hands or feet, squirms in seat.
b) Often leaves seat in classroom or other situations in which remaining seated is expected.
c) Often runs about or climbs excessively in situations where it is inappropriate (in adolescents or adults this may be limited to subjective feelings of restlessness).
d) Often has difficulty playing or engaging in leisure activities quietly
e) Is often “on the go” and acts as if “driven by a motor”
f) Often talks excessively

IMPULSIVITY

g) Often blurts out answers to questions before the questions have been completed.
h) Often has difficulty waiting in lines or awaiting turn in games or groups situations
i) Often interrupts or intrudes on others (e.g. butts into others’ conversations or games)
j) Some symptoms that cause impairment were present before age 7.
k) Some symptoms that cause impairment must be present in two or more settings (e.g. at school, work, and at home).
l) There must be clear evidence or clinically significant impairment in social, academic or occupational functioning.
m) Does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder.

Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type: If criterion A (1) is met by not criterion A (2) for the last 6 months.

Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive /Impulsive Type : If criterion A (2) is met but not criterion A (1) for the past 6 months.

Attention-Deficit/Hyperactivity Disorder, Combined Type: If both criteria - A (1) and A (2) - are met for the last 6 months.
Appendix A3:2

ICD 10 Criteria for Hyperkinetic Disorder

A. Demonstrate abnormality of attention and activity at home, for the age and developmental level of the child, as evidenced by at least 3 of the following attention problems:

1. short duration of spontaneous activities
2. often leaving play activities unfinished
3. over-frequent changes between activities
4. undue lack of persistence at tasks set by adults
5. unduly high distractibility during study, e.g. homework or reading assignments

and at least 2 of the following activity problems:

6. continuous motor restlessness (running, jumping etc.)
7. markedly excessive fidgeting and wriggling during spontaneous activities
8. markedly excessive activity in situations expecting relative stillness
9. difficulty in remaining seated when required.

B. Demonstrate abnormality of attention and activity at school or nursery, for the age and developmental level of the child, as evidenced by at least 2 of the following attention problems:

1. undue lack or persistence at tasks
2. unduly high distractibility, i.e. often orientating towards extrinsic stimuli
3. over-frequent changes between activities when choice is allowed
4. excessively short duration of play activities

and by at least two of the following activity problems:

5. continuous and excessive motor restlessness (running, jumping, etc.) in school.
6. markedly excessive fidgeting and wriggling in structured situations.
7. excessive levels of off-task activity during tasks
8. unduly often out of seat when required to be sitting

C. Directly observed abnormality of attention or activity. This must be excessive for the child's age and developmental level. The evidence may be any of the following:

1. direct observation of the criteria in A or B above, i.e., not solely the report of parent and/or teacher
2. observation of abnormal levels of motor activity, or off-task behaviour, or lack of persistence in activities, in a setting outside home or school (e.g. clinic or lab.)
3. significant impairment of performance on psychometric tests of attention

D. Does not meet criteria for pervasive developmental disorder, mania, depressive or anxiety disorder.

E. Onset before the AGE OF SIX YEARS

F. Duration of AT LEAST SIX MONTHS.

G. IQ above 50.

NOTE: The research diagnosis of hyperkinetic disorder requires the definite presence of abnormal levels of inattention and restlessness that are pervasive across situations and persistent over time, that can be demonstrated by direct observation, and that are not caused by other disorders such as autism or affective disorders. Eventually, assessment instruments should develop to the point where it is possible to take a quantitative cut-off score on reliable, valid, and standardized measures of hyperactive behaviour in the home and classroom, corresponding to the 95th percentile on both measures. Such criteria would then replace A and B above.
What specific factors need to be considered in assessing and treating depression in older people? In what ways do therapeutic approaches need to be adapted to meet the needs of this client group? Discuss evidence on the emotional impact of such work on therapists.
Introduction

It is only recently that there has been increasing awareness of the potential use of psychological therapy with older adults (e.g. Landreville & Gervais, 1997; Knight, 1996; Morris & Morris, 1991), with most of the investigations being carried out on treatments for depression. Along with a growing awareness of the success of treatments has been an increasing understanding of the emotional demands and prejudices of therapists with regards to working with this client group. This essay will firstly discuss the prevalence, presentation and assessment of depression in this client group. Secondly the developmental and social issues specific to this cohort will be addressed. This will be followed with a review of the specific ways in which psychodynamic, cognitive and behaviour therapies have been adapted for older adults and their efficacy. Finally, the ways in which the emotional impact of such work on therapists has been conceptualised, and the evidence for this will be considered.

Prevalence and Presentation

Prevalence

It is now acknowledged that depression is one of the most common mental health problems for older adults (e.g. Landreville & Gervais, 1997; Knight 1996; & Blazer, 1982). Blazer (1982) reviews the results of epidemiological studies between 1965 and 1980. Interestingly this revealed that studies which used symptom checklists to identify those who were depressed in the community revealed rates from between 10% and 45%, whereas those studies which used psychiatric interviews to identify depressed individuals revealed lower rates of between 0.5% and 34%. Suicide, which is closely associated with depression, is acknowledged to be at its highest rate during this life stage (e.g. Knight, 1996; & Blazer, 1982).

Presentation

The discrepancies in prevalence rates, which Blazer (1982) revealed, reflect the lack of standardised research methods. However it also reflects the complex presentation of
depression in this client group and also the difficulties clinicians have in reliably diagnosing it.

Crawford, Prince, Menezes & Mann (1998), for example, found that GPs were aware of depression in only 50% of their older adults. The DSMIV criteria (appendix A4:1, APA, 1994) lists the criteria for depression. However as Blazer highlights in his outline of 'symptoms and signs of depression in late life' (see appendix A4:2), the presentation of depression in older adults can appear under various guises. For example, older adults may not be 'psychologised' in their thinking to label their mood as 'depressed', complaining more of emptiness and manifesting physical symptoms such as clinging, crying and stooping. Feelings of hopelessness may be more entwined with the reality of new hardships they face and with pessimism about the future. Sexual difficulties are less often a complaint in depressed older adults.

A number of assessment tools have been devised reviewed by Blazer (1982, see appendix A4:3) which attempt to incorporate the various presentations of depression. However, as can be seen in the table, the scales cover a variety of combinations of symptoms. Although using such a scale should increase inter-rater reliability for clinicians using the same scale, the lack of consistency between them makes criterion reliability difficult to establish.

Differential Diagnosis
The co-existence of depression with other medical problems and prescribed medication can also add to the difficulty of differential diagnosis. Pseudodementia is a concept used to describe the fact that functional or non-organic disorders can present as dementia. For example, depressed individuals report difficulties in concentration and short attention, yet do not have the same deficits in performance on other cognitive tasks as the demented individual. McClean (1987) reviews the literature on this and reports that depression accounts for almost 60% of reported cases of pseudodementia. The term serves as a reminder for clinicians to be aware of the similarities and dissimilarities
between the two. Hypochondriasis is also frequently diagnosed among older adults (Busse & Blazer, 1980 cited in Blazer, 1982), which essentially refers to distorted interpretations of bodily symptoms leading to exaggerated fears of having a serious disease. A depressed mood is commonly associated with this disorder. However, unlike depression, the individuals tend to insist on discussing the ailments to the exclusion of other personal issues. They commonly follow a chronic and more consistent course and tend to present without suicidal thoughts (Blazer, 1982). Sleep disturbance is also a common complaint for older adults, with frequent awakenings being reported and restless sleep (Blazer, 1982). This also needs to be distinguished from the sleep disturbance being associated with depression according to DSMIV criteria.

Loss

Furthermore depression commonly occurs after the loss of family or a friend, with older adults typically experiencing three or more deaths of personal friends or family in the two or three years prior to the onset of depression (Knight, 1996). It is generally acknowledged that distress is an inevitable and necessary part of the bereavement process (e.g. Knight, 1996). However, this does not explain why some become depressed and others do not. Loss can also be in the form of the loss of physical abilities and health. Landreville & Gervais (1997) highlight how the relationship between disability and depression is reciprocal, with higher levels of disability being linked with an increase in depressive symptoms.

In all, the assessment of depression in older adults seems a complex task for the clinician. It would also seem that a careful history and observation, the use of measures and neuropsychological assessment would be essential in many cases, particularly when the client may not articulate that they are depressed. It also raises questions about how the clinical psychologist may raise the awareness of other carers and professionals in recognising depression, bearing in mind that the older client is less likely to recognise themselves as depressed and thus less likely to ask for help.
Cohort Adaptations

Changes in Cognitive Skills

It is now acknowledged (e.g. O'Leary & D'Alton (1996); Knight, (1996); & Morris and Morris, (1991) that there are cognitive changes that commonly occur in this age group. Knight highlights the slowing down of cognitive processes that occurs within normal ageing, which may be exaggerated with depression. The working memory reduces in its capacity to process information and the therapist is advised to slow down the pace of the conversation. However, memory for well organised material remains unimpaired (e.g. Craik & Trehub, 1982, cited in Knight, 1996) and it is advocated that this, as well as older adults' 'expertise' through life experience, should be well-used. Although this makes instinctive sense and is based on information processing theory, there are no systematic studies which have investigated older adults processing within the therapeutic process. Gallagher-Thompson, Hanley-Paterson & Thompson (1990) investigated the efficacy of psychological therapies for depression with older adults, finding an equivalent rate of success to that of the younger adults. Interestingly they used only sixteen to twenty sessions of therapy, the equivalent number of session commonly used with younger adults (Fennell, 1996). The length of session times however, were not reported. It may be that the slower pacing during the session means that the sessions need to be longer, even though the number of contact sessions does not need to be extended. More research is needed to clarify this.

Social/Cultural Issues

It is worth considering, briefly, cohort differences that are aside from developmental changes. The socio-economic climate that a cohort's life-span covers, and differences and their educational experience and values can be highly significant for the therapist to understand (O'Leary & D'Alton (1996); & Knight, 1996). Essentially it is important for the therapist to recognise what is normative for the individual; and this includes everything from vocabulary to values. Knight (1996) also argues that the therapist should be aware of the social prejudice that older adults experience. This can be important in
terms of understanding the depressed individual’s negative view of the world, and to what extent it is grounded in reality.

**Adaptations of Psychological Therapies and their Efficacy**

Three models (psychodynamic, behavioural and cognitive), and ways in which they have been applied to older clients, will be discussed. The outcome literature regarding these will then be reviewed.

*Psychoanalytic/Psychodynamic Approaches*

It was within the psychoanalytic tradition that the first significant statements about working with older adults were made, and yet it is now the least researched approach with older adults. Psychoanalysis approached this age group with a retrospective view by explaining current presentation in terms of childhood experiences. However, Freud (1905-1953, cited in Knight, 1996) held the view that by the time an individual reaches fifty, they lack the flexibility and plasticity to engage in therapy. Abraham, in 1949, (cited in Blazer, 1982) offered a more positive response to this age group claiming that it is the age of neuroticism rather than the chronological age of the client which is significant. The central debate at this time seemed to be regarding the rigidity, susceptibility and flexibility of this age group.

As psychological theories developed from long-term psychoanalytical to psychodynamic, there has been more of emphasis on the pertinence of transference and countertransference issues when working with older adults. This will be discussed in more detail later (see ‘Emotional Impact of Work’). However, what is significant is that this has led to the introduction of ‘brief psychodynamic’ therapy which has given more options for therapists who commonly seem to feel that short-term work is appealing to this age group (e.g. Blazer, 1982; O’ Leary & Alton, 1996).
Malan (Malan, 1979 cited in Molnos, 1995) offers a model for brief psychodynamic therapy postulating the triangle of conflict:

\[ \text{Defence (against } A + X) \]

\[ D \]

\[ \text{True Feeling} \quad X \quad \Delta \quad A \quad \text{Anxiety about } X \]

\( \text{(Taken from Molnos, 1995, p 35)} \)

Within this theory, depressive symptoms and negative feelings can be seen as a 'defence' against the true feeling and anxiety about the true feeling. The true feeling is unknown at the beginning of therapy, and the process of therapy is to explore the problem and help uncover the true feeling and how it relates to the client's current life with significant others. Therapy is used to create a space in which the past can reappear through unconscious processes.

The briefer approaches have given a practical option to the clinician. It is still debatable whether long-term psychotherapeutic work is appropriate for this client group. However, the lack of resources within the NHS and the high rates of poverty during this life stage raises doubts over the accessibility of such work for this client group. Ironically, older adults usually have more time to give to therapy (Knight, 1996)!

\textit{Behavioural Therapy}

Behaviour therapy refers to treatment which focuses on maladaptive behaviour and aims to use the role of learning in its interventions. With respect to depression, Zeiss & Lewinsohn (1986) have developed a model which is specifically adapted for older adults. They argue that depression in this age group is due to a significant reduction in positive
reinforcement, or an increase in aversive responses to their actions, which is often due to a decline in physical abilities. Clients are asked to complete a Pleasant Events Schedule (PES) and an Unpleasant Events Schedule (UES). Interventions are essentially targeted at teaching new behaviours to increase the number of pleasant events they experience and decrease the number of negative experiences.

However, they stress the need to adapt the behavioural interventions to suit this age group. For example, they have adapted the PES checklist to include more items which do not require physical strength, as well as other items which are more age appropriate. The modified UES schedule includes items such as concern with physical disability or loss of mobility. The amount of activities they are encouraged to do is also moderated, bearing in mind that if they attempt too much the consequences could be aversive. Like other behavioural approaches, it also includes relaxation. However, they stress the need to adapt the approach to take into account any physical limitations. For example, an individual with arthritis should not be encouraged to tense and relax muscle groups, but a more appropriate relaxation strategy should be selected.

Zeiss & Lewinsohn (1986) also advocate that the therapist should “say it, show it and do it” to compensate for slower information processing. In line with this, the therapist explains, writes down and demonstrates the ideas within the session. They also suggest taping the sessions and using a notebook to reinforce learning.

Cognitive Therapies

Cognitive therapy, often used in collaboration with behavioural strategies, is the most researched treatment, possibly because clinicians thought that the short-term nature of the work would appeal to older adults (Blazer, 1982; O’Leary, 1996). The most predominant model of cognitive therapy is Beck’s model (Beck, 1967). At the basis of this model is the theory that depression results from the cognitive triad: the negative view of the self, the world and the future. Beck identifies ‘cognitive errors’, or thinking styles, which distort the persons interpretation of information and arguably helps
to maintain depression. In other words, depressive symptoms are the result of distorted thinking styles rather than a direct consequence of events in the environment.

Treatment within this model usually involves the client making records of their thoughts and feelings, with the therapist helping the client identify triggers and the resulting thoughts and emotions. The session usually involves setting an agenda, feedback and homework. Morris and Morris (1991) summarise the adaptations that are thought to enhance the therapeutic relationship when working in this approach (see appendix A4:4).

As Landreville and Gervais (1997) highlight, for older adults, common triggers for distorted beliefs may be the loss of physical ability, change of appearance or the consequences of illness. Such experiences may activate distorted beliefs which can lead to the resulting depression. They highlight how social prejudices and biased beliefs about old age can be held by older clients themselves, adding to their depression. Trezona (cited in Landreville & Gervais, p199, 1997) provides some examples of negative beliefs in this age group. For example, “I cannot do anything for myself (negative view of the self), ‘I will never be able to enjoy life again (negative view of the future) and ‘There are too many things that people are asking me to do’ (negative view of the world”. Therapy would involve finding alternative explanations to these interpretations. Morris & Morris (1991) also highlight how cognitive work can be a useful approach to helping older clients “develop a greater flexibility in thinking” (p409) with regards, for example, the guilt older adults often feel about things that happened a long time ago.

Comparison of treatment modalities and outcome studies
Unfortunately, most of the adaptations suggested above are based on anecdotal evidence, with no studies comparing specific adaptations within a therapeutic model. Recent research has focused on the comparative effectiveness of treatments. Surprisingly, the effectiveness of psychological treatments with this client group is being found to be effective and modality non-specific.
Most of the research has been carried out on the cognitive and behavioural approaches, though much of this research has been carried out on group treatment programmes. However, an early study was carried out (Zeiss, Lewinsohn & Munoz, 1979) using individual therapy. They compared cognitive, behavioural and interpersonal skills training and reported all treatment modalities showed equal improvement. Scogin’s & McElreath’s (1994) meta-analysis led to similar conclusions. They included seventeen studies which, overall, incorporated cognitive, behavioural, reminiscence (life-review work), psychodynamic and eclectic approaches in the format of groups, individual sessions and self-administered therapy. They also concluded that psychological therapies were “quite effective” (p72) at comparable levels to the younger adult population, with a mean effect size of .78. However, the relatively small number of studies, and the broad definition it uses of therapy (e.g. it includes group and self-administered therapy) limits the conclusions that can be drawn. Koder, Brodaty & Anstey (1996) reviewed the literature, narrowing the definition of cognitive therapy to include only individual treatment. They found that cognitive therapy was more effective than behavioural or psychodynamic therapy. However, they also note that cognitive therapy often involves behavioural elements, and they are difficult to disentangle.

One of the most significant studies undertaken to compare treatment modalities is Thompson, Gallagher & Breckenridge’s study (1987) and the follow up to this in Gallagher-Thompson et al (1990). The study uses rigorous methodology to randomly assigned depressed older adults to either brief psychodynamic, cognitive, behavioural or to a 6 week delayed treatment condition. Strict diagnostic criteria for being in a current episode of major depressive were used and follow-up data was collected up to twenty four months post-treatment. The authors concluded that psychological treatment is effective and so was maintained for a 2 year period, with no significant differences revealed between treatment modalities. This is particularly interesting in that it includes a brief psychodynamic treatment modality (involving the same number of sessions as other treatments) within an experimental design.
However, the limits of this study also need to be considered. Firstly, the sample consisted of volunteers, with good health, who sought help other than medication. It excluded those with psychosis, alcoholism, a bipolar disorder, or those who presented with a suicide risk. Though these restrictions are understandable within this experimental design, it means generalisability of the findings are limited. Furthermore, the average duration of depression before treatment was not controlled meaning that the spontaneous recovery rate may be hidden within the outcome data, and may be significantly higher than in the younger population. Finally, the fact that no differences were found between treatments may also reflect the assessment measures used, which may not be sensitive to differences between treatment modalities. More research is needed to investigate which clients are more suited to which treatment, and to clarify what are essential treatment-specific ingredients.

On the basis of what the research tells us so far, the clinician is justified in offering the older client a choice of therapies - and the clinical psychologist should be qualified to offer this. Interestingly, the drop-out rates in Gallagher-Thompson’s et al. (1990) study were higher for cognitive behavioural therapy (10) than for behavioural (4) and brief psychodynamic therapy (4). This is a direct challenge to assumptions about older adults being more suited to cognitive work.

The Emotional impact of Work with Older Adults on Therapists
Therapists have avoided working with older adults, though it is recognised that the reluctance to work with this age group is commonly connected with a “perceived lack of expertise and anxiety” rather than “ageist prejudice per se” (Knight, p 22). However, the resulting avoidance obviously has serious repercussions for service delivery.

Therapist anxiety when working with older adults is now being increasingly acknowledged, being commonly conceptualised as a transference/countertransference issue within the psychodynamic theoretical framework (e.g. Knight, 1996; O’Leary and D’Alton, 1996; Martindale, 1989; & King, 1980.). ‘Transference’ is a concept which
has undergone various evolutions and definitions (see Makari & Michels, (1993) for a review). In general terms, transference refers to the client’s projections of unresolved issues on to the therapist. These may include feelings and demands from the past that are not based on the ‘reality’ of the therapeutic relationship. ‘Countertransference’ refers to the therapist’s reaction, including emotional reaction, to the relationship, which similarly, is not based on the reality, or on real patient characteristics. Within the Kleinian tradition, highlights Makari & Michels (1993), ‘countertransference’ can give useful information to the self-scrutinising therapist.

King (1980) highlights that the transference which occurs when working with older adults is often intense, whether the effect is positive or negative. She highlights some recurring ‘transference’ themes. The age of the therapist, for example, can be a trigger for transference from the client, with the therapist experiencing the conflict the client has experienced within their own son or daughter relationship. But perhaps most pertinent to this essay in terms of therapist anxiety are some ‘countertransference’ themes that frequently emerge. Commonly underneath these fears, argues Knight (1996) is the “therapists personal conflicts and anxieties about ageing” (p68). The “reluctant therapist” as coined by Kastenbaum back in 1964 (cited in Knight, 1996) to explain this phenomenon, was one who reflected on the emotional impact of death on the client and the therapist. Fears about death, dependency and aging (e.g. Martindale, 1989) as well as unresolved issues with parents and grandparents (e.g. O’Leary, 1996; King, 1996) can commonly cause discomfort for the therapist when working with this age group. Considering the high rates of illness, disability, and natural death - as well as suicide in depressed older adults - therapists are unlikely to be able to avoid their own fears. Knight (1996) highlights how society encourages us to avoid thinking about death; working with this age group often does not allow the therapist to do this.

The main difficulty with conceptualising therapist anxiety in this way is the difficulty of proving transference issues empirically. Knight (1996) reports the clinical signs as being “denial, adoption of unrealistic world views, avoidance of difficult patients or burnout”
(p74), although this, and the bulk of evidence, is based only on clinical case examples and the therapist’s clinical interpretations of these. O’Leary and D’Alton (1996) review the empirical literature, and conclude that little research has been undertaken. The ‘First Empirical Demonstration of Transference in Psychotherapy’ was claimed in 1992 by Fried et al. (cited in Makari & Michels, 1993). They claimed to demonstrate similarity between the patient-therapist relationships and patient relationships outside of therapy. However, this can also be explained in terms of “persistence of character patterns across object relationships” (Makari & Michels, 1993), rather than in terms of transference, and is not specific to therapist transference anxiety discussed here. However, difficulty establishing tools to measure such complex and intangible processes does not mean they do not exist. Widespread recognition by clinicians of these issues gives it face validity. Furthermore, psychodynamic work, which uses countertransference and transference as central therapeutic tools is proving, as described earlier, to have positive outcome results (Gallagher-Thompson et al. (1990). Although this cannot prove the conceptualisation of therapist’s anxiety in terms of transference, it does add further weight to its utility.

Final Comments
What pervades the literature in this field is the complexity of the work on a clinical and emotional level. Depression is difficult to diagnose and the therapist needs to be aware and thorough in disentangling its presentation. However, various psychological approaches are now proving encouragingly successful, although research is needed to clarify which components of therapy are essential for positive outcome. Many adaptations to psychological therapies have been suggested, although this is mainly at an anecdotal level. Again, more research is needed to investigate the comparative effectiveness of different adaptations within specific models. Finally, the emotional impact on therapists has been considered. Therapist anxiety should not be underestimated, as it can lead to the avoidance of such work and a depletion of clinical psychologists working in the field. This has best been conceptualised in terms of countertransference, though this is difficult to prove empirically. Specialist supervision is recommended to empower the clinical psychologist to feel competent in the field.
A4: Bibliography


Appendix A4: 1


A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or 2) loss of interest of pleasure. Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful). Note: in children and adolescents, can be irritable mood.

2) markedly diminished interest, or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: in children, consider failure to make expected weight gains.

4) insomnia or hypersomnia nearly every day.

5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

6) fatigue or loss of energy nearly every day.

7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for Mixed Episode (see p.335).

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g. drug of abuse, a medication) or a general medical condition (e.g. hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of the loved one, the symptoms persist for longer than 2 months or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.
Appendix A4:2

Symptoms and signs of depression in late life
(Adaptation of Beck’s Cognitive Model, *Taken from Blazer, 1982, p21*)

**Emotional**
- Dejected mood or sadness
- Decreased life satisfaction
- Loss of interest
- Impulse to cry
- Irritability
- Emptiness
- Fearfulness and anxiety
- Negative feelings toward self
- Worry
- Helplessness
- Hopelessness
- Sense of failure
- Loneliness
- Uselessness

**Cognitive**
- Low self esteem
- Pessimism
- Self-blame and criticism
- Rumination about problems
- Suicidal thoughts
- Delusions
  - of uselessness
  - of unforgivable behaviour
  - nihilistic
  - somatic
- Hallucinations
  - Auditory
  - Visual
  - Kinesthetic
- Doubt of values and beliefs
- Difficulty concentrating
- Poor memory

**Physical**
- Loss of appetite
- Fatigability
- Stiffness of the body
- Sleep disturbance
- Initial insomnia
- Terminal insomnia
- Constipation
- Loss of Libido
- Pain
- Restlessness

**Volitional**
- Loss of motivation or “paralysis of will”

**Emotional**
- Stooped posture
- Sad face
- Uncooperative
- Social Withdrawal
- Hostility
- Suspiciousness
- Confusion and clouding of consciousness
- Diurnal variations of mood
- Drooling (in severe cases)
- Unkempt appearance (severe cases)
- Occasional ulceration’s of skin secondary to picking
- Weight Loss
- Bowel Impaction

**Psychomotor retardation**
- Slowed speech
- Slowed movements
- Gestures minimized
- Shuffling slow gate
- Mutism (in severe cases)
- Stupor or semicoma (in severe cases)
- Cessation of mastication and swallowing
- Decreased or inhibited blinking (in severe cases)

**Psychomotor agitation**
- Continued motor activity
- Wringing of the hands
- Picking of skin, which may lead to ulcerations
- Pacing
- Restlessness sleep
- Grasping at others

**Bizarre or inappropriate behaviour**
- Suicidal gestures or attempts
- Negativism such as refusal to eat or drink and
- Outbursts of aggression
- Falling backward
Appendix A4:3

Comparison of symptoms assessed by various depression rating scales:
* Taken from Blazer (1982, p 25)

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<td>Loss of interest</td>
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<td>Slowed thinking</td>
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<td>Sleep disturbance</td>
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<td>Diurnal variation</td>
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<td>Desire to withdraw socially</td>
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<td>Suicidal impulses</td>
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<td>Desire to receive help</td>
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<td>Work inhibition</td>
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Factors enhancing therapeutic contact with elderly people
Taken from Morris and Morris, 1991, (modified from Church, 1986).

Less abstract
Compensate for reduction in memory for meaning
Flexible session length (client comfort)
Time limited contract
Explicit, concrete realistic goals
Awareness of real social and physical limitations
Interpersonal context of problem
Active rather than passive therapist
Awareness of age contrast in goal-setting and empathy
Absence of ageism in therapy
Compare and contrast two models of family therapy. Consider their theoretical assumptions and models of intervention. What evidence is there for the effectiveness of these models?
Introduction
This essay will compare and contrast the structural and systemic models of family therapy. It will begin with a brief overview of their historical context. It will then consider the structural then systemic, models under the following headings: ‘historical context’, ‘theoretical assumptions’, ‘goals of therapy’, ‘therapist’s role’ and ‘techniques and outcome data’. A critique of each model will also be given.

Historical Context
The evolution of family therapy occurred in the latter half of the twentieth century. Prior to this, psychotherapists had concentrated on working with individuals, with early family work coming from a psychodynamic perspective. In the 1960’s, Laing (1965, cited in Barker, 1998) was interested in families with schizophrenic members, who seemed to present with striking patterns of interactions. Such research led people to hope that family therapy may be the way forward with such families and led to pioneering work in the field.

Alongside this work, a shift towards systems theory was occurring in science. Systems were seen “as being structured by feedback, reaching a stable state as the opposing forces for change and stability create a balance for each other” (Partridge, 1992, p152). The ‘structural’ and ‘systemic models’ of family therapy were influenced by this shift and represent significant contributions to the field of family therapy. They can both be described as being ‘first order cybernetic’ approaches in that they involved a therapist, or team, standing outside the family, or system, in order to describe its characteristics (Partridge, 1992). However, they also hold many significant differences, which will be highlighted below.

Structural Family Therapy
Historical context
The work of Minuchin (e.g. 1974) represents the development of structural family therapy and is acknowledged (e.g. Nichols & Schwarz, 1998; Barker, 1998) to be the
most influential model in this field. It was developed through his work with delinquent adolescents and their families.

**Theoretical Assumptions**

A main assumption of this theory is that the individual should be viewed within their social context. This was a significant step away from the approaches which had constructed an "artificial boundary" (Minuchin, 1974, p2) between the individual and the world.

As the name suggests, the emphasis within this model is on the structure of the family. However, it is important to note that the structure is viewed as constantly forming and re-forming. Many authors have summarised the theoretical underpinnings of structural family therapy (e.g. Nichols & Schwarz, 1998; Barker, 1998; Partridge, 1992; Reay, 1988; Fraser, 1982). The main points will be outlined here. Barker (1998) offers a useful summary (six points) which are listed in *appendix A5:1*. Underlying most of these points is the concept of 'boundaries'. Boundaries refer to transactional patterns that exist between family members. They mark out the subsystems within the family and regulate the contact of the family from and with the outside world. Minuchin (1974) postulates that boundaries range from rigid to diffuse (see below):

<table>
<thead>
<tr>
<th>Disengaged</th>
<th>Clear boundaries</th>
<th>Enmeshed</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Inappropriately) rigid boundaries</td>
<td>(normal range)</td>
<td>(diffuse boundaries)</td>
</tr>
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</table>

(taken from Minuchin, 1974)

Within this model, boundaries which are rigid can lead to minimal contact with other subsystems, which can result in 'disengagement'. Although 'disengagement' can be positive in that it can lead to the autonomy and growth of an individual, it can lead to
isolation and difficulties. For example, if the parents are in a 'disengaged' relationship with their child it may mean that they are less likely to notice if their child is experiencing difficulties. At the other end of the spectrum, a 'diffuse' boundary can lead to 'enmeshed' subsystems. Such relationships are characterised by high levels of contact, and are often loving and considerate relationships. Enmeshed subsystems, however, can lead, for example, to children to becoming too dependent on their parents.

It's postulated within this model that clear boundaries help to establish a hierarchical structure; a clear hierarchy is seen as significant for a family to be 'healthy'. The parents, or 'executive couple', should be placed higher in the family hierarchy. They should be in positions of leadership, with the associated responsibilities and rights. It is argued that the marital system should have 'closed boundaries' to enable the marital couple to protect their privacy, but that the couple should also have a 'permeable' boundary which will allow children to move in and out of the parental system. The siblings should also have their own subsystem, with boundaries, within which they should be encouraged to take on responsibilities according to their age. Moreover, there is also the boundary around the family with the outside world, which is influenced by religious and cultural factors, as well as individual boundaries, which respect the rights of the individual.

Minuchin also identified certain common 'alignments, such as 'alliances' and 'coalitions', which can occur as subsystems within the family. The term 'coalition' is used to refer to when two or more individuals in the family join together against other individuals in the family. These are usually covert, whereas an alliance refers to close relationships between two members, without relating to anyone else, and are usually overt.

The family life-cycle is also seen as significant within this model. It's postulated that development is marked by transitional stages, such as the birth of a child or the onset of adolescence, which are markers for the reorganisation of the boundaries. It is postulated
that realignments need to occur at these stages. Difficulties are seen as commonly arising at such points if realignments appropriate to the developmental stage do not occur. There are cultural problems with this in that expectations at certain life stages are embedded in the cultural context. It is unclear how this model takes into account political and cultural norms when considering what ‘should’ be happening at such transition points.

**Goals of therapy.**

As described above, the model is based on the assumption that families require certain features, the main of which are clear boundaries and an effective executive. It is postulated that families attending therapy may have unhelpful structures with rigid rules. The aim of therapy, therefore, is to block unhelpful transactions, and activate repertoires of transactions which are not being used. Little significance is paid to the past, with therapeutic change being focused on the ‘here and now’. There are usually between 6 and 10 sessions.

**Therapists role and techniques**

One of the main tools that the therapist uses is the genogram, or family tree. This allows the therapist to map out the structure of the family, their developmental stages and major life events. The therapist is then able to generate a series of hypotheses focusing upon the structure of the family and the rigidity of their boundaries, coalitions and triadic structures.

**Joining, Enactment, Intensification and Unbalancing**

Before intervening, Minuchin (1974) proposed that the therapist should ‘join’ the family. At this stage the therapist is seen as taking the role of the “active intruder” (Partridge, 1992, p158), who mirrors the family’s interactions. This involves making a connection with each member of the family. Although the therapist may make hypotheses, no challenges are made at this point.
However, the next stage involves the therapist using ‘enactment’, ‘intensification’ and ‘unbalancing’. ‘Enactment’ involves the family acting out interactional patterns in the session. These are usually around a spontaneously occurring issue, which the family is then asked to enact while the therapist observes. The therapist then becomes involved for example, to encourage alternative interactions, involve other family members or block transactions that are unhelpful. ‘Intensification’ is achieved, for example, by prolonging the length of the interactions, or using repetition. The therapist may also ‘take sides’ to ‘unbalance’ the existing subsystems. Such techniques were developed in the USA by therapists who have been described as “charismatic” and “virtuoso” performers (Reay, 1988). This raises the question of how well such techniques can be transferred to other, more reserved, cultures.

**Outcome**

Structural family therapy is one of the most researched models of family therapy (see Nichols & Schwarz, 1995; Chamberlain & Rosicky, 1995 for a review), with evidence to show the effectiveness of this treatment with a range of problems. One of the most impressive studies is by Minuchin, Rosman & Baker (1978). They provide impressive data on the treatment of 53 cases of anorexia nervosa with this model, reporting 90% improvement rate on the basis of medical remission of anorexia symptoms and psychosocial functioning. Unfortunately there was no control group, though the authors claim that only a third of such clients usually recover. However, it is worth noting that 40% of the sample had been treated, with individual methods prior to family work - which may have contributed to the high success rate. It is noted that the drop out rate (only three) was also impressive, which may also contribute to the particularly high success rates. This suggests that families felt comfortable with the model, though it is acknowledged that the life threatening nature of the problem may also have encouraged commitment.

More recently, the work of Szapocznik (1989; 1986 cited in Chamberlain, 1995) reviewed by Chamberlain (1995) explored the expectations of Hispanic families for
structural family therapy. They found it was well suited for this cultural group in that it targeted the intergenerational conflict which was found to be prevalent in this group. This is interesting in that one of the criticisms of the model is that it may be culturally biased towards white, middle class families. More research is needed to ascertain for which cultural groups it is appropriate, and how it could be adapted for others.

More generally, there is a lack of research looking at the range of techniques (e.g. 'unbalancing' and 'intensification') used in this model. More research is needed to establish which techniques are effective and why.

**General Critique of the Structural Model**

The structural model is relatively easy for the trainee therapist to learn in that it has clear criteria for family analysis and a clear set of techniques. This may have contributed to its wide usage. There is also empirical evidence to support its general efficacy with a wide range of problems, though the high cost of team work may still leave this model less attractive to service developers.

However, the model has been criticized for pathologizing families' difficulties and making assumptions about what constitutes a healthy family. The techniques have been criticised as being controlling (see Simon, 1995 for a review). Simon disputes that this is the case, arguing that the important assumptions of the model are that families are fundamentally 'competent' and 'unique', and that they have the right to determine their own specific outcome. He states that the structural diagnosis should not be viewed as 'representing' the family, but should be seen as "*the state of affairs in the ongoing dialogue between the client system and its context*" (Simon, 1995, p22). He argues that the technique of 'enactment' is actually an enactment of these assumptions in therapy. Simon's arguments are convincing, though one wonders whether the challenging techniques used in this model can possibly leave the family feeling 'competent'. Furthermore, Partridge (1992) highlights how this model does not account for any
‘resistance’ to change within the family, which is addressed by the ‘systemic’ model discussed below.

Systemic Family Therapy

Brief background

The Milan model, known as the systemic approach, refers to the work developed by the group of four psychiatrists-psycholoanalysts in Milan over the period of ten years. Their most well known publication is described in ‘Paradox and Counterparadox’ (Palazzoli, 1978) which was based on their work with families who had a member with schizophrenia or anorexia. Tomm (1984) is now recognised as a spokesperson for the model (e.g. Partridge, 1992).

Theoretical assumptions

The systemic model (reviewed by e.g. Nichols & Schwarz 1998; Barker, 1998; Partridge, 1992) closely ascribes to Bateson’s (cited in Partridge, 1992) communication theories, which laid emphasis on ‘context’ providing meaning to behaviour, different levels of meaning and a circular relationship between cause and effect. It is argued that such an emphasis de-pathologises the individual and directs the focus on to patterns of interaction.

The Milan team also took a ‘non normative’ stance. This refers to the absence of criteria with which to judge families as ‘healthy’ or ‘normal’. There is only a problem if the family, or individual, experience something as a problem. This is a direct challenge to the structural model, which postulates clear beliefs about healthy family hierarchies and boundaries. However, there is some overlap. The Milan team laid emphasis on the importance of clear relationships (without ambiguity), but were not interested in defining what relationship should be within the hierarchy.

A crucial difference with the structural model is that the Milan team attempted to address the concept of ‘resistance’ in the family. They believed that systems reached equilibrium
round a stable, central, point. Systemic theorists evolved the concept of the ‘double bind’ to account for this, which will be described in more detail below. An assumption of this model is that if the rules that organise the system are changed, using certain techniques, the system will be reorganised and symptoms would be alleviated. Thus, although, like the structuralists, they believed that a reorganisation of the system could alleviate the problem, they were not interested in the hierarchical power structure within the system which Minuchin had given such significance.

A key word in their approach is that it is ‘reflexive’; there is a continual interaction between theory and practice. Unlike the structural approach, which can be defined quite easily by its theoretical assumptions about family structure and alliances, the theoretical basis of the systemic approach can best be illuminated by its techniques, which have a reciprocal relationship with the model’s theoretical assumptions.

**Goals of therapy**
The aim of therapy is to address *behaviour and contextual meaning so that a family can reorganise itself and continue on a non-symptomatic evolutionary path*. (Burnham & Harris 1988). The therapy is sometimes called the ‘long brief therapy’ (Tomm, 1984) in that a relatively small number of sessions (ten) were offered which were spread out over a long period of time (e.g. two years). Change is mainly viewed as occurring outside the session, compared with the structural model which considers initial change to occur within the session and then to develop and become sustained outside the session.

**Therapist’s role and techniques**
The overall format for the practice of systemic therapy involves five stages: the intake process (involving a telephone call from the referrer), the session itself, the intersession break, the intervention and the post-session discussion.
Tomm (1984) highlights the three core principles which are at the basis of the systemic interview: hypothesizing, circularity and neutrality. Each of these are inter-related and are described in Palazzoli Boscolo, Cecchin & Prata’s paper (1980).

Like the structural model, hypotheses are generated. However, compared to the structural model which bases its hypotheses around the family structure, the systemic hypotheses are based on various sources of information and psychological models. For example, the therapist may consider information about the family and make behavioral observations. Other psychological theories, such as attachment theory and structural theory may be used. These hypotheses may differ in each session. As Tomm (1984) states: “the goal in hypothesising is not to identify the ‘truth’ about the family but to generate the most useful explanation of the family as a totality that the team can create at that particular moment.” (Tomm, 1984, p258). Interestingly, this seems to overlap with Simon’s (1995) interpretation of the structuralist approach (see page 4) as being “an ongoing dialogue between the client system and its context.” Simon, 1995 p 22).

Circular Questioning
Hypotheses within the systemic model are investigated in a different way to that of the structural model. One of the main techniques used is ‘circular questioning’, introduced by Palazzoli et al. (1980, see appendix A5:2 for examples of circular questioning). Such questions connect people, events and ideas and are at the core of the notion of circularity. It is postulated that they allow the therapist to identify any connection between behaviours within a spatial and temporal context, and within the context of their interaction and pattern.

Neutrality
As described above, the therapist, within this model, takes a stance of ‘neutrality’. This offers an alternative to the directive (criticised as being controlling) stance of the structural therapist. Tomm describes the therapist taking a ‘metaposition’, or a “dance” (Tomm, 1984, p262) with the family. They should be curious, respectful and accepting.
They should not agree, disagree, form coalitions or alliances with any of the family members like the structuralists. Interestingly, it is the neutrality issue which has received much criticism (e.g. Nichols & Schwarz 1995). It is debatable whether 'real' neutrality is possible to achieve, and this has been criticised on the grounds seeming 'uncaring' or hiding prejudice.

*The Message*

The intervention, known as 'the message', is constructed by the team during the 'intersession' break. This begins with 'reframing', which refers to a summary of the families 'story' of the problem. However, what is significantly different to the structuralists is that the problem behaviours are constructed as solutions to other hypothetical problems which would be present if the family had not found such a solution. For example, a child refusing to eat may be a solution to the problem that they are not listened to by their parents. It is argued that such 'reframing' makes the intervention more acceptable to the family.

The intervention also usually includes 'prescriptions'. This refers to a task for the family which is seen as an opportunity to experiment and to try and offer clarity. The original team, for example, was known to prescribe 'no change' to the family. 'Ritual prescriptions' were also used. One well known example, presented by Palazzoli (1978, cited in Partridge, 1992), was the 'odd days-even days' ritual. This was directed at parents who were finding it difficult to control their children. Each parent was asked to take sole responsibility for their children on alternate days. The other was asked to observe any differences. It was postulated that this highlighted incompatible injunctions which resulted in 'double bind' situations (e.g. when an individual would verbally say one thing when their non-verbal language was implying the opposite). The temporal element of this task meant that it was impossible for incompatible injunctions to occur at the same time.
These techniques were seen as addressing the 'resistance' to change observed in families. It is postulated that such tasks allow the therapist to align with the central tendency of the system, with the paradoxical nature of the tasks actually helping to create change. Interestingly, this seems to be a covert way of forming an alliance with the family which is comparable to the overt 'joining' process outlined by the structuralists.

**Outcome**

Not only should the therapist have a neutral attitude towards therapy, but also towards outcome. In other words, the therapist should not have specific behavioural goals in mind for therapy. Tomm highlights how the goal is to “enhance the families effective freedom to change” (Tomm, 1984, p263) meaning that families should have the choice to remain unchanged. Measuring outcome is made particularly difficult as there are no clear criteria to define what a ‘healthy’ family is. Furthermore, therapists utilise a number of models when generating the hypothesis, making it impossible to isolate changes as a result of a systemic intervention.

As a result of these issues, the Milan approach is acknowledged as being under-researched (Nichols & Schwarz, 1995; Chamberlain & Rosicky, 1995; Partridge, 1992; Mashal, Feldman & Sigal, 1989; Gurman, 1988; Burnham & Harris, 1988; Tomm, 1984). The Milan team (e.g. 1978, cited in Nichols, 1998) gave powerful and positive anecdotal evidence for the family treatment of schizophrenia, anorexia nervosa and delinquency with the Milan model, though the team became more critical of their own approach over the years. Tomm (1984) cites preliminary evidence for comparable success rates with 25% fewer sessions over four years. This bodes well for an economically viable treatment model. However, no details are given of control group or how outcome was measured.

A significant study was carried out by Mashal et al. (1989). They carried out a systematic two-year follow-up study, exploring the degree of efficacy and satisfaction with the Milan approach. The parents and identified child-patients were asked whether
they were the same, better or worse compared to when they began treatment. They were also asked how much they liked treatment. The results indicated that 56% of fathers, 67% of mothers and 78% of children thought things were ‘better’ when questioned. With no control group, the authors concluded that the improvement rates should be considered in the light of other outcome rates of 60-70% (Gurman, 1978, cited in Marshal et al. 1989). Compared to these outcome rates, mothers and children found comparable improvement, whereas fathers did not. Interestingly, 56% of mothers disliked the treatment compared to 47% of fathers and 44% of children. 37% voiced strong negative opinions about therapy compared to 11% who gave positive opinions. Negative comments related to the impersonal nature of the team.

Although this study is significant in that it gives some evidence in support of the model, and in that there are so few systemic outcome studies, there are many methodological difficulties with it. This includes the lack of control group and small numbers (14 families and five couples). The way in which improvement was measured also poses problems in that patient satisfaction does not suffice as a sufficient measure of outcome (Ruggeri, 1994). To have one item to measure outcome also casts doubt on the reliability of this study. However, the results also raise some interesting questions. For example, it is unclear as to whether the Milan team intended to provoke negative reactions and whether this relates to the dislike of the model and subsequent rates of improvement. The study also offers a direct challenge to the overwhelming success initially reported by the Milan team. Clearly more research is needed. Unfortunately, the field is seeing a loss of interest in this model as “it seems to have gone the way of dinosaurs” (Nichols & Schwarz, 1988). This highlights the need for thorough evaluation of new models before their use is advocated.

**General Critique of the Systemic Model**

The systemic model appears to address some of the criticisms of the structural model in that it challenges the idea of the normative family, and its debatable pathological and controlling stance. It also goes some way to deal with ‘resistance’, and suggests
techniques for working with it. The model also reportedly demands fewer sessions, thus offering a more economically viable way of working with families. Thus, if proved effective, it could offer a more practical option for service delivery.

However, it is debatable whether the covert way in which the therapist forms an alliance with the system is less controlling than the structural therapist’s overt techniques. It is not hard to imagine families feeling confused with the paradoxical nature of the ‘message’. The systemic model also attempts to de-pathologise the family by introducing the ‘neutral’ therapist. However, it does not address how the therapist may deal with racism, or sexism within the family, or within themselves, and it is naïve to expect the therapist to remain entirely neutral. The ‘neutral’ therapist has also reportedly caused negative reactions in families. Marshal et al’s study (1989) revealed client criticisms regarding the impersonal nature of the team. This raises questions regarding how much clients feel heard and understood within this model, and how this may impact on outcome.

Unfortunately, the enormous problem with this model, as described above, is the lack of evidence for its efficacy. However, difficulty measuring such complex interventions, and their impact on interactional processes, does not mean they are not effective. Partridge (1992) highlights the growth of “new wavers” (p164) who argue for new research methods to be evolved for ‘nonpositivistic’ models. Although on a theoretical level the systemic model offers convincing challenges to the structural model on some points, its utility in practice has yet to be satisfactorily established.

**Summary and Conclusions**

This essay has provided an overview of two ‘first order cybernetic’ approaches of family therapy. Both models emphasise the social context of problems and are interested in the pattern of interactions within family systems - and how they relate to the presenting difficulties. However, there are also some significant differences. The structuralists place emphasis on the structural hierarchy of the family and the ‘boundaries’ of the
relationships. Their intervention is openly challenging. It has been criticised for being judgmental and controlling. The systemic model challenges the ‘normative’ judgments of ‘healthy’ families, and claims to de-pathologise problems by postulating a circular relationship between cause and effect. It also argues for the ‘neutral’ therapist. It is argued here that the systemic model is potentially more controlling in its covert use of strategies. There is now substantial evidence to support the efficacy of the structural model. Unfortunately, the systemic model has proved harder to research, with insufficient data to conclude its efficacy. More research is needed to investigate the efficacy of some of the specific techniques used by both models.
A5: Bibliography


Appendix A 5:1

Theoretical underpinnings of Structural Family Therapy

1) **The family 'structure'.** This consists of the arrangements, or unwritten rules, which govern the transactions between family members. Boundaries are important to this.
2) **The flexibility of the family's patterns of function, and its capacity for change.**
3) **The family's resonance, that is the extent to which family members are enmeshed or disengaged with each other.**
4) **The family's life context.** This is the suprasystem, or the sources of stress in the family's environment. The environment will normally include the extended family, neighbours, and the neighbourhood, work and school environments.
5) **The family's developmental stage.**
6) **The ways in which the identified patient's symptoms are used by the family and how they fit into transactional patterns.**

(quoted from Barker, 1998, p51-2)
Appendix A5:2

A Summary of the three Types of ‘Circular Questions’

1. “difference questions” refer to questions inquiring to differences on a continuum in beliefs, e.g. “who believes this the most strongly”.

2. ‘behavioural questions’ focus on the observed behaviour between family members during interactions, e.g. “What does Sally do when father walks out?”. This allows the therapist to identify any connections between behaviours within a spatial and temporal context. The aim is that behaviours can be seen in the context of their interaction and pattern.

3. Triadic questions are a further form of circular questioning. This refers to the questioning of “a third person about the relationship between the other two”, e.g. “when your mother and brother are fighting, what does your father do?” (Tomm, 1984 p261). A variation on this is the ‘mind reading’ question which refers to what a person would have said if they had been here. The therapist is looking for patterns within such triangles.

(Summarised from Tomm, (1984) p260)
Part 2: Clinical Dossier
1. Summary of Clinical Experience

1.1 Adult Mental Health

Supervisor: Susan Simpson
Location: Chichester

During my adult mental health placement I had the opportunity to work, and observe others, with a range of psychological difficulties. These difficulties included obsessional-compulsive disorder, social phobia, bulimia nervosa, and bereavement. I also had the opportunity to work, throughout the six months, with a client who was suffering from the impact of sexual abuse.

I also ran a group, jointly with my supervisor, for women with low self-esteem. This was a structured group, within the cognitive-behavioural model, which covered issues such as assertiveness skills, stress and body image.

This placement gave me an excellent introduction to cognitive-behavioural assessment, formulation and therapy skills. A strength of this placement was the high number of opportunities I had to observe my supervisor and to be observed during joint work.

1.2. People with Learning Disabilities

Supervisor: Hilary Smith
Location: Worthing

This placement gave me the opportunity to gain a range of assessment and therapy experience with people with learning disabilities presenting with a range of difficulties. These included self-injury, depression, sexual vulnerability, anger management, and distress regarding living arrangements.

During this placement I gained extensive experience of working with people with mild to moderate learning disabilities. From this I developed an awareness of the importance of adapting communication skills for therapy with this client group. I also undertook an
assessment with individuals with severe to profound learning disabilities which involved liaising closely with staff teams and carers.

Much of this work was undertaken in community settings, involving contact with a range of other professionals and carers. This experience contrasted well with my experience during my adult mental health placement.

Child and Adolescents

Supervisor: Nick Kirby-Turner
Location: Haywards Heath

This placement gave me a broad range of experience of working with children and adolescents both in inpatient and outpatient settings. I utilised social learning theory, behavioral, cognitive and systemic models in my work.

Outpatient work involved assessment and therapy with children and their parents presenting with a range of difficulties. These difficulties included obsessional-compulsive disorder, anger management, bereavement, domestic violence, ‘bedwetting’ and communication difficulties. This work involved trips to schools and consultations with social workers and teachers.

Part of my placement was spent at a children’s psychiatric impatient unit. This work included an assessment of a child presenting with Aspergers and parenting skills work with a mother whose child had behavioural difficulties.

This placement also gave me my first experience of systemic family therapy. I had the opportunity to participate as a member of the ‘reflecting team’ at a fortnightly clinic.
1.4 Older Adults

Supervisor: Corrie Meesters
Location: Worthing

My older adults placement involved a range of work with people over the age 65. Therapy work included cognitive-behavioural treatments with people presenting with a range of difficulties. These included panic attacks, anxiety regarding health issues, depression, and car phobia.

There was an opportunity to develop my neuropsychological assessment skills. This included the assessment of memory problems, intellectual decline, executive functioning impairments and depression. This involved the consideration of appropriate assessment tools for people within this age range.

Regular experience within a multi-disciplinary team was also gained. I had experience working with a range of professionals including psychiatrists, community psychiatric nurses, social workers and support workers.

There was also the opportunity to facilitate a programme of staff training with a team involved in the running and care of a respite care unit for people with dementia. This initially involved a ‘dementia care mapping’ assessment, which was undertaken in collaboration with a specialist nurse. This was followed by the development of reminiscence and sensory work in the service.

1.5. Post Traumatic Stress Disorder Placement

Supervisor: Peter Scragg
Location: London

My first specialist placement was based at a specialist service for people who had experienced traumatic events. The placement involved extensive experience of assessment and therapy with people who had experienced a range of traumatic events.
These events including car crashes, assaults, knife attacks, rape and kidnapping. I also undertook some observations of assessments with refugees.

A particular feature of this placement is that it gave me the opportunity to develop my clinical and psychometric assessment skills. I used a number of psychometric measures including those specific to post traumatic stress disorder, but also for personality disorders and other psychiatric disorders. I was also required to undertake extensive clinical interviews aimed at establishing differential diagnosis. I also had the opportunity to develop my skills at writing evidence-based reports.

This was placement was particularly valued for the specialist supervision which I received within the cognitive-behavioural model. I had the opportunity to become familiar with a range ‘exposure’ and cognitive therapy techniques and feel that my skills developed considerably in this area.

1.6 Systemic Placement

Supervisor: Annette Lumsden
Tracey Harris
Lorna Atkins
Location: Frimley

My second specialist placement was chosen in order to gain experience specifically within the systemic model. This placement was based at a family therapy service for adults. My role involved working as part of a family therapy team both as the ‘lead’ key therapist for a number of clients and as a ‘co-therapist’ as part of a reflecting team. Other team members consisted of clinical psychologists, family therapists, community psychiatric nurses and social workers.

I was involved in a wide range of families and couples who had been referred to the team. These included families with members who had been diagnosed with manic depression, personality disorders, anxiety, post traumatic stress disorder and depression. Other families were referred for issues such as physical and sexual abuse, addiction and
physical health issues. This work also included some work with children and their parents.

I also had the opportunity to undertake consultancy work, on regular basis, to a newly established assertive outreach team. This was an interesting insight into the wide potential for this model.

This placement gave me an excellent opportunity to develop my skills purely within the systemic model. This was in contrast to my previous specialist placement which had been focused within the cognitive-behavioural model. It was also particularly helpful to have the opportunity to observe other therapists, to be observed, and to receive 'live supervision'.
2. Copies of placement contracts

PSYCHD IN CLINICAL PSYCHOLOGY

ADULT CORE PLACEMENT

TRAINEE PLACEMENT CONTRACT - October 1996

LOCATION: Chichester Priority Care Services NHS Trust.

TRAINEE: Jackie Allt.

PLACEMENT SUPERVISOR: Ms S Simpson.

ADDITIONAL SUPERVISOR: Mr W Reavley

REGIONAL CLINICAL TUTOR: Mary John.

AGENCY DESCRIPTION: Chichester Priority Care Services is a Mental Health and Community Service under the auspices of the NHS Trust. It provides help for people with mental health problems, including inpatient, day patient and outpatient care, from a variety of hospital and community settings. The service is staffed by a range of professionals including psychologists, psychiatrists, psychiatric nurses, occupational therapists, physiotherapists and social workers. Areas of mental health dealt with by the psychology department include Child and Adolescent Mental Health, Adult Mental Health, Mental Health of the Elderly, Learning Disabilities, Rehabilitation, Pain Management and Alcohol and Substance Abuse.

CONDITIONS OF PLACEMENT

1. The trainee will work within the Trust from 27 September 1996 to 28 February 1997 for 3 days each week. Annual leave can be taken during this time. The trainee will be based at Graylingwell Hospital.

2. A minimum of two hours 1:1 contact each week will be allocated to supervision in order to review progress of current activities and reflect on issues arising. (As per Minimum Standards, page 113, Clinical Placement Handbook). Supervision will include presentation of patients, tape recordings of clinical sessions and pre and post discussions with supervisors.

3. One session per week to be allocated to trainee’s private study.

AIMS OF PLACEMENT

a. To provide trainee with experience of the full range of clients referred to adult services.

b. To expose trainee to a wide variety of service settings.
c. To enable trainee to gain experience of using the theory and methods of cognitive behavioural psychotherapy to work with adult patients and their problems.

d. To enable trainee to develop a level of clinical skills and competence consistent with this stage of training.

**CLINICAL EXPERIENCE**

Experience will be gained along a continuum as follows:

- as an observer;
- a participant in assessment and therapy;
- contributing to ongoing therapy;
- by seeing "screened" clients;
- by seeing clients independently.

1. **Range of presenting problems**

The trainee should gain experience of independent client work in the following problem areas:

- Anxiety.
- Depression.
- Obsessive compulsive disorders.
- Eating disorders.
- Adjustment and adaption difficulties/bereavement.

It would be desirable for the trainee to gain experience of working with clients with the following presenting problems, either through observation or independent client work:

- Sleep disorders.
- Health/somatic difficulties.
- Problems of emotional control and adjustment, social skills and assertiveness, suicide and parasuicide and personality disorder.
- Survivors of sexual abuse.
- Sexual and relationship problems/family problems.
- Disability.
- Substance misuse.

The trainee should spend up to one session per week working in the area of Acute Psychotic Disorders/Longer Term Mental Health Problems/Rehab and Continuing Care. Experience would include visiting the ward, attending ward rounds, observing assessment approaches of psychologists and other professionals. It is desirable for the trainee to carry out direct client work in this area, possibly involving assessment and psychological intervention.

The trainee will observe the supervisor providing a programme of longer term treatment to a client.
2. Range of clients

The trainee should gain experience of working with the full range of clients referred to adult services.

i) Age - The trainee will see clients across the age span, covering late adolescence and young adulthood, middle and later ages up to 65.

ii) Sex - The trainee will see an appropriate mix of male and female clients.

iii) Ethnic background - Where possible, the trainee will have some level of clinical contact with at least one client from a different ethnic and/or cultural background.

3. Neuropsychology and psychometric assessment

The trainee will gain experience of using psychometric assessment through observation of qualified psychologist and independent client assessment. This will include a WAIS-R, Weschler Memory Scale and other relevant tests.

4. Structure of therapy and intervention

i) Individual therapy work - The trainee will gain direct experience of individual client work.

ii) Therapy work with couples and/or families - The trainee will gain indirect experience of this type of therapy through observation of qualified clinicians.

iii) Group therapy work - The trainee will gain direct experience of group work through co-facilitating a therapy group with a qualified clinician.

5. Settings

The trainee should gain experience of working in as wide a range of settings as possible, for example:

- Psychology Department and outpatients clinics.
- Community Mental Health Teams and Resource Centres.
- Primary Care Settings.
- Day Centres.
- Hostels and Group Homes.
- Inpatient wards (acute long stay and rehabilitation)
- Client’s homes.

The range of settings should include other agency facilities.
OTHER EXPERIENCES

1. The trainee will write psychological reports, case notes and letters as required.

2. The trainee will keep administrative records consistent with the requirements of the department.

3. The trainee will attend and participate in departmental meetings as well as meetings and other professional development activities appropriate to the placement.

4. The trainee will keep a record of experiences gained in the placement.

5. If possible, the trainee will be involved in teaching or training.

REVIEW

Meetings between the trainee, the placement supervisor and the Regional Clinical Tutor at the middle and end of the placement will be used to review the trainee’s progress towards achieving goals and to renegotiate the contract if required.

Jackie Allt  
Susan Simpson
**Learning Disabilities Placement Contract**

**Psychologist in Clinical Training**

Jackie Allt, University of Surrey, Psych. D. Clinical Training Scheme

**Supervisor**

Hilary Smith (Head of Specialty: Learning Disabilities)

**Location**

Community Team for People with Learning Disabilities
Worthing Priority Care NHS Trust
1 St George’s Road
Worthing, West Sussex, BN11 2DS

**Placement Dates**

12th March - 22nd August 1997

**Aims of placement**

1. To gain knowledge of local service provisions for people with learning disabilities, and of agencies differing responsibilities.

2. To have experience of assessment and intervention work with up to ten clients. Clients should cover a range of ages from adolescence through young adulthood and middle aged to older adults; a range of abilities from mild through to profound disability; present a balance of sexes and include work with a client from an ethnic minority. Clinical problems should include a wide range of commonly occurring difficulties for this population, and work should be undertaken in a range of settings and at a variety of levels. A range of clinical approaches will be explored.

3. To work effectively within a multi-disciplinary team, and to undertake collaborative work with colleagues of other disciplines where appropriate.

4. To have the opportunity to observe the supervisor in clinical activities ranging from individual assessments or intervention through to meetings about clients, and other activities undertaken by Clinical Psychologists.

5. To be observed undertaking clinical work at the beginning and end of the placement.

6. To take up relevant opportunities for continuing professional development during the placement.
7. To contribute actively to the work of the Specialty within the Team and the Department, as appropriate.

8. To receive regular weekly supervision on all aspects relating to the placement - (2 hours)

9. To discuss issues relating to the transition from Assistant Psychologist to Learning Disabilities Clinician.

10. To gain knowledge and understanding of "complementary" provision especially, art, drama and music therapy.

Hilary Smith
Chartered Clinical Psychologist
Head of Specialty: Learning Disabilities
(19th March 1997)

Jackie Allt
Psychologist in Clinical Training
University of Surrey, Psych. D.
Psychology Training Scheme
This Contract is designed to set the parameters for JACKIE ALLT in the Child & Adolescent Psychology placement with Nick Kirby-Turner in the Mid-Downs Health Authority

INDUCTION PROCESSES

For Jackie Allt to gain an understanding of the relationship of Child Psychology to services in Child Mental Health, and also in Child Health & Child Protection Services. Specifically:

a) Observe Clinical Child Psychologists working in different settings
b) Observe an Educational Psychologist at work
c) Observe a Clinical Medical Officer conducting a developmental assessment
d) Observe a Juvenile Court
e) Attend a session in a playgroup
f) Visit Larchwood Children's Unit
g) Visit Collwood Adolescent Unit
h) Visit the Family Therapy Clinic
i) Become familiar with issues surrounding Child Protection Assessment
j) Endeavour to observe children with Pervasive Developmental Delay

CLINICAL WORK

For Jackie Allt to familiarise himself with the range of assessment procedures and therapeutic techniques by:

a) Outpatient work in the Psychology Department. A variety of cases, reflecting the full age range, to illustrate the breadth of the speciality in terms of reasons for referral and therapeutic approaches applicable. Opportunities for individual and family centred work. Some joint work with Nick Kirby-Turner.

b) Inpatient work at Larchwood Children's Assessment Unit. If possible participating in individual work involving assessment and where appropriate intervention.

TEACHING

The trainee will present in the Child Seminar Series to other Child Psychologists. As opportunities arise, the trainee may engage in formal teaching to other professionals, possibly through case-based teaching.

RESEARCH

Discussion of on-going audit and research issues in child work. The trainee will undertake a research project with Children and Adolescents during her placement. For this, one half-day a week will be allocated to collect data and interview sample.
STUDY DAY

The trainee will have a full day on a fortnightly basis for study leave whilst on placement.

PROFESSIONAL DEVELOPMENT

The trainee will endeavour to gain a perspective of service delivery issues through clinical work, and to explore issues of service development, by attending Department Meetings and discussing issues as they arise.

SUPERVISION

The trainee will receive two hours formal supervision a week. Further supervision will be obtained through informal meetings and via peer group supervision meetings. Informal/emergency supervision can be arranged at the trainee’s request. There will also be some direct observation of the trainee’s work through joint sessions and the use of the VCR.

OTHER EXPERIENCES

1. The trainee will write psychological reports, letters and case notes, as required.

2. The trainee will keep administration records consistent with the requirements of the Department.

3. The trainee will keep a log book of experiences gained during placement.

GOALS OF PLACEMENT

It is hoped that by the end of the placement, the trainee will have gained a broad experience of working with children and families and an understanding of appropriate therapeutic intervention. The level of knowledge and understanding with regard to these issues will be increased.

MID-PLACEMENT REVIEW

Meetings between the trainee, the placement supervisor and the regional clinical tutor, at the middle of placement, will be used to review the trainee’s progress towards achieving these goals and to re-negotiate the contract if required.

Jackie Allt

Nick Kirby-Turner
CLINICAL PSYCHOLOGY

with older adults

PLACEMENT CONTRACT

April – October 1998

Worthing Priority Care NHS Trust, Directorate of Clinical Psychology
Introduction

In this placement we aim to give an introduction to working as a clinical psychologist with older adults with mental health problems.

This contract is drawn up between

Ms Jacqueline Allt
Trainee Clinical Psychologist (= the trainee)

And

Drs. C.A.J. Meesters
Chartered Clinical Psychologist (= the supervisor)

The placement is from 23-4-1998 to 5-10-1998.

Aims of placement

The main aim of the placement is to offer the trainee the opportunity to gain experience in all aspects of clinical psychology, applied to a setting for older adults: direct and indirect work with clients, clinical and educational work with carers and relatives, structural and supportive work with staff members and – if desired – involvement in ongoing clinical research.

We also hope to introduce the trainee to the challenge of working in this specialism and the implications for multidisciplinary work.
Operationalisation

Setting

Worthing Priority Care NHS Trust has a service for elderly people with mental health problems. The service emphasises that it aims to serve elderly people with both 'functional' mental health problems and with problems against the background of organic brain dysfunction. The service has a strong commitment to multidisciplinary approach to client care and treatment. This commitment is visible in all parts of the service:

Four community teams

Two inpatient units

A day hospital (with travelling 'satellites')

Respite facilities for people with dementia

Long term nursing/care facilities both for people with severe chronic physical problems and people with equally severe mental health problems.

The inpatient units specialise in short term assessment of the client's problems resulting in extensive care plans. One unit is specialised in assessment and short-term treatment with emphasis on clients with 'functional' problems; the other unit gives more attention to clients with problems based on (suspected) organic brain dysfunction.

The Clinical Psychology Service, although autonomous and technically not part of the mental health services, maintains a very close link with all these components. In addition the service is also directly accessible to GPs and qualified practitioners within the Worthing Priority Care NHS Trust.

Placement content

The trainee will be based in a shared office with the supervisor, and from that position she will be introduced to the community teams, the assessment units and the day hospital.

All settings will provide opportunities for familiarisation with specialist assessment techniques, treatment and research. Seeing the time limitations of the placement, the trainee will be expected to concentrate on direct client work in the assessment units and the community. In addition there is space for short-term projects of structural work, either client-related or staff-oriented in any setting (see appendix for details).
Techniques

The trainee will gain experience in:

- Performing and interpreting specialist assessments (neuropsychological, functional analysis, structural interviews)
- Applying and evaluating a range of treatment methods (client centred therapy, cognitive techniques, memory training, behavioural interventions)
- Contributing to multidisciplinary client reviews and treatment planning in a consultative mode

Working arrangements

The trainee will be introduced to the service through an induction period, in which she will meet the most relevant workers in the service components. After the induction period she will be expected to bear increasing responsibility for the organisation and management of her workload, in close consultation with the supervisor.

Two hours per week have been set aside for formal supervision in a fixed arrangement. In addition the trainee will know at all times where and when to reach the supervisor for urgent or informal supervision.

The Directorate of Clinical Psychology in the Trust has a monthly business meeting, followed by a clinical presentation. The trainee is welcome to attend these meetings. The professional meetings will also serve as an opportunity to compare the work with older adults with work aimed at other client groups. A third function of the meetings is to create a forum for meeting other psychologists.
In addition to the general content of the contract Jackie will have:

- Opportunities to focus on developing skills in choice, administration and interpretation of neuropsychological assessment
- Opportunity for regular exposure to community mental health team work by regular fortnightly attendance of a CMHT meeting
- Opportunity to go on joint visits with members of the CMHT and carry out appropriate joint work with them
- Opportunity for exposure to at least one case involving a suicidal client, and develop awareness of assessment issues in this case
- Opportunity for exposure to and – if appropriate – direct or indirect work with at least one client with psychotic problems
- Opportunity for involvement in a reminiscence project in the respite unit in a joint effort with a CPN
- Opportunity for exposure to clients over the age of 75 years
Outcome expectations

The trainee is expected to gain understanding of all aspects of older adult psychology as a specialism from this placement. Growing insight and expertise in technical aspects of the placement should become apparent in her progress through reports and professional correspondence; growing understanding of the specialist role of the clinical psychologist in a setting for older adults is expected to be demonstrated via feedback on diverse exposure experiences.

Finally the placement should be a challenging and positive experience, encouraging and guiding the trainee towards conscious choices for her future career development.

Shoreham by Sea, 23 April 1998

Ms Jacqueline Allt
Trainee Clinical Psychologist

Drs. C.A.J. Meesters
Chartered Clinical Psychologist
PLACEMENT CONTRACT AT THE TRAUMATIC STRESS CLINIC

TRAINEE: JACKIE ALLT

SUPERVISOR: DR PETER SCARRAG

START DATE: 21ST OCTOBER 1998

FINISHING DATE:

Aims:

1. To gain experience of a range of client/patients who have experienced major traumatic events.
2. To become independent and confident in the assessment of traumatic sequelae.
3. To become independent and confident in treatment planning for patients who have experienced major trauma.
4. To develop and broaden cognitive behavioural therapy skills.
5. To learn particular cognitive behavioural skills appropriate for Post-Traumatic Stress Disorder.
6. To gain some understanding and appreciation of the legal and compensation issues that arise from working with patients who have been traumatised.
7. To develop greater skill in concise report writing.

Objectives

To gain experience of acutely traumatised people.

To gain experience in administering a semi-structured interview for Post-Traumatic Stress Disorder.

To develop an understanding of the reliability and validity of questionnaire measures of PTSD.

To develop advanced skills in cognitive behavioural case formulations.

To develop advanced skills in imaginal exposure therapy techniques.

To develop skills in cognitive restructuring via imaginal techniques.

To gain observational experience of the preparation of legal reports.

To gain observational experience of court appearance by clinicians
To gain observational experience of children with PTSD.

To gain experience of working with an interpreter in assessment and intervention

To become more aware of working with cultural issues.

PARAMETERS OF PLACEMENT

1) The placement will include observation of qualified clinical psychologists assessing and treating patients. The supervisor will expect to sit in on some initial assessment interviews and to listen to some tapes of therapy.

2) Supervision will provide a forum for developing specific and advanced cognitive behavioural skills, advanced formulations skills and an opportunity to debrief following difficult sessions with patients.

Signed by: Jackie Allt

Signed by: Dr Peter Scragg, Supervisor
Experience

Jackie will have the opportunity to observe and participate in providing a family systems approach to a range of referred patients.

Jackie will have the opportunity to work directly with a minimum of two families, receiving live supervision.

Jackie should aim to develop an understanding of key systemic theories and practices and develop the ability to reflect on their usefulness and usability for the trainee.

Supervision

- Jackie is to experience the use of live supervision.
- Jackie is to work as part of a systemic family therapy team.
- Jackie is to receive 1 hour per week to enable her to question, explore issues emerging.
- Jackie should aim to develop her ability to utilise constructive feedback.
- Jackie should aim to develop her ability to self-reflect on her case work and therapy issues which emerge.
**Professional Behaviour**

Jackie should aim to be aware and relate to current practise of the content of the following documents:

- AFT Code of Conduct and BPS Code of Conduct

- Jackie will have the opportunity to use systemic theory in a ‘consulting’ role to a new team undergoing service development.

- Jackie should aim to demonstrate an ability to manage the challenges and difficulties of applying different models.

**Assessment**

- Jackie should aim to develop an understanding of the meaning of the referral within a mental health context, and within a systemic model.

- Jackie should aim to develop her assessment skills in relation to engagement, patterns, life cycle issues, and themes leading towards developing a mandate for therapy.

**Intervention**

- Jackie should aim to develop an understanding of ‘circularity’ - and make use of circular questioning.

- Jackie should aim to develop a sense of curiosity to her case work.

- Jackie should aim to identify and explore relevant themes and hypotheses within the systemic model.

- Jackie will have the opportunity to develop formulation and conceptualisation skills within the systemic model.
**Communication Skills**

- Jackie should aim to acquire greater awareness of the 'tyranny' of language.
- Jackie should aim to acquire an understanding of hermeneutic processes in communication.
- Jackie will be given the opportunity to acquire experience in the use of genograms.
- Jackie will be required to write reports and formulations for GPs and other referrers within the systemic model.

**Research Knowledge and Skills**

- Jackie should aim to be able to critically consider the relevant literature and apply the findings to the clinical context.
- Jackie will have the opportunity to participate in discussion of the literature.
- Jackie will have the opportunity to participate in the discussion of research and evaluation issues within the systemic model.
- Jackie will have the opportunity to advise on outcome within a clinical setting.

**Presentation**

- Jackie will be given the opportunity to present material on systemic ideas to another agency.
Personal Awareness

- Jackie should aim to self-reflect on case-work so as to consider her own beliefs and thoughts associated with couples/families.

- Jackie will have the opportunity be able to discuss her therapeutic approach, style and personal relationships.

- Jackie should aim to reflect on the impact of her work on her personal and professional development.

- As a member of the team, Jackie should be given the opportunity to develop an awareness of her own and others own personal experiences, and to consider the impact this has on the team.

Jackie Allt
Psychologist in Clinical Training

Annette Lumsden
Clinical Psychologist/Family Therapist

Lorna Atkins
Family Therapist

Tracey Harris
Clinical Psychologist/Family Therapist

May 1999
3. Summaries of case reports

3.1 Adult Mental Health Placement: Couple Therapy within a Cognitive-Behavioural Model

Therapy with a couple was undertaken following the referral of a woman with depression. After an initial assessment, it was established that a significant factor contributing to her low mood was conflict within her relationship.

The initial assessment had involved a clinical interview, within the cognitive-behavioural model, with the referred client. This was followed by a clinical interview with her husband. The Maudsley Marital Questionnaire was administered to both. The case was formulated within the Social Exchange model of distress (Jacobson, 1979), which views marital distress as a function of the rate of reinforcement or punishment within the relationship.

The intervention was based around 4 main stages. Firstly, communication skills were taught using modelling and role-play. Secondly, cognitive therapy was used to address assumptional thinking patterns. Thirdly, problem solving skills were introduced, with emphasis on the generalisation of these. Finally, relapse prevention work was introduced to establish strategies for any ‘set-backs’. Homework tasks were an integral part of these interventions.

The couple generally engaged well in therapy, though had some difficulty prioritising time for themselves and their homework tasks. The Maudsley Marital Questionnaire was re-administered at the end of therapy. This revealed improved levels of satisfaction for the referred client, with the biggest improvement for her being with regards to how well they were able to compromise. The client’s husband perceived less significant levels of improvement.
3.2 Learning Disabilities Placement: Assessment and intervention with an adolescent with learning disabilities.

This client was referred to the Community Team for People with Learning Disabilities by her school teacher. Concerns were highlighted regarding her sexual vulnerability and conflicts with her sister. The referral also highlighted the lack of social opportunities she had. The client's intellectual functioning fell within the mild range of learning disability.

This case involved a complex assessment. The first aim was to establish the client's level of social skills, her social opportunities and self esteem. This involved clinical interviews with the client, her mother and her teacher. It also incorporated the administration of The Culture-Free Self-Esteem Inventory and the use of Brookes package 'Not a child Anymore'. This assessment disconfirmed the hypothesis that the client had significant problems with social skills, social opportunities and self-esteem.

The next stage in assessment was to explore, via clinical interview, the client's mothers beliefs with regarding her daughters vulnerability. Within the cognitive model, it was hypothesised that her beliefs may be significant in causing her anxiety. This hypothesis was confirmed.

The intervention was twofold. Firstly, cognitive therapy was undertaken with the client's mother. The aim of this was to challenge her beliefs around adolescence, sexuality and safety so as to decrease her anxiety regarding her daughter. Secondly, joint work was planned to discuss future social opportunities for the client and to discuss how to make social 'rules' explicit.

The client's mother reported finding the intervention useful and was to seek further therapy through adult services. The client and her mother had begun discussions regarding her obtaining a Saturday job.

The client was referred to the child psychology service by his GP due to concerns regarding his ritualistic behaviour. The request was for the “fine tuning” of the client’s coping skills following some recent improvement with his difficulties.

The assessment consisted of clinical interviews with the client and his family as well as a number of psychometric and other measures. The clinical interviews were used to obtain a developmental history of the problem, as well as undertaking a behavioural analysis of the physiological, emotional, cognitive and behavioral aspects of John’s difficulties. Structured measures included the Achenbach Child Behaviour Checklist (CBCL), The Yale-Brown Obsessive Compulsive Scale (YBOCS) and a self-report diary.

The diagnosis of Obsessive Compulsive Disorder was confirmed. The case was initially conceptualised within a behavioral ‘response-prevention’ model (Foa, 1987). The initial part of the intervention was aimed at encouraging the client to practice exposure and ‘response-prevention’ strategies with a number of short-term goals. These strategies were then generalised to other goals. The second part of the intervention was based on the observation that the client had difficulty accepting improvement. The client’s negative self-rating was formulated within the Rational-Emotive Therapy model (Ellis, 1977). The second part of the intervention was therefore based on encouraging positive self-rating and tolerance of a low level of symptoms. Finally, a plan for relapse prevention was devised.

The YBOCS and Achenbach CBCL were re-administered at the end of treatment. They indicated a significant decrease in symptomology. The client and his parents both reported his improved tolerance of his residual low level symptoms.
3.4 Older Adults Placement: A neuropsychological assessment of 69 year old man

This client was referred for neuropsychological assessment by his primary nurse. He was an inpatient in an assessment unit for older adults suspected with organic brain problems. It had been postulated that he was suffering from dementia of the vascular type. Further assessment was requested to "determine the degree of brain damage".

The assessment and diagnosis was undertaken using an adapted version of Folstein's algorithm for the process of differential diagnosis. The current author added an additional stage to this model to include the possibility of functional disorders. Assessment involved reviewing the medical notes, interviewing nursing staff and the administration of a battery of psychometric tests. The following tests were administered: The Middlesex Elderly Assessment of Mental State, the National Adult Reading Test, the Weschler Adult Intelligence Scale-Revised, the Rivermead Behavioural Memory Test and the Behavioural Assessment of Dysexecutive Syndrome.

Although there was evidence to confirm the diagnosis of vascular dementia, this diagnosis did not account for the client's hallucinations. Furthermore, the history of onset was difficult to establish. Some other possible diagnoses were considered. It was postulated that the client's profile may best fit that of Lewy Body Disease. The results of the assessment were fed back to the client's primary nurse.

3.5: Specialist placement: An assessment and formulation of a client who had experienced childhood abuse, sexual assaults and a recent mugging.

This case study reported on the assessment and formulation of a complex trauma case. The client was referred by a victim support agency due to her difficulties following a mugging incident. She was having difficulties sleeping, was experiencing feelings of panic and was fearful when outside her home.
The first part of the assessment was undertaken according to DSM-IV criteria for axis I disorders. It was hypothesised that the client may be suffering from Post Traumatic Stress Disorder (PTSD). However, a number of other possible diagnoses were considered such as depression and generalised anxiety. An extensive clinical interview was undertaken to obtain information on the client’s personal history, prior experience of traumatic events, mental health history and details of the recent mugging. A number of measures were administered. These included the Beck Depression Inventory, the General Health Questionnaire, the Alcohol and Drugs questionnaire (devised by the service), the Clinician Administered Post Traumatic Disorder Scale, the Impact of Event Scale and a Schema Questionnaire. The assessment data revealed that the client fulfilled the criterion for PTSD with concurrent depression.

The case was formulated within Dual Representation Theory (Brewin, Dagleish & Joseph, 1996) which combines social-cognitive and information processing perspectives on PTSD. This formulation highlighted the need to pair ‘situational’ memories with new knowledge and a decrease in physiological arousal. The main part of the treatment plan for this involved imaginal exposure to the situational memories of the attack. This was not reported on in detail.

The imaginal exposure work gave further opportunity to gather evidence regarding the client’s schema. The work had cued distressing memories she had experienced as a child. The second part of the assessment therefore focused on schema identification, schema activation, schema conceptualisation and schema education according to Young’s (1994) model. The second stage of intervention, which was not reported in detail, focused on exploring the impact of the recent mugging in terms of her relevant schema.

The client engaged well in this therapy. The re-administration of measures revealed a significant decrease in the client’s distress and symptomology.
Part Three: Research Dossier
Referrer Satisfaction with a Children’s Inpatient Psychiatric Unit

Research on Placement

Submitted: July 1998 (Year I)

Due to reasons of confidentiality, all place names used in this document are fictional.
Abstract

This study is a survey of referrer satisfaction for referrers to an inpatient child psychiatric unit. It was the result of a request by the psychologist working in the unit to find out what referrers thought about the service.

The study was approached via close liaison with the staff team of the unit. A questionnaire was conceptualised around staff concerns and issues raised in the literature. All referrers who had referred a child during a two year period were included in the survey. This amounted to 22 referrers. Of these, 12 questionnaires were returned.

The responses indicated that referrers had a good understanding of the service, though most would only consider referring a child over 4 years of age. The majority of respondents were satisfied with technical aspects of the service including assessment, treatment and management of children's behaviour. However, satisfaction was lower regarding the flexibility of the length of stay for children in the unit. Respondents were generally satisfied with the information they received, with the exception of discharge recommendations. A number of issues regarding these were made. The majority of respondents were satisfied with the accessibility of staff, but were not satisfied with the length of the waiting list.

The results were fed back to the team for discussion, and a number of points were raised.
Introduction

"Surveying referrer satisfaction provides readily available, accurate and relatively inexpensive total quality management data which can lead to improvements in service delivery, tailoring of services to reflect the diverse needs of referrers and more 'shared care' - of use in these days of medical rationing" (Eyers, 1994, p503).

There is very little literature specifically on referrer satisfaction with regards to psychiatric services, acknowledged by Eyers, Brodaty, & Roy, (1996), Philips, Wright, Robertson & Sengoz (1996), Phillips, Dennerstein, & Farish, (1996) and Bradley & Clark (1993). However, there is recent and growing awareness that surveys assessing the satisfaction of referrers can be an important part of service evaluation (Eyers et al. (1994 & 1994), Parker et al. (1996), Phillips et al. (1996), Bradley & Clark (1993). As Eyers et al. argue information gained from such surveys may help improve those services, as well as influence resource allocation, planning and quality assurance.

Evaluation within health care settings is now seen as a vital part in service delivery (e.g. Nolan & Grant, 1993). However consumers’ views generally, have not been considered as a particularly significant part of such evaluations until recently (Ruggeri 1994). This, argues Ruggeri (1994), has been due to a number of reservations about using satisfaction as a measure. For example, it was considered that the concept of satisfaction was too general and that the degree of satisfaction may be more related to expectations. Ruggeri argues that although consumer satisfaction was an important variable to be measured in service evaluation, it should be clearly stressed that consumer satisfaction “is only one evaluative perspective and that it is reasonable to consider satisfaction a necessary, though not a sufficient, component in the assessment of quality and effectiveness of care. ” (p215). Though he states this in relation to patient and relative satisfaction, it is also considered relevant in the context of referrer satisfaction.
It is worth highlighting at this point how 'satisfaction' differs from 'service evaluation'. Service evaluation is a complex undertaking. A popular model (Donabedian, 1966, cited in Nolan & Grant, 1993) advocates that there are three perspectives from which an intervention can be evaluated: the structure of care, the process of care and the outcome of care. There is much debate over how these elements relate, which will not be considered in detail here. However, in contrast, satisfaction studies investigate an evaluative perspective which, argues Ruggeri (1994) "may be viewed both as a measure of outcome and quality per se and/or as a factor in the process of care" (p212). Ruggeri (1994) also highlights the methodological difficulties that riddle the literature in this field. The design of studies is often limited due, for example, to the lack of confidentiality and low response rates. There are also limitations in the construction of instruments including a low range of response options and a lack of evidence for content validity. The field has very few validated measures, with validity and reliability rarely being reported. Concern has also been raised regarding the sensitivity of measures in detecting 'dissatisfaction', with the majority of studies finding approximately 75% of respondents to be satisfied. Such evidence would suggest that satisfaction should not be viewed as a discriminate variable, thus limiting the usefulness of information such studies can provide. However, recent developments hold promise. For example, Lebow (1982, 1983, cited in Ruggeri, 1994) found that for those studies which gave the responders multiple-response options, only 49% of respondents rated themselves as highly satisfied. Such evidence suggests that the design of the response options can highly influence the results.

Problems with the design of questionnaires used, particularly the lack of response options given, is reflected in the literature. For example, Philips, (1996) assessed referrer and patient satisfaction with regard to the evaluation of a consultation-liaison psychiatry service to an obstetric gynecology hospital. Although she concludes that there was high referrer satisfaction, the authors equated satisfaction with 'helpfulness' and assessed this using one global question; thus the conclusions need to be treated with caution. Bradley & Clark’s (1993) questionnaire design was more promising in that it used a multiple
response seven point Likert scale (ranging from very helpful to very unhelpful) which asked the referrers to rate the quality of the inpatient child unit’s service on a range of issues (e.g. treatment and recommendations). However, the results reflect widespread satisfaction, which does raise doubts regarding the sensitivity of the measures.

Recently there have been some well designed studies (e.g. Parker et al. 1996; Eyers et al. 1994), which have been particularly useful in terms of establishing underlying factors which are important for satisfaction. For example, Parker et al. (1996), compiled a list of 36 items from non-psychiatric referrer satisfaction measures and presented them to GPs, physicians, neurologists, obstetricians and gynecologists who were asked to rank order the items in terms of their judged importance to a referrer’s potential satisfaction with a psychiatric service. A principal component analysis identified four main dimensions. These were “accessible and helpful” (p340) (e.g. “the psychiatrist available at all times”), “Quality report” (p340) (i.e. the psychiatrist’s initial report to the referrer), a “flexible psychiatrist” (p340) (i.e. collaboration with community mental health services and family) and “joint versus delegated management” (p340) - a bipolar factor which consisted of those who wanted shared management of the patient versus those who wanted the psychiatrist to take over complete responsibility. Interestingly, there were no significant differences between the different groups of referrers in terms of their perceived perception of the importance of each of the four domains. This is promising in terms of establishing an item set which is representative across professions.

Eyers et al’s. study (1994) also holds promise. This study looked at referrer satisfaction with a mood disorders unit. A survey was sent to 75 psychiatrists, 59 GPs and 13 others. These were asked to rate their satisfaction on a 1-5 scale (from very unsatisfactory to very satisfactory) for various aspects including treatment, outcome, communication and follow-up arrangements. A principal component analysis identified three main components:
Factor 1. "Technical competence" (p 498): This accounted for 39% of the variance. The significant items which were relevant to this project included ratings of clinical aspects of care (proposed and undertaken treatment), medication (changes or withdrawal); length of stay; clinical investigations and the units plan of management.

Factor 2. "Adequate information and follow-up support" (p498). This accounted for 15% of the variance. Significant items which were relevant to this study included the comprehensiveness of written information and the promptness of information received.

Factor 3. "Access" (p498). This accounted for 9% of the variance. The significant items which were relevant to this study included the availability of in-patient beds “and the competence of assessment” (p501).

The strength of these studies (Parker et al. (1996); Eyers et al. (1994) lies in the multiple response options given to respondents, the large samples and the high response rates. Both provide particularly useful insights into the dimensions underlying referrer satisfaction which can help with the development towards much need validated tools.

The Current Study

Preliminary Aims
It was highlighted by the clinical psychologist involved at Fallowfield that it would be useful to find out what referrers thought of the service. From the early stages this was conceptualised as a referrer satisfaction study.

Due to financial constraints and limited resources, it was decided from the outset that a postal questionnaire would be the most appropriate way of investigating referrer satisfaction.
The Service
Fallowfield Children’s Unit, established since 1975, is an inpatient unit for children up to the age of eleven with a range of psychiatric difficulties. It offers residential (usually for a period of approximately twelve weeks) and day treatment (including an educational service) for children for whom out-patient work has usually been tried without success. The unit is clinically led by a Consultant Psychiatrist, with a staff team consisting of junior medical and nursing staff and educational, psychology and social work professionals.

Procedure: Stage 1
In the light of the sensitive nature of the study, which could have been professionally threatening to staff, a number of meetings were held to liaise with key professionals:
- Consultant Psychiatrist with overall responsibility for the unit
- Two qualified nurses
- Other nursing staff

A brief questionnaire regarding the potential ‘referral satisfaction’ study was sent to all nursing staff (appendix R1:1) to obtain their views on how useful they thought such a project would be, and what issues would be useful to include. Approximately 50% of day nursing staff returned these.

All those contacted (face-to face or by questionnaire) were supportive of the project. The issues that were raised can be considered under the following headings:
1. Communication (between Fallowfield and the referrers)
2. Involvement of Referrers
3. Satisfaction of response time/waiting times
4. Flexibility of the length of stay: flexible enough?
5. Outcome.
The Development of the Questionnaire

The conceptualisation and development of the questionnaire was based on a consideration of the literature outlined above, staff views and the statement of service aims. It was noted that there was high overlap between the components highlighted in Eyer's et al. (1994) study and the issues raised by Fallowfield staff. However the staff also wanted to investigate referrers' perceptions of the aims of the service. It was decided not to include 'outcome' in this study due to the complexity of the issue. However, perceptions of the aims of the service were included.

In all, it was thought that the issues raised in the literature and by staff could be based around the following components: Aims' (component 1), 'Technical' (component 2), 'Information' (component 3), 'Access' (component 4), Global (component 5) and Miscellaneous (component 6). These are described in more detail below.

Component 1

Aims: Referrers' perceptions of the 'aims' of the service

In order to investigate referrers' perceptions of the aims of the service, a general statement regarding the aims of the service was required. Such a statement was abstracted from a leaflet published by the unit (appendix R1:2). The following aims and objectives were identified:

a) Fallowfield admits children up to the age of eleven years.

b) Admissions reflect the full range of psychiatric problems and disorders including emotional and behavioural problems.

c) The service is for children for whom out-patient treatment was insufficient or unsuitable

This was investigated in Section 1 of the questionnaire, questions 1 to 4 (appendix R1: 3)

This section was aimed at assessing the referrers understanding of the service according
to these statements and the questions were devised to ‘test out’ the statements listed above.

Components 2, 3, 4, 5 & 6
These components were included in section 2 of the questionnaire. The individual items were placed in random order within section 2 and are listed, according to their components in appendix 4 (Appendix R1:4). The items within the components were selected according to Eyers et al.’s. (1996) study and staff opinion. Question 13 and 16 and 20 were added at the particular request of staff. The opportunity for comments on Question 5, 7, 11, 12 and 14 were also added due to staff concern that low satisfaction in response to these questions would require clarification (Appendix R1:4).

Specific considerations regarding Questionnaire Design

Wording
The aim of the survey was to assess satisfaction. Therefore, the word satisfaction was kept in each statement. Care was taken to write short statements using familiar words and avoiding any ambiguity in meaning. Double-barrelled statements (i.e. statements which contain two points) were also avoided.

Halo effect
Care was taken to try and minimise potential halo effects (i.e. when a respondent gives minimum attention to individual items and is influenced by an overall feeling, or attitude (Oppenheim, 1966; 1992). Items from each component were placed in random order and both negative and positive statements were used in attempt to minimise this effect.

Measuring satisfaction
A consideration in the design was the potential use of the data. The primary use of the data was for staff consideration. Data in terms of percentages was the most accessible and understandable. A Likert scale was, therefore, chosen to measure satisfaction.
according to 5 categories. The respondents were asked to rate their level of agreement with regards to each statement in terms of “strongly agree” - “agree” - “neutral” - “disagree” and “strongly disagree”.

Pilot work:
A draft of the questionnaire, developed by the author, was presented at a child clinical psychology seminar for review, and changes were subsequently made. A number of drafts were also presented to professionals involved in the unit.

Methodology
Participants
The names of the referrers were obtained from the ongoing recording system at Fallowfield which records all children who have been referred (whether admitted or not), their referrer, their admission and discharge date. Referrers consisted of consultant child psychologists, psychiatrists and pediatricians.

All referrers who had referred at least one child on or after the 2/2/96 who had been discharged by 2/2/98 were included in the survey. A two year period was chosen as a reasonable time sample, bearing in mind that referrers may have difficulty remembering a child they had referred before this time. Referrers who had referred a child within this time period who had not subsequently been admitted, for whatever reason, were also included. For those referrers who had a child admitted, it was important that the child had been discharged so that they had experienced the whole ‘process’ of the service. These two sources gave twenty two referrers.

Procedure: Stage 2
The questionnaire was posted to each referrer. To maintain confidentiality to a maximum, each referrer was given an identification number. They were informed that their responses would be kept anonymous in the summary of data.
Those referrers who had not returned the questionnaire by the closing date, were then all contacted by telephone and prompted to return the questionnaire. They were given the option of giving their responses over the phone at this stage.

Results

Response rate
The questionnaires were sent to twenty two referrers. Three were not contactable (one had retired, one was on long-term sick leave and one on authorised leave). One respondent gave their response by telephone. In total, twelve out of the remaining nineteen responded giving a response rate of 63%.

Analysis of data.
The questionnaire was designed as such so that most of the data could be summarised in terms of percentages. The results were analysed according to six components (Aims, 'Technical', 'Information', 'Access', Global and Miscellaneous) outlined above. The data and main points are presented below.
COMPONENT 1 (Referrers perceptions of the Aims of the service)

Question 1): What age range of children would you consider referring to Fallowfield?

Table 1: Age-Ranges of children that Respondents would refer

Please note that all percentages have been rounded to the nearest whole number

<table>
<thead>
<tr>
<th>Age band indicated</th>
<th>Number of responses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No response *</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>1 to 12</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>4 to 11</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>5 to 11</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>8 to 11</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>7 to 11</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>5 to 12</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>6 to 12</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

* the 'No response' category represents those who did not answer the question at all.

The majority of respondents (66%) would consider referring a child of 4 years onwards, and 25% would incorrectly consider referring a 12 year old. There were no respondents who indicated the correct age band of ‘up to 11 years’.
Question 2: I would consider referring a child to Fallowfield with one of the following difficulties:

Table 2: Referrers’ Indication of which Difficulty Respondents would Refer

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Number of responses</th>
<th>Disorder</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention Deficit Disorder</td>
<td>7</td>
<td>Depression</td>
<td>10</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder</td>
<td>10</td>
<td>Anxiety</td>
<td>8</td>
</tr>
<tr>
<td>Autism</td>
<td>7</td>
<td>Encopresis</td>
<td>10</td>
</tr>
<tr>
<td>Aspergers</td>
<td>8</td>
<td>Conduct Disorder</td>
<td>8</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulties as a result of abuse</td>
<td>10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NB: Respondents were able to tick a number of boxes, thus up to 12 respondents could tick each box.

Others difficulties which referrers would chose to refer to Fallowfield were stated as:

- “particularly co-morbid problems”
- “Possible schizophrenia”
- “Any of the above but usually the most complex”
- “Psychosis, mania, elucidation of unusual mental states”

The majority of the respondents would refer a child with a range of psychological difficulties. All of the respondents indicated that they would refer a child with eating disorders.
Question 3): Under what circumstances would you consider sending a child to Fallowfield?

Table 3: Circumstances under which respondents would refer.

<table>
<thead>
<tr>
<th>Circumstances</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis situation</td>
<td>9</td>
</tr>
<tr>
<td>Outpatient treatment has been tried without improvement</td>
<td>11</td>
</tr>
<tr>
<td>Chronic family problems</td>
<td>6</td>
</tr>
</tbody>
</table>

Nearly all (11 out of 12) of the respondents indicated that they would refer when outpatient work had been tried without improvement. One referrer indicated that they would make a “strategic” referral to the service and another stated that it “may help to clarify the contribution of these (chronic family problems) and the child’s response to separation”.

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Results with regards to Q 4) *In your view, what could be the main aims of sending a child to Fallowfield?*

Table 4: Main aims of referring a child to Fallowfield

<table>
<thead>
<tr>
<th>Identified Aims</th>
<th>No. of responds. who raised this</th>
<th>% of responds. who raised this</th>
<th>Identified Aims</th>
<th>No. of responds. who raised this</th>
<th>% of responds. who raised this</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Diagnostic classification</td>
<td>3</td>
<td>25</td>
<td>f) Education asst. and recommendations.</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>b) i) Assessment (total)</td>
<td>9 (4)</td>
<td>75</td>
<td>g) Treatment/therapy (total)</td>
<td>7 (2)</td>
<td>58</td>
</tr>
<tr>
<td>ii) Asst. of child 'away from normal environment'</td>
<td>(1)</td>
<td>34</td>
<td>ii) 'intensive treatment'</td>
<td>(1)</td>
<td>17</td>
</tr>
<tr>
<td>iii) 'multimodal' asst.</td>
<td></td>
<td>8</td>
<td>iii) 'range of therapy'</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>c) Gain info./rec. for future work.</td>
<td>2</td>
<td>17</td>
<td>h) Recommendations for treatment</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>d) For 2nd opinion</td>
<td>1</td>
<td>8</td>
<td>i) To break deadlocked situation</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>e) To get advice on future placement</td>
<td>1</td>
<td>8</td>
<td>j) When family finding the child difficult to manage</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>k) When child is not responding to outpatient work</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

NB: This was an open question. Thus respondents were able to give multiple responses.

The majority of respondents indicated that they considered the main aims to be Assessment (75%) and treatment (58%). These categories can be broken down into the subheadings listed in the table.
COMPONENT 2 (‘Technical Competence’)

Table 5: Responses to questions regarding Technical Competence

<table>
<thead>
<tr>
<th>Questions</th>
<th>strong agree</th>
<th>agree</th>
<th>neutral</th>
<th>disagree</th>
<th>strong disag.</th>
<th>N/A</th>
<th>D/K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q 8. The flexibility of the length of stay at Fallowfield is not satisfactory</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>%</td>
<td>0</td>
<td>17</td>
<td>8</td>
<td>50</td>
<td>8</td>
<td>0</td>
<td>17</td>
</tr>
</tbody>
</table>

N/A = not applicable
D/K = Don’t know

For all of the subsequent tables, this key (N/A and D/K) will be used.

7 out of 12 (58%) respondents considered the length of stay to be satisfactory. One was not sure, two were not satisfied and 2 did not know.

Table 6: Responses to Question 11.

<table>
<thead>
<tr>
<th>Question</th>
<th>strong agree</th>
<th>agree</th>
<th>neutral</th>
<th>disag.</th>
<th>strong disag.</th>
<th>N/A</th>
<th>D/K</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. I am not satisfied with the assessment of children at Fallowfield.</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>%</td>
<td>0</td>
<td>17</td>
<td>17</td>
<td>34</td>
<td>34</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

8 out of 10 (68%) of referrers were satisfied, or very satisfied with the assessment of children at Fallowfield. 2 (17%) were neutral, and 2 (17%) agreed with the statement that they were not satisfied. One referrer indicated that there was “not enough liaison with me whilst the child is at Fallowfield”.

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Table 7: Responses to question 12.

<table>
<thead>
<tr>
<th>Question</th>
<th>strong agree</th>
<th>agree</th>
<th>neut.</th>
<th>disag.</th>
<th>strong disag.</th>
<th>N/A</th>
<th>D/K</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. The treatment carried out at Fallowfield is satisfactory.</td>
<td>1</td>
<td>8</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>8</td>
<td>67</td>
<td>17</td>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

9 out of 12 (75%) of respondents were satisfied or very satisfied with the treatment carried out. 2(17%) were neutral and 1 (8%) was not satisfied. Additional comment that was given stated that “the experience has varied - very satisfactory and not so satisfactory” and that “the difficulty is family work”.

Table 8: Responses to question Q 14.

<table>
<thead>
<tr>
<th>Question</th>
<th>strong agree</th>
<th>agree</th>
<th>neut.</th>
<th>Disag.</th>
<th>strong disag.</th>
<th>N/A</th>
<th>D/K</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. The management of children’s behaviour at Fallowfield is satisfactory</td>
<td>1</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>8</td>
<td>67</td>
<td>17</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
</tbody>
</table>

9 out of 12 respondents (75%) were satisfied or very satisfied with the management of children’s behaviour at Fallowfield. 2 out of 12 (17%) were neutral and one (8%) did not know.
7 out of 12 (59%) of respondents were either neutral or not satisfied with the conceptualisation of problems. Four (34%) were satisfied and one (8%) did not know.

Summary of ‘Technical Competence’ Component

The majority of respondents were satisfied, or very satisfied with the management of children’s behaviour (75%), assessments (68%), treatment (75%) and the flexibility of the length of stay (58%). However, only 34% indicated that they were satisfied with the conceptualisation of problems, with 59% being either neutral or not satisfied.

COMPONENT 3: (‘Information’)

Table 10: Responses to questions 5.

<table>
<thead>
<tr>
<th>Questions</th>
<th>strong agree</th>
<th>agree</th>
<th>neut.</th>
<th>disag.</th>
<th>strong disag.</th>
<th>N/ A</th>
<th>D/ K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q 5. The discharge recommendations are satisfactory</td>
<td>0</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>0</td>
<td>58</td>
<td>25</td>
<td>17</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

7 out of 12 respondents (58%) were satisfied with the discharge recommendations. Three (25%) were neutral and 2 (17%) were not satisfied which means that 42% were unsure or not satisfied. A number of comments were offered by those who were not
satisfied. One respondent stated that “They are factual and medical. I would like formulation/hypotheses and more plans for future work. include plans of other significant disciplines”. Another stated that there “some difficulties with recommendations around family involvement. Some discontinuity between family work/Fallowfield”. Two respondents referred to the time elapsed before receiving the discharge recommendations. One referrer stated “They reach me too long after discharge...they are not always clear who is to be responsible for continuing care/follow up” and another that they “haven’t had them yet”. Finally, one respondent referred to the amount of information given for follow-up stating that “I didn’t have involvement or information for adequate follow-up!”

Table 11: Responses to Question 7

<table>
<thead>
<tr>
<th>Question</th>
<th>strong agree</th>
<th>agree</th>
<th>neut.</th>
<th>Disag.</th>
<th>strong disag.</th>
<th>N/A</th>
<th>D/K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. I am satisfied with the comprehensiveness of written information provided by Fallowfield.</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>17</td>
<td>17</td>
<td>50</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

7 out of 12 (58%) of respondents remained neutral or said they did not know about the comprehensiveness of written information provided by Fallowfield, with 4 (34%) indicating that they were not satisfied. Only one respondent (8%) was satisfied. Comments from those who were not satisfied included one respondent who had not received any written information. Another respondent also had not received any, stating that they “have often been invited to review meetings at such short notice that I am unable to attend. I have apologised for not being able to attend and have requested notes of the meetings but rarely received them”.

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Table 12: Responses to Question 15.

<table>
<thead>
<tr>
<th>Question</th>
<th>strong agree</th>
<th>agree</th>
<th>neut.</th>
<th>Disag.</th>
<th>strong disag.</th>
<th>N/A</th>
<th>D/K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q15. I am satisfied with the promptness of written information</td>
<td>0</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>0</td>
<td>67</td>
<td>17</td>
<td>17</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

8 out of 12 (67%) were satisfied with the promptness of written information, whereas two (17%) remained neutral and two (17%) were not satisfied. One respondent made the additional comment that written information was “often received weeks after discharge”.

Summary of ‘Information’ Component

The majority of people (67%) were satisfied with the promptness of written information and the discharge recommendations (58%). However, although 58% of respondents were satisfied with the discharge recommendations, nearly half (42%) were either neutral or not satisfied with them. A number of comments were made which are included above. There was no clear level of satisfaction with the comprehensiveness of written information, with 50% remaining neutral and 58% indicating that they were either satisfied or very satisfied. Comments were made with regards to this, which are included above.

COMPONENT 4 (‘Access’)

Table 13: Responses to Question 13

<table>
<thead>
<tr>
<th>Question</th>
<th>strong agree</th>
<th>agree</th>
<th>neut.</th>
<th>Disag.</th>
<th>strong disag.</th>
<th>N/A</th>
<th>D/K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q6. I am satisfied with Fallowfield’s ability to take on non-urgent referrals.</td>
<td>2</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>17</td>
<td>67</td>
<td>8</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

10 out of 12 (84%) were satisfied with the unit’s ability to take on non-urgent referrals. 1 respondent remained neutral (8%) and one (8%) was not satisfied.
Table 14: Responses to Question 14

<table>
<thead>
<tr>
<th>Question</th>
<th>strong agree</th>
<th>agree</th>
<th>neut.</th>
<th>Disag.</th>
<th>strong disag.</th>
<th>N/A</th>
<th>D/K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q.9 I am satisfied with the length of waiting time before a child is admitted.</td>
<td>1</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>17</td>
<td>67</td>
<td>8</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

9 out of 12 (84%) were satisfied with the length of waiting time before a child is admitted. The remaining two (16%) were either neutral or not satisfied. One respondent added that they “would like it (waiting list) to be shorter, but understand the difficulties”.

Table 15: Responses to Question 15

<table>
<thead>
<tr>
<th>Question</th>
<th>Strong agree</th>
<th>agree</th>
<th>neut.</th>
<th>Disag.</th>
<th>strong disag.</th>
<th>N/A</th>
<th>D/K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Fallowfield’s ability to take on urgent referrals is not at a satisfactory level.</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>%</td>
<td>0</td>
<td>34</td>
<td>17</td>
<td>0</td>
<td>25</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

5 out of 12 (42%) respondents were either neutral of indicated ‘Don’t Know’ with regards to Fallowfield’s ability to take on urgent referrals. Four (34%) were satisfied, though three (25%) strongly disagreed with the statement, indicating strong dissatisfaction.
Table 16: Responses to Question 16

<table>
<thead>
<tr>
<th>Q13. I am not satisfied with the accessibility of staff at Fallowfield to discuss the appropriateness of referrals.</th>
<th>strong agree</th>
<th>agree</th>
<th>neut.</th>
<th>Disag.</th>
<th>strong disag.</th>
<th>N/A</th>
<th>D/K</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>0</td>
<td>8</td>
<td>17</td>
<td>42</td>
<td>34</td>
<td>0</td>
<td>0-</td>
</tr>
</tbody>
</table>

9 out of 12 (76%) referrers were satisfied with the accessibility of staff. Two (17%) remained neutral, and one respondent was not satisfied (8%).

Summary of ‘Access’ component

76% of respondents were satisfied or very satisfied with the accessibility of staff and the unit’s ability to take on non-urgent referrals. Over half the respondents (59%) were either not satisfied or neutral about the length of the waiting list. 51% of respondents were not satisfied or neutral at the unit’s ability to take on urgent referrals, although 25% were very satisfied with this aspect of the service. 42% were neutral or didn’t know with regards their satisfaction with urgent referrals,
COMPONENT 5: Global

Table 17: Summary of data for Question 17

<table>
<thead>
<tr>
<th>Q. 17. I am satisfied with the overall quality of the service that Fallowfield provides</th>
<th>strong agree</th>
<th>agree</th>
<th>neut.</th>
<th>disag.</th>
<th>strong disag.</th>
<th>N/A</th>
<th>D/K</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>8</td>
<td>50</td>
<td>34</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

58% (7 out of 12) were satisfied with the overall quality of the service, with 4 (34%) remaining neutral and one (8%) not satisfied.

Table 18: Responses to Question 18

<table>
<thead>
<tr>
<th>Q. 18. I would refer a child to Fallowfield again</th>
<th>strong agree</th>
<th>agree</th>
<th>neut.</th>
<th>Disag.</th>
<th>strong disag.</th>
<th>N/A</th>
<th>D/K</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>25</td>
<td>75</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

100% of respondent indicated that they would consider referring a child to Fallowfield again.
Table 19: Responses to Question 19

<table>
<thead>
<tr>
<th>Q. 19. I would definitely recommend Fallowfield to others</th>
<th>strong agree</th>
<th>agree</th>
<th>neut.</th>
<th>Disag.</th>
<th>Strong disag.</th>
<th>N/ A</th>
<th>D/ K</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>7</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

| % | 17 | 58 | 25 | 0 | 0 | 0 | 0 |

9 out of 12 (75%) indicated that they would recommend Fallowfield to others, with the remaining 3 (25%) remaining neutral.

Summary of the 'global' component

Overall, there was a high level of satisfaction on measures relating to recommending Fallowfield to others and referring a child to the unit again. Although the majority (58%) of respondents indicated that they were satisfied with the overall quality of the service, this was not to such a high degree as on the other two items within this component.

COMPONENT 6: Miscellaneous

Table 20: Responses to Question 20.

<table>
<thead>
<tr>
<th>Question (Miscellaneous)</th>
<th>Key</th>
<th>strong. agree</th>
<th>agree</th>
<th>neut.</th>
<th>disag.</th>
<th>strongly disag.</th>
<th>N/ A</th>
<th>D/ K</th>
<th>No resp.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q.20. I would benefit very much from an educational visit to Fallowfield to find out more about the service.</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

| % | 8 | 0 | 17 | 25 | 17 | 25 | 0 | 8 |

Only one (8%) respondent indicated a clear interest in wanting an educational visit to the unit.
Discussion and Critique

Component One: Referrers’ perceptions of the aims of Fallowfield
The data demonstrated that the referrers generally had a good understanding of the service according to service aims a), b) and c) extracted from the leaflet (see p 6). However, most referrers would only consider referring a child from the age of 4 years, and that 25% would also refer a 12 year old (i.e. even though the upper age limit is specified as 11). It was unclear to the author how strictly Fallowfield wanted to adhere to the age criteria. This point was fed back to the staff team - which will be discussed later. The majority of referrers would refer children with a range of difficulties, which matched aim b). All the referrers said they would refer a child with eating difficulties and it is postulated that this is because eating difficulties were seen as potentially life threatening.

It seems clear that referrers perceived correctly that the service is a secondary resource for when outpatient work has already been tried and/or in a crisis situation, which, again, matches aim c) extracted from the service leaflet. The main aims identified were assessment and treatment, though some specified it was the assessment away from the child’s normal environment which was important and the intensity/range of treatment on offer.

Component two: Technical Competence
The majority of respondents were satisfied or very satisfied with 4 out of the 5 items, with particularly high levels of satisfaction for assessment (68%) treatment (75%) and the management of children’s behaviour (75%). This was encouraging in that assessment and treatment were identified as the main aims (see component 1), and it is for these items that there was the highest level of satisfaction. There was a lower level of satisfaction for the flexibility of the length of stay (58%). On reflection, this item may be more appropriately placed within the ‘Access’ component. The exception in this component was the low levels of satisfaction with ‘the conceptualisation of problems, with most (59%) being either neutral or not satisfied. Unfortunately, respondents were
not asked for further comment. However, it is acknowledged that different professions within the sample may have different expectations regarding this.

Component three: Information
The majority of respondents were satisfied with two out of three of the items on the information component: the promptness of written information and the discharge recommendations. However, 42% were neutral or not satisfied with the discharge recommendations and a number of criticisms were given. These referred to a range of issues including lack of involvement, difficulties with recommendations and lack of formulation and hypotheses. There were no recurring complaints between respondents who gave extra comments, though this may be due to the small size of the sample. There was also no clear satisfaction with the comprehensiveness of written information, with the majority of people being neutral or not satisfied. Two respondents gave further comments on this; both commented on the lack of written information they had received. An overall theme within this component seems to be the lack of information dissemination. It may be that the unit wants to carry out further research to explore this further.

Component four: Access
The majority of respondents were satisfied with the accessibility of staff and the ability of the service to take on non-urgent referrals. Though the majority were not satisfied with waiting list, it is acknowledged that this may reflect a general dissatisfaction with waiting lists (this was commented on by two respondents). The level of satisfaction with the service’s ability to take on urgent referrals is unclear. It is acknowledged that those who indicated ‘Don’t know’, or were neutral, may have done so because they had not attempted to make an urgent referral. This leaves a small sample of 8, three of which were very satisfied and four of which were not satisfied. In retrospect, the service does not attempt to offer an emergency service, and so the item may have been misleading. In summary, there seemed to be lower levels of satisfaction for those items affected by time; waiting time and urgency.
Component 5: Global
The majority of respondents were satisfied with all three items within the ‘Global’ component. However, although 100% said they would refer to Fallowfield again, and 75% would recommend Fallowfield to others, only 58% indicated overall satisfaction with the service. This leaves 42% as either neutral or not satisfied; whether this is acceptable is debatable, bearing in mind that respondents are usually more positively biased when completing questionnaires. It is acknowledged that although 100% said they would refer to Fallowfield again, this probably reflects a sample bias in that those who would not refer to Fallowfield again are less likely to have been included in the sample.

Component 6: Miscellaneous
The miscellaneous item indicated that the majority did not think they would benefit from an educational visit. This is likely to be due to the fact that many of the referrers have regular contact with the service and have already attended meetings (also indicated by the three ‘not relevant’ responses).

General Critique Issues

Sample Size and Response rate
Although the number of respondents was small (12), the original sample represents 100% of those who referred within the specified two year period. Though three referrers were not contactable, the 63% response rate was above the suggested minimum of 50% for postal questionnaires (Erdos, 1983, cited in Schweigert, 1994). There was no evidence to suggest any systematic differences in the group of seven who did not respond, which makes the results more credible.

Design
There were very few ‘don’t know/ not applicable’ responses to questions, which is indicative of respondents’ ability to answer the questions appropriately. The layout of
the questionnaire also seemed to work well, with respondents missing few questions out, with the exception of question one, which had the highest 'no response' score. This question could be re-formatted as a 'tick option' question, with referrers being given a number of age-bands from which to select. It is acknowledged that a negative response to a negative statement resulted in a double negative, which was possibly confusing. However, bearing in mind that the respondent would be experienced in questionnaires, and the apparent consistency in answers, this did not appear to cause problems.

Limitations of descriptive statistics
The questionnaire was designed so that the data could be considered in terms of the percentage of respondents who were satisfied. The limitations of this are that the percentage of those who are 'satisfied' which is taken to be acceptable is ultimately subjective. In retrospect, it would have been useful to decide, with staff, on what percentage was satisfactory before the questionnaire was administered. To state, for example, that the majority were satisfied may be misleading if the actual percentage of respondents who are satisfied is not considered at an acceptable level.

Reliability and validity
Due to the limited number of cases in the sample, it was not possible to use exploratory multivariate analysis to look at reliability and validity. One option would be to conduct a test-retest reliability on the questionnaire.

Staff Feedback
The results of the survey were presented back to the staff team for discussion. A summary of the outcome of this can be seen in Appendix R1:5.
R1: Bibliography


Appendix R1:1

I am thinking of carrying out a 'Referral Satisfaction' study, which will entail sending a questionnaire to all referrers who have referred children to in the last approx. two years. I would be grateful for your opinion on the following:

1) How useful do you feel this would be?

ii) What issues, if any, do you think would be good to include in the questionnaire?
   e.g. clarity of the information referrers get regarding the aim of the service

Name:

I'd be grateful if you could return this to by Wed 28th January.

Thanks for your help!

Jackie Allt

(Psychologist in Clinical Training)
Appendix R1:2

Extract from Service Leaflet

"The base unit is part of the in Haywards Heath, and admits children up to the age of 11 with psychiatric disorders and problems reflecting the full range of psychiatric practice in the childhood age groups which includes emotional and behavioural problems, developmental disorders, eating disorders and abuse...........

has, since it began admitting patients in 1975 offered residential and day treatment for children with emotional and behavioral difficulties for whom outpatient treatment was sufficient or unsuitable............

The common aim of treatment in the base unit is to help the individual child to learn patterns of behaviour and communication that are more adaptive than those presenting at referral. The treatment plans are always based on a consideration of the quality of the child's functioning and closely embrace the family system in the therapeutic work..........."
We'd be grateful if you could return this, by March 28th, to Jackie Allt, Psychology Dpt, at the above address.

Thank you!

We'd be grateful if you could answer these TWENTY QUESTIONS. The first section is designed to gain your perspective on the aims of the service, and the second section to assess your level of satisfaction with different aspects of the service.

Job Title/Profession.............................................................................

Section 1

1) What age range of children would you consider referring to.
   (Please state the age range you would consider)

2) I would consider referring a child to Larchwood with one of the following difficulties:
   (Please tick any of the following)

   Attention Deficit Disorder
   Obsessive Compulsive Disorder
   Autism
   Aspergers
   Eating Disorder
   Difficulties as a result of abuse
   OTHER/S: Please state below:

   Depression
   Anxiety
   Encopresis
   Conduct Disorder

3) Under what circumstances would you consider sending a child to
   (Please tick any of the following)

   Crisis situation
   Outpatient treatment has been tried without improvement
   Chronic family problems
   OTHER (Please describe below).

4) In your view, what could be the main aims of sending a child to
   (Please state briefly below).

Please turn to Section 2
Thank you for help! Please Return this Questionnaire by March 28th to:
Jackie Alt
Psychology Dept.
6S1

Any Other Comments Would be Welcome:

1. I am not satisfied with the assortment of children
2. I am not satisfied with the assortment of children
3. I am not satisfied with the assortment of children
4. I am not satisfied with the assortment of children
5. I am not satisfied with the assortment of children
6. I am not satisfied with the assortment of children
7. I am not satisfied with the assortment of children
8. I am not satisfied with the assortment of children
9. I am not satisfied with the assortment of children
10. I am not satisfied with the assortment of children
11. I am not satisfied with the assortment of children

If you do not want to explain why:

1. I am not satisfied with the assortment of children
2. I am not satisfied with the assortment of children
3. I am not satisfied with the assortment of children
4. I am not satisfied with the assortment of children
5. I am not satisfied with the assortment of children
6. I am not satisfied with the assortment of children
7. I am not satisfied with the assortment of children
8. I am not satisfied with the assortment of children
9. I am not satisfied with the assortment of children
10. I am not satisfied with the assortment of children

For this section (Questions 5 to 20),

SECTION 2
Appendix R1: 4

Questions Extracted from the Questionnaire, listed according to their components

Component 2

2) Technical: Referrers satisfaction of the ‘Technical competence’ of the service

The following items were included in this component and integrated in section 2 of the questionnaire.
8. The flexibility of the length of stay at Fallowfield is not satisfactory
11. I am not satisfied with the assessment of children carried out at Fallowfield
12. The treatment carried out at Fallowfield is satisfactory
14. The management of children’s behaviour at Fallowfield is satisfactory
16. The conceptualisation of problems derived from the assessment is satisfactory.

Component 3

3) Information: Referrers satisfaction with ‘Information’ received from the service

The following items were included in this component and were integrated into section 2 in the questionnaire.
5. The discharge recommendations are satisfactory
7. I am satisfied with the comprehensiveness of written information provided by Fallowfield
15. I am satisfied with the promptness of written information

Component 4

4) Access: Referrers satisfaction with the accessibility of the service.

The following items were included in this component and were integrated into section 2 in the questionnaire.
6. I am satisfied with Fallowfield’s ability to take on non-urgent referrals.
7. I am satisfied with the length of waiting time before a child is admitted.
8. Fallowfield’s ability to take on urgent referrals is not at a satisfactory level.
13. I am not satisfied with the accessibility of staff at Fallowfield to discuss the appropriateness of referrals.
Appendix R1: 4 cont’d

Component Five

Global: Referrers Global ratings of satisfaction

The following items were included in this component and were incorporated at the end of section 2 in the questionnaire.

17. I am satisfied with the overall quality of the service that Fallowfield provides
18. I would not refer to Fallowfield again
19. I would definitely recommend Fallowfield to others

Component Six

6) Miscellaneous

This item was incorporated at the staff’s request

20. I would benefit very much from an educational visit to Fallowfield to find out more about the service
Appendix R1: 5

Summary of Staff Feedback and Action Plan
The results of this study were fed back to the staff team. Discussion around the results regarding the four core components elicited the following points:

1) With regards to the aims of the service, the staff team thought that there should be some flexibility with regards to the upper age limit for referrals. The possibility of adding to the service leaflet that exceptions could be made was discussed. However, the possible implications of this for the educational curriculum were highlighted.

2) With regards to the ‘technical’ competence component, the consultant psychiatrist highlighted that the conceptualisation of problems needed to be reviewed.

3) With regards to the ‘Information’ component, it was suggested that the provisional dates of individual programme meetings were sent out to referrers at an earlier stage. A discussion regarding discharge recommendations also took place. This was centered around who was best placed to summarise the information and write the report. Overall, there was strong opinion that this should be reviewed.

4) With regard to the ‘Access’ component, the team thought that their waiting list (3 months) was comparable with other units. They did not see themselves as a service designed to take on urgent referrals. However, the possibility of a crisis information service was currently being considered.
Ms Jackie Allt,
Flat C
166 Springfield Road
Brighton
East Sussex BN1 6DG

21st July, 1999

Dear Jackie,

Thank you very much for sending the copy of your Referrer Satisfaction Survey undertaken during your child placement.

It was a very useful Survey and I would appreciate receiving a further copy to be held at

All very best wishes to you.

Yours sincerely,

Dr Jenny Alvarez
Principal Clinical Psychologist
What are the Risk Factors for Developing Post Traumatic Stress Disorder?

Literature Review

Submitted September 1997 (Year I)
Introduction

We know surprisingly little about the risk factors for developing Post Traumatic Stress Disorder (PTSD), bearing in mind that we have been aware of PTSD, in various guises, for centuries. Yet this is an important area for the clinician. Recognising which aspects of the traumatic event, the individual and the recovery environment are significant, (as well as how they inter-relate in the development of PTSD), is a first step towards establishing the theoretical groundwork necessary for devising effective clinical interventions. It is also the basis for establishing good practice to reduce risk, both within working organisations and by services offered to victims of trauma after the event.

Relevance of the Issue

What is PTSD?

Post-Traumatic Stress Disorder (PTSD) has now been recognized, as a serious mental health problem (e.g. Litz & Roemer, 1996; Joseph, Williams & Yule, 1995; Scott & Stradling 1995) which is thought to effect 1% of the general population. It has been recognised, in various guises, across many cultures and is commonly reported to occur after an individual has experienced a traumatic event, such as combat, rape, disasters and road traffic accidents. It is now characterised (DSM IV, APA, 1994) by three main clusters of symptoms: the re-experiencing of the event, the avoidance of the stimuli associated with the trauma and persistent symptoms of increased arousal (appendix R1:1). The most reported symptoms include flashback memories (intrusive recollections of the event), nightmares, difficulties maintaining relationships and feelings of guilt.

The effects of traumatic experiences have been referred to in literature for centuries. Pepys’ diaries, for example, include descriptions of the nightmares he experienced after the Great Fire of London in 1666. Observations of war veterans from the first and second world wars advanced our understanding of PTSD. Clinicians observed veterans continue to experience intrusive memories of events they had witnessed, experience nightmares, intense physiological and emotional reactions and extreme startle reactions. These
symptoms were given a variety of terms such as ‘traumatophobia’, ‘war neurosis’ and ‘shell shock’. Saigh (1991) argues that it is this nosological confusion which has slowed progress in research and caused a lack of continuity in the research literature.

Issues to be Addressed

There has been continued debate about the diagnostic criteria for PTSD, particularly with regards to what constitutes a traumatic event. DSM-III-R (APA, 1987) criteria had defined a traumatic event as “outside the range of usual human experience” (APA, 1996), yet studies revealed that potentially traumatizing events in the general population are not at all rare. Breslau and Davis (1992) reported that 70% of individuals reported experiencing, or witnessing, at least one traumatic event in their lives. This raises the question of why only some individuals develop PTSD, why some develop chronic PTSD, why others recover in the short-term, and why some experience a delayed onset of the symptoms. Litz and Roemer (1996) describes the etiology of PTSD as the “complex interplay among features of the trauma and a number of aspects of the individual and aspects of the recovery environment” (p 157). This essay will consider the research which has addressed the possible risk factors associated with adults developing PTSD. The areas to be considered here are: the ‘nature’ of the stressor, aspects of the individual, social support, the individual’s history of psychopathology, their experience to prior traumatic events and aspects of the recovery environment. The aim of this review is to provide an overview of the research in the most relevant areas, and to highlight any areas for future research. It is useful to begin with a brief consideration of the background issues relevant to the disorder.

Background Issues

It is worth, initially, considering the moral and legal issues around PTSD. The issue of individual vulnerability for the disorder, for example, is particularly sensitive in the context of the military and their recruitment policies, and can become confused with beliefs about ‘cowardice’. Political and social issues are also likely to have affected research, particularly as early research has focused on the military. The prevailing
attitude at the time of the Vietnam war was that conscripted soldiers should get compensation, possibly influencing researches against identifying vulnerability factors. Prejudice and suspicion can also be an issue around claimants of financial compensation. An individual's vulnerability is directly relevant in these cases, as the legal question is whether their symptoms can be accounted for solely by the traumatic event.

Another difficulty when considering the research is the pre-selection of service men and women. For example, screening for a family history of psychiatric disorders, means that the research sample will be skewed. It has also been suggested (McFarlane, 1990) that service personnel may withhold such information, particularly if they are seeking compensation. In addition to this, the fact that personnel have chosen such careers, which are more likely to involve danger, means that they are self-selecting, and therefore probably atypical of the general population. These issues have important methodological implications when considering the data.

The Stressor Nature of the Traumatic Event

The behavioural conceptualisation of PTSD, based on Mowrer's two factor theory (1960, cited in Warren & Zgourides, 1991) has been developed by Keane (1985) to account for how higher order conditioning occurs when a neutral stimulus is paired with a traumatic experience, and how this can generalise to other stimuli and lead to the avoidance behaviour characteristic of the PTSD sufferer. However, though an individual must have experienced a stressor to be diagnosed with PTSD, it does not account for individual differences in the development of the disorder. The nature of the stressor has now been acknowledged in the literature as an important variable (e.g. Jones, & Barlow, 1990; Green, 1994; Litz & Roemer, 1996; Joseph & Yule, 1995).

Severity or Level of Exposure to the Stressor

The stressor criterion has been the subject of discussion for some time. As outlined above, DSM-III-R (APA, 1987) had defined a traumatic event as "outside the range of
usual human experience” until it became clear that it was necessary to add the perception of intense fear of death and perceived life threat to the stressor criterion. The individual’s perception of the stressor is clearly a different issue to its objective severity and needs to be considered separately. Appraisal factors will be considered in more detail under subsequent headings.

The early focus on the severity of the stressor in DSM-III led to an interest in the relationship between the severity of the stressor and its relationship with PTSD development. This also raised the question of how severity could be graded objectively. Research so far has been mainly in the war veteran literature, Foy, Rueger, Sipprelle & Carroll (1984) devised a Combat Exposure Scale (which he demonstrated to have reproducibility), which consisted of seven items ranging from ‘no combat experience’ to having served three tours of duty in Vietnam. Number four, for example, was “Responsible for death of enemy civilian”. Subjects were assigned one exposure score according to their experience. Foy et al. found that there was a relationship (25% variance) between PTSD severity and the extent and severity of combat exposure. Laufer, Brett & Gallops (1985) also used a ‘Combat Scale, which consisted of 10 item measure (reliability .83) of exposure to and participation in combat, plus open-ended questions on exposure to abusive violence. He found that different dimensions of war symptomology varied across individuals exposed to different types of trauma; particularly that participation in ‘atrocities’ (abusive violence) significantly increased the risk of developing PTSD. Breslau and Davis (1987) also found that combat exposure was significantly related to PTSD symptomology. They administered an interview schedule based on seven items (reliability .73) which, again, formed an additive scale measuring the number of combat stressors the veteran had experienced. They replicated Laufer’s (et al.) finding that participation in atrocities increased the risk. The fact that the results of these two studies were consistent suggests that their findings may be generalised, despite having used different measures.
However, these results must still be viewed with caution. Hennessy and Oei (1991) found, in their study on 64 Australian Vietnam war veterans, that the level of combat exposure had no significant effect on the development of PTSD symptoms, even though 29.85% of the veterans were diagnosed with PTSD. This may have been due to the relatively vague assessment method of combat exposure. No detail was given of a structured tool. The authors sought to establish such information as to whether the veteran had been a regular soldier, or at had been at the battle Long Tan (famous battle). This is likely to flaw the results in that the veterans will have experienced a range of exposure within these categories. The data was also collected twenty years after their exposure, suggesting that biases in recall are very likely.

This conflict in results highlights the difficulties of carrying out such research without standardised measures, even when focusing on combat exposure. Even with reliable assessment tools, the information gathered is based on retrospective recall by the veterans, which may be effected by their current PTSD status. For example, those not experiencing PTSD symptomology may recall less atrocities, and thus confound the results.

There is much less research into the significance of stressor severity in other types of trauma, such as natural disasters and civilian trauma. McFarlane’s (1988 & 1989) longitudinal study on 469 bushfire firefighters looked at the relative importance of the intensity of the exposure to the disaster, personality factors and ways of coping in the development of PTSD. No detail was given of the inventory used to measure the exposure, though 44% believed they were close to death, 62% had been injured, 40% were bereaved and 38% had sustained property loss. The 11 subjects who developed PTSD were no different in their experience of disaster when compared to the 34 subjects with no disorder. Feinstein and Dolan (1991) also found no support for the correlation of the severity of the stressor with the development of PTSD. This study was based on 48 subjects who were exposed to a range of traumas (including Road Traffic accidents, sport, accidental fall, and domestic occupational) but were assessed as having injuries of a
similar severity. Again, it is unclear how the severity of exposure was rated. Information on the nature of the trauma (e.g. motorbike accident) was obtained, and also whether the subjects had been active or passive participants, whether they saw themselves as responsible, and how stressful they perceived the event. However, these would seem to be subjective ratings which would give no objective rating of the severity of exposure, and thus the results should be viewed with caution. These two studies revealed no support for the correlation of the severity of the stressor with the development of PTSD, suggesting that this relationship is specific to the type of trauma. More research is needed within different trauma types to clarify this.

Personal Injury

Sustaining an injury from a traumatic experience has now been acknowledged to increase the risk of developing PTSD (e.g. Jones and Barlow 1990; Joseph et al. 1995; Green, 1993), and has also been considered as an indicator of the severity of a traumatic experience. However, it seems that the type of injury, the context in which it is received and its severity may also be important. Helzer Robins & McEvoy (1987) found that 3.4% of Vietnam veterans who were not wounded developed PTSD, compared to 20% of those who were injured (no detail of the injuries were given). Pitman, Altman & Macklin (1989) found that 40% of a sample of 156 Vietnam veterans with musculoskeletal injury had a definite or probable diagnosis of PTSD (though no non-injured control group was used). Kilpatrick, Saunders, Amick-McMullan, Best, Veronen & Resnick (1989) found that crime-related PTSD was positively associated with having “a sustained injury” (p206) during the crime in a sample of 294 female crime victims who had experienced range of crimes including rape, and assault. They found that in the group of crime victims who had not been raped, 20.6 %, who had not sustained injuries developed PTSD, compared to 30.8% of those that had sustained injuries. For those who had suffered rape, 28.6% of those with no injury developed PTSD compared to 57% of those who had been raped and sustained an injury. This suggests that there is an interaction between injury and other variables such as the type of trauma experienced. More recently Blanchard, Hickling,
Mitnick, Taylor, Loos & Buckley (1995) looked at the development of PTSD in 98 Motor Vehicle victims. The authors used blind ratings using the Abbreviated Injury Scale (ASI), a validated scale (Baker, O’Neill, Haddon & Long 1995) which asks for ratings (0-6) of the worst injury to seven body areas. They found that scores on the ASI significantly predicted the development of PTSD.

Blanchard et al. (1995) took this a step further to explore the relationship between the extent of injury, using the measure described above, and the likelihood of developing PTSD. He found a statistically significant relationship, claiming that this is the first data to demonstrate such a relationship. However, Perry, Difede, Musngi, Frances & Jacobsberg (1992) also looked at the relationship and the severity of injury (measured as a % of burned area and facial disfigurement) and the likelihood of developing PTSD in burn injury patients. They found that patients with more severe burns were not more likely to develop PTSD. This suggests that the significance of the severity of the injury may vary across trauma types. It may be that the type of injury sustained may be significant. This is also suggested by Delimar’s and Sivik’s study (1995), which found that Croatian war soldiers who sustained non-disabling injuries were actually more likely to develop PTSD than those soldiers who sustained permanently disabling injuries. The authors point out: “we found out that the majority of badly wounded soldiers did not consciously live through the trauma or feel a threat to their lives” (p638). Head trauma and burns have also been acknowledged (Pitman et al. 1987; Hezler et al. 1987) as atypical injuries which are not necessarily likely to increase the risk of developing PTSD.

This selection of studies reveals how difficult it is to cross-refer between such studies; each is concerned with different type of injury in a variety of contexts, and uses different measures. More specific research is needed in this field which targets, and gives details of the assessment and type of injury sustained in particular contexts. The severity of injury, and its relationship with the likelihood of developing PTSD, also needs exploring systematically within targeted trauma types.
Body Recovery’ as a ‘Stressor’

More recently, research is now showing that people who witness, or are involved in tasks such as body recovery and identification in the aftermath of a disaster are also at risk of developing PTSD or experiencing high levels of stress (e.g. Ursano & McCarroll 1994; Taylor & Fraser 1982; Bartone, Ursano, Wright & Ingraham 1989; Rapheal, Singh, Bradbury & Lambert 1983; Jones, 1985). What is it about the nature of this sort of stressor, which is generally not life threatening, that leads to the development of PTSD? Ursano et al. (1994) reports on data collated in 1990, based on observations and interviews from various ‘body handlers’. From this they highlighted factors which seemed to be particularly difficult to deal with. Disturbing bodies (e.g. such as children’s bodies, or ‘natural’ looking bodies) were identified as stressful. Profound sensory stimulation (such as bad smells) were also recognised as extremely stressful as well as the “novelty, surprise, and shock” (p55) elements of handling dead bodies. The identification and emotional involvement with the dead person was also recognised as distressing (e.g. handling personal letters of loved ones). This suggests that it is an interaction between environmental stressors and the cognitive assimilation of information which is difficult, rather than the threat of the stressor.

Though there are studies which describe the management, or common reactions in such situations, which often includes body handling, (Laughlin 1980; Palmer, 1983; Fullerton, McCarroll & Ursano 1992; Alexander, 1991) there are only a few studies which have systematically shown that stress reactions are likely in such workers (e.g. Taylor & Fraser 1982; Jones 1985), and even fewer that have assessed individuals according to DSM criteria. Durham, McCammon & Allison (1985) did assess according to DSM criteria and found that 80% rescue, fire, medical and police officers who had helped victims of an apartment building explosion had least one symptom of PTSD, with 10% having 8 out of 21 PTSD symptoms. It was the ‘on-the-scene workers’ who were more at risk.
Research in this field suggests that individuals are generally at risk when exposed to these sort of stressors, though we still know little about individual vulnerabilities, and whether the same sort of risk factors that have emerged for other trauma types apply in this field. The ethical restrictions are particularly difficult in this field; it is difficult to set up control groups to explore the protective value of certain management practices. It is also difficult to control and measure the type of exposure that has been experienced.

Aspects of the Individual

Though research has revealed that some type of stressors may be considered to be objectively more likely to cause PTSD, it has also been revealed that the level of threat perceived by the individual is a significant factor in the likelihood of developing PTSD (e.g. Kilpatrick et al. 1989; Blanchard et al. 1995). The current DSM-IV (APA, 1994) definition now incorporates this by stating that the individual’s response to the trauma must involve intense fear, helplessness or horror. That people will vary in the individuality of their response to an objectively similar event is at the basis of the cognitive perspective (e.g. Scott and Stradling, 1995). Thus, there has been more emphasis on the individual appraisal of the stimuli. Joseph, Williams and Yule (1995) offer a comprehensive review which was used to guide the current author. Research has focused on various aspects of individual appraisal which will be considered here.

Beliefs

It now seems to be recognised in the review literature e.g. (Scott & Stradling, 1995; Joseph et al. 1995) that dysfunctional beliefs may be activated by a traumatic event. Janoff-Bulman (1992) argues that it is the shattering of basic beliefs of invulnerability, beliefs about the self and beliefs about the world as meaningful that lead to difficulties. Beck, Emery & Greenberg (1985), in relation to depression and anxiety, postulate that the process of appraisal is significant, and is influenced by personality characteristics. They identified cognitive schemata, which can be thought of as organisational structures of the personality, which enable the individual to process stimuli rapidly, and apply the “appropriate ‘formulas’ to their analysis” (p55) without conscious processing. They
argued that there may be vulnerable individuals who have dysfunctional attitudes, leaving them more vulnerable to developing anxiety or depression. These rules, developed throughout childhood, may possibly be protective of the individual’s self-esteem. However, it is argued that these rules can be too rigid. If a traumatic event challenges a rule, it is hypothesised that this can lead to the shattering of beliefs and the protective value they have. Joseph et al. (1995) reports on his study which tested this theory. They developed a measure of negative attitudes to emotional expression. E.g. “you should always keep your feelings under control”. The hypothesis was that the more the dysfunctional belief was believed, the higher the subsequent level of PTSD symptomology would be; which was found to be the case. Though the author points out that this does not prove a causal relationship with cross-sectional data, it is argued that dysfunctional assumptions could be helping to maintain symptoms, possibly through the blocking of processing.

Attributional Style and Locus of Control
Attributional style is one aspect of stimulus appraisal which may go some way to account for individual differences in the development of PTSD. There is now evidence to suggest that there is a link between the way people attribute causes to events and their psychological outcome following a traumatic event (e.g. Mikulincer & Solomon, 1988; McCormick, Taber & Kruedelbach 1989). Mikulincer and Solomon looked at the relationship of attributions for good and bad events and combat-related PTSD in a sample of 262 Israeli soldiers who had suffered a combat-related stress reaction during the Lebanon War in 1982. Results suggested that the “attribution of good events to uncontrollable, external, and unstable causes, and bad events to uncontrollable, internal, and stable causes may be associated with important features of the PTSD syndrome” (p308). The PTSD veterans seemed to make external attributions, rejecting self blame, but also seemed to be rejecting responsibility for good events. Mikulincer & Solomon (1988) speculate that there may be a “circular relation” (p312) in that PTSD may lead to a maladaptive attributional style which perpetuates the disorder. However, there are methodological difficulties with this in that the subjects already had PTSD symptoms
prior to the study, meaning that a causal relationship cannot be clearly established. McCormick et al.'s 1989 study revealed a different relationship between attributional style and PTSD. The study, which looked at the relationship in a group of 99 patients seeking treatment for alcohol or gambling addiction, revealed that patients with PTSD seemed to explain causes for negative events in more internal ways than patients without PTSD. What could account this discrepancy? McCormick et al. (1989) highlight how the addicted individuals often have a history of reinforced personal helplessness, which may effect the results in this case.

Locus of control has also been a focus for research. It is noted that though locus of control is linked with attributional style, it does not account for whether outcomes are positive or negative. It is defined as internal when an individual attributes environmental events to themselves, and external when the individual attributes events to things outside their power. It has generally been found in the field of mental health, that people with a high internal locus of control have better prognoses from psychiatric disorders (Solomon, Mikulincer & Benbenishty 1989). Frye and Stockton, (1982), found that combat veterans who were diagnosed with PTSD had a more external locus of control than those who were not diagnosed with PTSD. Solomon’s et al.’s (1989) study of Israeli combat veterans also found a relationship between locus of control and PSTD intensity for veterans who had experienced low level battle intensity, but not for those veterans who had experienced high level intensity. The authors argue that threat appraisal is the important link between control expectancies and PTSD in that the individual’s locus of control affects how threatening they perceive the event which, in turn, is related to the severity of PTSD symptoms which develop. The relationship between battle intensity and locus of control also suggests that context and situational factors maybe very relevant as to when locus of control effects PTSD outcome. However, it must be noted again that a clear causal relationship is difficult to establish due to the variables being measured simultaneously, and reverse interpretations also being plausible.
Coping

There is now evidence to suggest that different ways of ‘coping’ can be a mediating factor between a traumatic or stressful event and psychological outcome. Gleser, Green & Wright (1981) for example, found that whether people who were able to clean and repair their homes after the Buffalo Creek Flood was the best predictor of psychiatric distress. Folkman & Lazarus (1985) conducted a study that explored emotion and coping across three stages of a college examination. Coping was assessed using the ‘Ways of Coping Checklist’ (68 item) developed by Folkman and Lazarus in 1980. They found that subjects used, on average, between 6 and 7 different ways of coping, including combinations of both problem-focused and emotion-focused based coping strategies, highlighting how complex an individual’s coping strategies are likely to be. However, they found that individuals who obtained poorer grades were using more emotional-focused strategies of coping, whereas there was a strong correlation between problem-focused coping, emphasising the positive and seeking social support. However, it is noted that the data was self-report data, which may actually reflect the subject’s implicit theories about coping rather than the actual process.

Solomon (1990) explored the intervening role of battle intensity, threat appraisal and coping among Israeli soldiers. Coping was, again, assessed using the ‘Ways of Coping’ checklist (Folkman & Lazarus, 1980). They found that the greater the appraisal of threat, more negative emotions and more emotion-focused coping was found to be predictive of a larger number of PTSD symptoms when following a combat stress reaction. It is argued by the authors that high battle intensity may mean that there are few opportunities for control, thus preventing individuals using their effective coping style. However, lower battle intensity may leave more opportunity for control, thus leaving those with internal locus of control with more opportunity to use their coping style. However, the retrospective nature of the data for the data raises the question of accuracy of the data. For example, emotional-based coping may effect the judgment the individual has of the emotional impact the event had on them at the time.
Social Withdrawal, Blame and Shame

The question has been raised as to what is the relationship between low levels of support, the environment and individual differences. Brewin & McCarthy (1989) looked at causal attributions concerning negative outcomes and whether they are inversely related to seeking support when dealing with a traumatic experience. They found that individuals who thought that a negative event was more likely to happen to them, and who blamed their own lack of competence for an event, were less likely to have used coping strategies which involved others such as family, friends and people generally. However, they did not find that negative appraisal was related to the seeking of appropriate information, or seeking support from close confidants. Solomon’s & Smith’s study (1989), involving 5432 victims of flooding and dioxin contamination, found that ‘self-blamers’, who blamed the flood damage on themselves, were less likely to seek help from organisations than those who did not blame themselves. This is further evidence to suggest that a cognition such as ‘blame’ can affect the likelihood of an individual seeking agency help, and thus possibly affecting the risk of an individual developing chronic PTSD. However, such studies, based on the hypothesis that attributions play a mediating role, should be treated with caution as the interpretations of the results are based on correlations. It could be interpreted that it is the traumatic experience which is leading to an attributional search for meaning, rather than the other way round. Recently, the role of ‘shame’ and ‘guilt’ has also been identified as possibly having a differential relationship in the development of PTSD symptoms, though Tangney, Wagner & Gramzow’s study (1992) found no support for this.

Social Support

It has now seemed to be fairly consistent in the literature that that high levels of social support can act as a ‘buffer’ or moderator of the symptomology of PTSD (e.g. Fullerton et al. 1992; Joseph et al. 1995; Solomon & Smith, 1994; Jones & Barlow, 1990; Bartone et al. 1989). Unfortunately, one of the major problems with investigating social support is that often individuals have lost significant others in the traumatic event. It has also
been found that there is often a group structure in place between colleagues which is of significance in terms of support following a disaster (eg. Herlofsen, 1994).

Bartone's (et al. 1989) study which looked at the impact of a military air disaster on the health of Assistance Workers, found that the stress experienced by the workers was modulated by social supports from bosses, family and friends as well as a personality style identified as “hardiness” (p325). It was generally concluded that those with a greater degree of social support (measured by an index, which was constructed out of information provided by the respondents) remained healthy under prolonged stress, while those low in social support were most at risk for illness. Joseph et al. (1992) pinpoints crises support as a possible significant factor in explaining variation in the severity of symptoms in the survivors of the Jupiter cruise ship disaster. An follow-up study eighteen month's later (Joseph et al. 1993) was undertaken to test this hypothesis with a small number of survivors. The results showed that a higher score on the crises support measure was predictive of lower avoidance, but not intrusion (as assessed by the ‘Impact of Events Scale’, a widely used scale aimed at measuring intrusion and avoidance, Horowitz and Milner 1979). A subsequent study on the victims of the ‘Herald of Free Enterprise’ ferry disaster revealed similar results in that higher ratings of crises support were predictive of less avoidance behaviour (Joseph et al. 1995). The concept of crises support, Joseph argues, is appropriate as it is concerned with “received support rather than perceived support” (p533). Solomon and Smith’s (1994) study investigates in more detail the effects of providing and receiving support, bearing in mind that interpersonal encounters can also have negative consequences. For example, they found that single parents had the worst outcome when exposed to disaster, possibly because single parents are already experiencing heavy emotional and financial demands. They also found that for women, mid range levels of support had the most favourable outcome.
Experience of Previous Traumatic Events

There are very few studies which have looked at the persons’ exposure to any previous traumatic events, though it is now argued that prior exposures increases the risk of an individual developing PTSD when exposed to another traumatic event (e.g. Green, 1994; Solomon, 1990). Solomon’s study (1990) found that soldiers that had already experienced an episode of PTSD were more at risk for a future episode of PTSD if they continued to participate in battle. More research would be useful in this field.

History of Family Psychopathology

There is now growing evidence (McFarlane, 1990; Davidson, Swarts, Storck, Krishnan & Hammett 1985; Green 1994) to suggest that those with a history of family psychopathology may be more at risk. Davidson’s (et al. 1985) found that 66% of their DSM-III diagnosed Vietnam veterans with PTSD (n=36) gave a history that was positive of family psychopathology, with alcoholism, depression and anxiety disorders being the most commonly found. They argue that there is “a closer genetic relationship”(p92) between PTSD and generalised anxiety disorder with the percentage rates of anxiety (22%) and depression (20%) in the families with PTSD being comparable to the rates of anxiety (14%) and depression (14%) found in the relatives of patients with Generalised Anxiety. These rates were in contrast with the depressed proband’s families had a history of anxiety. These studies need to be replicated using a larger sample. It is also noted that a rigorous control group was not used in this case; family data from previous studies was used, with Panic Disorder not being separated from Generalised Anxiety.

McFarlane’s (1988) study of a group of 469 firefighters who had been exposed to a bushfire disaster, found that a family history of psychiatric disorder, along with introversion and neurasthenia, were premorbid factors significantly associated with the development of chronic PTSD. This was not the case with regards to the intensity of exposure, perceived threat, and losses sustained in the disaster. These results suggest...
further support for psychiatric history being a risk factor. However, Foy et al. (1987) develops this hypothesis further in a study looking at two groups of Vietnam war veterans. They found rates of familial psychopathology in the PTSD groups as comparable (66%) to the Davidson et al. study (1985). However, he also found that there was an increase in the probability of PTSD symptoms if familial psychopathology was taken in conjunction with low-combat exposure, but not when taken in conjunction with high-combat exposure. This, the authors argue, suggests the possibility that for those with a familial predisposition, only a lower level of stress exposure is required to precipitate PTSD. This adds support that family psychopathology is a risk factor, though possibly for only certain types of stressors.

Aspects of the recovery environment

Work environment
There is increasing research evidence that management practices within organisations following traumatic events can effect outcome (e.g. Duckworth, 1991; Fullerton et al. 1992; Alexander, 1991; Marks, Yule & Silva 1995; Taylor & Fraser 1982; Raphael et al. 1983-4). Practices thought to be possibly protective include predisaster training (e.g. Marks et al. 1995; Alexander, 1991), debriefing procedures (e.g. Taylor & Fraser 1982; Duckworth, 1991; Raphael et al. 1983-4), procedures for further intervention (e.g. Duckworth, 1991; Marks et al. 1995) and the use of rituals (e.g. De Silva, 1993; Fullerton et al. 1992). Marks et al (1995) emphasises the need for pre-disaster training of cabin crew. Taylor & Fraser (1982) also argue that stress levels may be reduced if personnel were given training, more protective clothing and de-briefing procedures to help ventilate negative feelings. It is difficult to establish the effects of such intervention due to the ethical reasons of having a control group. However Alexander (1991) found that 35 officers were free from signs of psychiatric morbidity after identifying human remains, argues that it is likely that the use of good management practices helped prevent the development of PTSD in the work force. Unfortunately, no detailed account of the management practices were given in this case.
Cultural influences

De Silva (1993) argues that the social and cultural meaning of a traumatic event is a crucial variable in determining psychological outcome. Social-cultural background effects the individual both directly and indirectly through beliefs that become internalised. However, empirical evidence for socio-cultural effects is still mainly speculative. The homecoming of the Vietnam war veterans provides an interesting example of the impact of society’s views. American attitudes towards the war in Asia were reported to have become more negative after 1967. Foy et al. (1986) reported that those with PTSD symptomology reported significantly higher rates of demeaning experiences, cynicism, alienation and physical neglect following the first six months of their homecoming.

More broadly speaking, it has now been acknowledged that social class, ethnicity, race and gender are relevant (e.g. Green, 1994; De Silva, 1993). For example, Sutker, Bugg & Allain (1990) found that socio-economic advantage, military rank and training were protective factors when investigating individual and situational correlates of PTSD among prisoner of War survivors. Breslau and Davis (1992) found that a family history of antisocial behaviour and being female were associated with chronic PTSD in a sample of urban population young adults. It would be useful for further research to explore who may be more at risk across different trauma types.

There is also evidence to suggest that cultural influences can have a protective value. Abe, Zane & Chun (1994) in a study which looked at differential responses to trauma among southeast Asian refugees, found that maintaining strong cultural ties may be protective against the development of PTSD symptoms, with reunification with family members reducing the likelihood of developing PTSD.
Conclusion

This essay has given an overview of the risk factors thought to be significant in the development of PTSD. Although the experience of a 'stressor' is essential for a diagnosis of PTSD, aspects of the individual, prior experience of trauma, a history of family psychopathology and aspects of the recovery environment are also revealed, however small the role, to be important. There are now a number of integrative models, which take into account the research on these factors (e.g. Joseph et al. 1995; Scott & Stradling, 1992; Jones & Barlow, 1990; Solomon, 1989). To have such models is useful for clinician in terms of targeting interventions effectively, helping identify those most at risk and providing supportive recovery environments. Recent research has particularly exciting implications for cognitive-behavioural interventions which, for example, may be able to target specific appraisal factors. However, there are still gaps and inconsistencies within the literature which, hopefully, have been highlighted throughout this essay.


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Appendix R2: 1

Diagnostic Criteria for 309.81 Post Traumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

1) the person experienced, witnessed, or was confronted with and event of events that involved actual or threatened death or serious injury, or a threat to the physical integrity of others.

2) the person's response involved intense fear, helplessness, or horror. Note. In children, this may be expressed instead by disorganized or agitated behaviour.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

2) recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content.

3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific re-enactment may occur.

4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three of the following:

1) efforts to avoid thoughts, feelings, or conversations associated with the trauma.

2) efforts to avoid activities, places or people that arouse recollections of the trauma.

3) inability to recall and important aspect of the trauma.

4) markedly diminished interest or participation in significant activities

5) feeling of detachment or estrangement from others

6) restricted range of affect (e.g. unable to have loving feelings)

7) sense of foreshortened future (e.g. does not expect to have a career, marriage, children or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1) difficulty falling or staying asleep

2) irritability or outbursts of anger

3) difficulty concentrating

4) hypervigilance

5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

with Delayed Onset: if onset of symptoms is at least 6 months after the stressor

Vicarious Trauma: an experimental investigation comparing the psychological impact of seeing versus hearing emotive material.

Small Scale Research Project
Submitted: October 1998 (Year II).
Abstract

This study used an experimental design to investigate whether intrusive thoughts could be induced from hearing clients' accounts (actors) of traumatic events. Participants were either shown scenes (on video) of road traffic accidents or were shown (on video) 'victims' personal accounts of road traffic accidents. The subsequent intrusions of these two groups, monitored daily by a diary, were compared with those of a control group who heard impersonal accounts of road traffic accidents.

The results revealed that intrusive thoughts, of a mildly distressing nature, were elicited not only by seeing, but also by hearing victim type accounts of traumatic material. In fact there was no significant difference in the level of intrusions experienced between the two groups. This demonstrates that intrusions can be induced from hearing emotive material.

Differences in the content of intrusions were also found. Those who saw visual scenes of road traffic accidents had significantly more 'flashback' type images (i.e. images of car crashes) they had actually seen on the video. However, those who watched victim's accounts of road traffic accidents had significantly more intrusive thoughts centered on the 'client' than those who watched the scenes. The implications of these findings were discussed.
Introduction

Recently, there has been growing awareness that people who work with victims of trauma may be at risk for developing Post Traumatic Stress Disorder (PTSD) symptomology. The effect on those working with victims has been termed "vicarious traumatisation" (e.g. Pearlman & Maclan 1995). Investigations have focused primarily on the development of PTSD amongst those who have seen the aftermath of a traumatic event on others, such as rescue workers (Ursano & McCarroll 1994). There is now some empirical evidence to suggest that therapists working with trauma victims may also experience PTSD symptomology through hearing about events from clients (e.g. Pearlman & Maclan, 1995).

Studies of trauma victims have found that the intensity of exposure to a traumatic event is positively related to subsequent posttraumatic reactions (e.g. Blanchard, Hickling, Mitnick, Taylor, Loos, & Buckley 1995; Green Grace & Gleser 1985). This suggests that posttraumatic reactions after seeing the impact of traumatic events may be more severe than reactions after less direct exposure through hearing a victim's account. Conversely, it may be that individuals who hear distressing information may construct images which may be worse. However, no studies have attempted to discriminate between the effects of different types of "vicarious trauma".

Intrusive thoughts are identified in the DSM-IV (APA, 1994) criteria as one of the major symptom clusters of PTSD. Recently, both Murray (1997), who looked at the relationship between information processing strategies and resulting intrusive thoughts, and Davies and Clark (1998), who investigated the effect of thought suppression on analogue post-traumatic intrusions, used emotive video material to induce stimuli-specific intrusions. Both studies showed that intrusive symptoms of PTSD can be induced vicariously through seeing emotive material. However, no study has yet attempted to investigate the induction of intrusive thoughts from hearing emotive material.
The current investigation aimed to investigate intrusive thoughts from hearing emotive material. Participants were either shown scenes of road traffic accidents or were shown victim’s personal accounts of road traffic accidents. The subsequent intrusions of these two groups, monitored by a daily diary, were compared with those of a control group who heard impersonal accounts of road traffic accidents.

It was predicted that intrusions would be induced by seeing and hearing traumatic material, and that more intrusive thoughts, with higher levels of distress, would be elicited in those seeing or hearing emotive accounts compared to those participants who heard impersonal accounts. It was also hypothesised that there would be differences in intrusions and avoidance one week later. A further aim of the study was to explore any differences in the nature and the content of intrusions reported.

Methodology

Design
Participants were randomly assigned to one of three groups. Group A was shown five scenes of road traffic accidents similar to ‘impersonal’ scenes witnessed by emergency workers (i.e. moving video material showing emergency workers at work during the aftermath of road traffic accidents). Group B was shown a video tape simulating the ‘personal’ accounts from five victims of the same road traffic accidents. Group C was shown a video tape simulating an impersonal narrative of the same five car crash events.

The study had three main stages. In the first stage, participants filled out ‘Pre’ and ‘Post’ video measures and watched the video material under controlled experimental conditions. In the second stage, participants completed a diary of intrusions over the next seven days. In the third stage participants completed follow-up questionnaires.
Video material

The video tape for group A was obtained with the kind permission of researchers at the University of Oxford. It depicts five short scenes of road traffic accidents taken mainly by fire and ambulance crews in Germany. Therefore, these scenes could be similar to that seen by emergency workers. Murray (1997) had recently used this video to reliably produce intrusive thoughts. The material for group B consisted of a video recording of 5 actors depicting ‘victims’ of car crashes. A broad script was devised by the author and a clinical psychologist familiar with working with trauma victims. This contained the sort of accounts of traumatic events typically given by victims. In order to match the material seen by group A and group B as far as possible, the information in each road traffic accident scene was incorporated into the victim’s account. The actors gave personal accounts of the same five events seen by group A. The description closely resembles how a therapist would hear a personal account of a traumatic event. For both videos A and B, an identical short introductory commentary, with some background facts, was provided to give the context for each incident. The video material for group C was a recording of an actor depicting a policeman giving an emotionally neutral narrative of the same five car crashes. This was similar to a statement which could be read in court. For all videos, each vignette was preceded by a number (1-5), which was displayed on the T.V screen for a few seconds. All three videos were approximately ten minutes in length.

The materials and procedure was piloted on eight volunteers. This gave the author the opportunity to ensure that the instructions were clear and that the procedure was consistent between groups.

Participants

Participants were recruited from the University of Surrey campus. The study excluded those who had suffered a recent trauma, those who suffered from a severe depressive illness and those who had had treatment for depression. It also excluded those who had had a severe psychiatric illness, or had an immediate family member who had suffered from a severe psychiatric illness. 62 people (30 men and 32 women) took part in the
video stage of the study. 20 (32.3%) of these were in group A, 22 (35.5%) in group B and 20 (32.3%) in group C. Of the total of the three groups, 54 (87%) completed the diary phase of the study. This represented 18 (30.5%) in group A, 19 (32.2%) in group B and 17 (28.8%) in group C. This group of ‘completers’ comprised of 27 men and 27 women, and had a mean age of 28.3 (s.d.12.3).

Measures

State Trait Anxiety Inventory. (Spielberger, 1983). The ‘Trait’ section of the questionnaire, consisting of 20 items, was administered (appendix R3:1). This is a well established valid and reliable measure which has been used extensively for research purposes. It was used in this case to establish equivalence between groups on trait anxiety levels.

Mood Scales. The mood of participants was assessed pre and post video to determine whether the material had any emotive impact. Likert scales (ranging from 0-100%) were administered for the following moods: ‘upset’, ‘happy’, ‘anxious’, ‘sad’ and ‘annoyed’ (appendix R3: 2 & 4).

Distress Rating Scale. Participants were asked how distressing they found each scene (whether seen or heard) on a 0 - 100 point scale (appendix R3: 5).

Trait Dissociation Questionnaire (TDQ). This measure was developed Murray (1997) to assess the information processing strategies used by participants when watching emotive video material, and to establish equivalence between groups (appendix R3: 4). It consists of three subscales: avoidance (3 items), dissociation (7 items) and emotional exposure (2 items). Participants were asked to rate each item on a Likert scale from 0-100% immediately after watching the video material.

Diary. Participants were asked to complete a diary each day (R3:5) over the 7 days following the video. This diary consisted of questions regarding the number and
frequency of intrusions experienced. Intrusive thoughts were defined as "images, verbal thoughts or memories that seem to "pop" into your mind". It also included any dreams participants had about the video material. These diaries were collected at the one-week follow-up meeting. The diary method was used by Trinder and Salkovskis (1994), who identified naturally occurring negative intrusive thoughts in a group of undergraduates over a four day period. Murray (1997) also asked students to record intrusive thoughts over a seven day period.

**Horowitz’ Impact of Event Scale.** (1986). This scale (appendix R3: 6) was administered at the one week follow-up meeting to obtain a further measure of the impact of the material. This is a widely used scale with subscales for intrusions and avoidance which have been proved to be both valid and reliable.

**Credibility Video Rating.** Participants were asked to rate how much they believed the video material they saw to be ‘real life’ material on a 0-100 scale (appendix R3: 7).

**Procedure**

Participants were initially approached with written general information about the project (appendix R3: 8). On volunteering, participants were assigned to each group on a strictly alternating basis. A summary of the procedure at each of the three stages is presented below:

**Stage 1**

1. Completion of the ‘consent form’ (appendix R3:9)
2. Completion of the Pre-video ‘Mood Scale’.
3. Viewing of either video A, B, or C, to which participants were randomly assigned. Participants were seen in groups of up to 8 in a testing laboratory under experimental conditions. The video material for each group was watched on a 14 inch screen. The lighting was dimmed for each group to maximise the impact of the video material.
4. Completion of the Distress Rating Scale immediately after each vignette.
5. Completion of Post-video ‘Mood Scale’ and TDQ questionnaire immediately after the video viewing.

**Stage 2**

6. Completion of a one-week diary of intrusive thoughts.
Stage 3

7. Collection of diaries and administration of Impact of Event Scale, and credibility of video rating scale.
8. Debriefing. Participants were informed of the aims of the study and were given the opportunity to ask any questions.

Instructions

Each experimental group was given specific instructions.

Group A was instructed that “this is a video tape of five real car crashes that took place in Germany a while ago.....when watching the video, try and make it as real as you can for yourself - as if the scene was really happening as you watch it”.

Group B was instructed that “this is a video tape of five clients who came to psychology services for help. They are either the witnesses of car crash scenes, the victims of car crashes or have been involved in emergency rescue work.....try and imagine each person is in the room telling you this”

Group C was instructed that “this is a video tape of a police representative giving a report of five car crash incidents. These were real-life incidents that the police had to deal with. Try and listen to the narrative as if the police officer were here in the room reporting it to you.”.

Each group was asked to “Try and concentrate on it (the video), and not to look away or distract yourself”.

Results

Statistical Analysis

Analysis of variance was used where assumptions for the normal distribution of scores and homogeneity of variances were met. Otherwise, non-parametric tests were used. Chi-Square tests were used to analyse categorical data. Correlations were used to investigate the relationship between variables where appropriate.
Preliminary Analyses

No significant differences were found between ‘completers’ and ‘non-completers’ for age or gender. Similarly, ‘premood’ measures, ‘Trait’ anxiety, and TDQ measures revealed no significant differences. Distress ratings and the impact of the video material on mood was also equivalent between ‘completers’ and ‘non-completers’.

Background Characteristics of Experimental Groups.

Table 1 shows the distribution of gender between groups. A Chi-Square test revealed no significant differences in gender between experimental conditions $X^2(2.\text{d.f.}) = .755$, $p \leq .686$).

<table>
<thead>
<tr>
<th>Gender</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male (50%)</td>
<td>10 (55.6%)</td>
<td>8 (42.1%)</td>
<td>9 (52.9%)</td>
</tr>
<tr>
<td>Female (50%)</td>
<td>8 (44.4%)</td>
<td>11 (57.9%)</td>
<td>8 (47.1%)</td>
</tr>
</tbody>
</table>

Table 2 shows the distribution of ages across the groups. No significant differences were revealed between groups.

<table>
<thead>
<tr>
<th>Mean (s.d.)</th>
<th>Mean (s.d.)</th>
<th>Mean (s.d.)</th>
<th>Statistic</th>
<th>P≤</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (n= 18)</td>
<td>B (n= 19)</td>
<td>C (n= 17)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 31.66 (14.26)</td>
<td>26.94 (12.39)</td>
<td>28.27 (12.32)</td>
<td>F(2,51) =1.039</td>
<td>.361</td>
</tr>
</tbody>
</table>

Table 3 shows the results for pre-video measures. The groups were compared on pre-video measures to determine whether there were any base line differences in Trait anxiety and mood.
There were no significant differences between groups on these measures. The mean raw scores for the three groups on the STAI fell between the 53rd and 55th percentile, indicating participants were within the normal range.

Table 3: Pre-Video Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean (s.d.)</th>
<th>Mean (s.d.)</th>
<th>Mean (s.d.)</th>
<th>statistic</th>
<th>P≤</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A (n= 18)</td>
<td>B (n= 19)</td>
<td>C (n= 17)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAI (Trait)</td>
<td>39.22 (9.15)</td>
<td>39.44 (8.54)</td>
<td>40.85 (40.85)</td>
<td>F (2.51) = .20</td>
<td>.817</td>
</tr>
<tr>
<td>Happy</td>
<td>74.44 (21.48)</td>
<td>71.57 (14.62)</td>
<td>63.53 (19.35)</td>
<td>F (2,51) = 1.60</td>
<td>.210</td>
</tr>
<tr>
<td>Anxious</td>
<td>18.33 (4.37)</td>
<td>23.68 (17.70)</td>
<td>27.65 (24.12)</td>
<td>F (2,51) = .940</td>
<td>.397</td>
</tr>
<tr>
<td>Upset</td>
<td>11.66 (17.90)</td>
<td>5.26 (7.72)</td>
<td>21.70 (27.44)</td>
<td>X² (2) = 4.16</td>
<td>.128</td>
</tr>
<tr>
<td></td>
<td>median = 0.00</td>
<td>median = .00.</td>
<td>median = 10.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sad</td>
<td>11.66 (18.23)</td>
<td>9.47 (12.24)</td>
<td>21.76 (24.55)</td>
<td>X² (2) = 3.374</td>
<td>.185</td>
</tr>
<tr>
<td></td>
<td>median = 0.00</td>
<td>median = 10.00</td>
<td>median = 10.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annoyed</td>
<td>10.56 (14.74)</td>
<td>13.68 (21.39)</td>
<td>7.6 (6.86)</td>
<td>X² (2) = .166</td>
<td>.920</td>
</tr>
<tr>
<td></td>
<td>median = 0</td>
<td>median = 10</td>
<td>median = 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4 shows the post video mood ratings, recorded immediately after watching the video material, between groups.

Table 4: Post video Mood ratings

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean (s.d.)</th>
<th>Mean (s.d.)</th>
<th>Mean (s.d.)</th>
<th>statistic</th>
<th>P≤</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A (n= 18)</td>
<td>B (n= 19)</td>
<td>C (n= 17)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>happy</td>
<td>35.55 (25.02)</td>
<td>43.16 (22.87)</td>
<td>45.29 (25.76)</td>
<td>F (2,51) = .77</td>
<td>.467</td>
</tr>
<tr>
<td>anxious</td>
<td>31.66 (20.07)</td>
<td>26.84 (17.65)</td>
<td>28.82 (26.19)</td>
<td>F (2,51) = .24</td>
<td>.791</td>
</tr>
<tr>
<td>upset</td>
<td>42.22 (25.56)</td>
<td>29.47 (25.05)</td>
<td>25.88 (23.73)</td>
<td>F (2,51) = 2.13</td>
<td>.130</td>
</tr>
<tr>
<td>sad</td>
<td>41.11 (25.64)</td>
<td>35.79 (26.73)</td>
<td>22.35 (20.78)</td>
<td>F (2,51) = 2.68</td>
<td>.078</td>
</tr>
<tr>
<td>annoyed</td>
<td>27.22 (25.16)</td>
<td>22.63 (22.81)</td>
<td>12.35 (18.21)</td>
<td>F (2,51) = 2.02</td>
<td>.143</td>
</tr>
</tbody>
</table>

No significant differences between groups were found.
Table 5 shows the results for the impact of video material (Time) on mood, and any interactions between time and group. A repeated measures, Anova, with Time as a factor, was used to assess mood change (pre and post video) between groups. For every mood, there was a significant effect of time, indicating that the video material did have an impact on mood in the expected directions.

There were no significant group by Time interactions for the emotions of ‘annoyed’, ‘anxious’ or ‘happy’. Significant group by Time interactions were found for ‘upset’ and ‘sad’. To investigate these interactions, Tukey-HSD Tests were conducted on the change in emotion scores (pre and post video) for these two emotions. This revealed that Group A became significantly more upset than Group C. Both Groups A and B became significantly sadder than group C after watching the video.

Table 5: Impact of the video material on mood

<table>
<thead>
<tr>
<th>Mood</th>
<th>Statistic</th>
<th>p≤</th>
</tr>
</thead>
<tbody>
<tr>
<td>Happy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>F(1) = 74.29</td>
<td>.00</td>
</tr>
<tr>
<td>Time * Group</td>
<td>F(2) = 3.16</td>
<td>.051</td>
</tr>
<tr>
<td>Anxious</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>F(1) = 4.22</td>
<td>.045</td>
</tr>
<tr>
<td>Time * Group</td>
<td>F(1,2) = 1.71</td>
<td>.191</td>
</tr>
<tr>
<td>Upset</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>F(1) = 32.58</td>
<td>.00</td>
</tr>
<tr>
<td>Time * Group</td>
<td>F(1,2) = 5.17</td>
<td>.00</td>
</tr>
<tr>
<td>Sad</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>F(1) =</td>
<td>.00</td>
</tr>
<tr>
<td>Time * Group</td>
<td>F(1,2) = 8.30</td>
<td>.00</td>
</tr>
<tr>
<td>Annoyed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>F(1) = 9.29</td>
<td>.00</td>
</tr>
<tr>
<td>Time * Group</td>
<td>F(1,2) = .96</td>
<td>.38</td>
</tr>
</tbody>
</table>
Table 6 shows participants’ ratings of information processing strategies recorded immediately after watching the video material. Video distress ratings were recorded immediately after watching each vignette (1-5).

However, this was not significant. There were no other significant differences between groups on either the TDQ avoidance, dissociate, exposure or distress rating items, indicating that the groups did not differ in the information processing strategies used during the video showing.

Table 6: Post-video measures: Immediate follow-up

| Measure            | Mean (s.d)          | Mean (s.d.)          | Mean (s.d.)          | Statistic | P<  
|--------------------|---------------------|----------------------|----------------------|-----------|----- 
|                    | A (n= 18)           | B (n= 19)            | C (n= 17)            |           |     
| TDQ Avoid          | 85.56 (69.98)       | 67.89 (69.98)        | 53.33 (37.72)        | F(2,51) = 1.46 | .242  
| TDQ Dissociate     | 205 (138.32)        | 214.21 (136.6)       | 181.47 (100.09)      | F(2,51) = .31 | .733  
| TDQ Exposure       | 100.56 (51.39)      | 118.95 (42.02)       | 82.5 (47.12)         | F(2,50) = 2.63 | .082  
| Video Distress     | 41.79 (18.87)       | 36.63 (23.88)        | 34.38 (21.35)        | F(2,51) = 0.53 | .580  

Table 7 shows the mean credibility rating for the video clips (i.e. how much they believed the video material to be ‘real life’ footage) between the three groups. There was a significant difference between groups in the belief rating of the video material. Posthoc comparisons (Tukey HSD Test) revealed that Group A’s credibility rating was significantly higher than B’s (p<.00). There were no significant differences between Group A and C (p<.07) and B and C ((p< .17).

Credibility ratings were correlated with all dependent variables using a series of Pearson correlations. No significant relationships were found, with the exception of a significant correlation between credibility ratings and the number of intrusions on Day 4 (r = -.283, p<.40) and credibility ratings and TDQ scores (r=.331, p<.016). However, on inspecting the scatter plots for these correlations, no linear relationships were observed. Therefore, credibility ratings were not partialled out in subsequent analysis.
Table 7: Credibility Rating

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean (s.d.)</th>
<th>Mean (s.d.)</th>
<th>Mean (s.d.)</th>
<th>Statistic</th>
<th>P≤</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A (n= 18)</td>
<td>B (n= 19)</td>
<td>C (n= 17)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credibility Rating</td>
<td>82.94 (28.67)</td>
<td>35.79 (32.71)</td>
<td>56.47 (39.04)</td>
<td>F(2,50) = 8.79</td>
<td>.001</td>
</tr>
</tbody>
</table>

Table 8 shows the frequency of intrusions per week and per day. Distributed. There were no significant differences between groups for the mean number of intrusions over the entire week. There were no significant differences for intrusions per day for days 1 to 7, although the differences between groups for ‘Day 1’ approached significance.

Table 8: Frequency of Intrusions

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean (s.d.)</th>
<th>Mean (s.d.)</th>
<th>Mean (s.d.)</th>
<th>statistic</th>
<th>P≤</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A (n=18)</td>
<td>B (n=19)</td>
<td>C (n=17)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean intrusions per week (thoughts and images)</td>
<td>4.28 (4.28)</td>
<td>5.63 (7.05)</td>
<td>2.12 (2.20)</td>
<td>X² (2) = 3.104</td>
<td>.212</td>
</tr>
<tr>
<td>Intrasctions/day 1</td>
<td>1.5 (1.15)</td>
<td>2.32 (2.69)</td>
<td>.88 (1.45)</td>
<td>X² (2) = 4.66</td>
<td>.097</td>
</tr>
<tr>
<td>Intrasctions/day 2</td>
<td>1.17 (1.38)</td>
<td>1.21 (1.65)</td>
<td>.4706 (.72)</td>
<td>X² (2) = 2.74</td>
<td>.254</td>
</tr>
<tr>
<td>Intrasctions/day 3</td>
<td>.33 (.77)</td>
<td>.74 (1.56)</td>
<td>.47 (.87)</td>
<td>X² (2) = .328</td>
<td>.848</td>
</tr>
<tr>
<td>Intrasctions/day 4</td>
<td>.39 (.60)</td>
<td>.68 (1.53)</td>
<td>.1176 (.3321)</td>
<td>X² (2) = 2.34</td>
<td>.310</td>
</tr>
<tr>
<td>Intrasctions/day 5</td>
<td>.2778 (.67)</td>
<td>1.2105 (4.57)</td>
<td>.2353 (.56)</td>
<td>X² (2) = .95</td>
<td>.954</td>
</tr>
<tr>
<td>Intrasctions/day 6</td>
<td>.167 (.51)</td>
<td>.0526 (.23)</td>
<td>.00 (0.00)</td>
<td>X² (2) = 2.06</td>
<td>.356</td>
</tr>
<tr>
<td>Intrasctions/day 7</td>
<td>.33 (.69)</td>
<td>.158 (.69)</td>
<td>.588 (.24)</td>
<td>X² (2) = 3.18</td>
<td>.204</td>
</tr>
</tbody>
</table>
Table 9 shows the mean distress per week between groups and the mean distress for each day between groups. The data revealed no other significant differences between groups.

### Table 9: Distress Ratings for Intrusions (100%)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean (s.d.)</th>
<th>Mean (s.d.)</th>
<th>Mean (s.d.)</th>
<th>statistic</th>
<th>P&lt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (n= 18)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean distress per week</td>
<td>14.6 (16.60)</td>
<td>8.44 (12.74)</td>
<td>20.20 (26.93)</td>
<td>$X^2 (2) = 2.29$</td>
<td>.319</td>
</tr>
<tr>
<td>median = 9.15</td>
<td>median = .67</td>
<td>median = 8.60</td>
<td>median = .75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B (n=19)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean distress: Day 1</td>
<td>17.77 (22.88)</td>
<td>10.56 (9.86)</td>
<td>9.86 (20.34)</td>
<td>$X^2 (2) = 3.85$</td>
<td>.146</td>
</tr>
<tr>
<td>median = 10</td>
<td>median = 0</td>
<td>median = 0</td>
<td>median = 8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C (n=17)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean distress: Day 2</td>
<td>8.37 (12.86)</td>
<td>7.91 (15.05)</td>
<td>8.53 (18.18)</td>
<td>$X^2 (2) = .613$</td>
<td>.736</td>
</tr>
<tr>
<td>median = 2</td>
<td>median = 0</td>
<td>median = 0</td>
<td>median = 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean distress: Day 3</td>
<td>3.6 (9.57)</td>
<td>6.54 (18.71)</td>
<td>6.76 (17.94)</td>
<td>$X^2 (2) = .16$</td>
<td>.922</td>
</tr>
<tr>
<td>median = 0</td>
<td>median = 0</td>
<td>median = 0</td>
<td>median = 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean distress: Day 4</td>
<td>5.28 (17.61)</td>
<td>4.26 (10.29)</td>
<td>2.6 (7.30)</td>
<td>$X^2 (2) = 1.15$</td>
<td>.562</td>
</tr>
<tr>
<td>median = 0</td>
<td>median = 0</td>
<td>median = 0</td>
<td>median = 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Distress: Day 5</td>
<td>.833 (2.57)</td>
<td>2.63 (8.06)</td>
<td>2.21 (9.95)</td>
<td>$X^2 (2) = .25$</td>
<td>.882</td>
</tr>
<tr>
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<td>median = 0</td>
<td>median = 0</td>
<td>median = 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Distress: Day 6</td>
<td>.278 (1.18)</td>
<td>.26 (1.14)</td>
<td>.00 (.00)</td>
<td>$X^2 (2) = .88$</td>
<td>.637</td>
</tr>
<tr>
<td>median = 0</td>
<td>median = 0</td>
<td>median = 0</td>
<td>median = .64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Distress: Day 7</td>
<td>1.25 (3.87)</td>
<td>.26 (1.15)</td>
<td>0.0 (.00)</td>
<td>$X^2 (2) = 2.39$</td>
<td>.304</td>
</tr>
<tr>
<td>median = 0</td>
<td>median = 0</td>
<td>median = 0</td>
<td>median = 0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 10 shows the analysis of the content of intrusions. To explore any differences between groups in the content of their intrusions, intrusions were first classified as thoughts or images. The content of the thoughts and images were broken down into a further four categories. Intrusive thoughts were categorised as ‘thoughts about the victim’ and thoughts which were identified as indications that participants’ beliefs about safety or emotional reactions’ had been challenged (e.g. “Drive more carefully”). These 2 categories accounted for 59% of the total number of intrusive thoughts recorded. It is noted that 11 (13%) intrusive thoughts were concerns about completing the diary. No
other recurring themes or categories emerged to account for the remaining 28% of intrusive thoughts. Images were classified as ‘real images’ (images remembered directly from the video material) and ‘constructed images’ (images which were imagined from what they saw or heard on the video). These categories accounted for 94% of the total number of intrusive images recorded.

There were no significant differences between the groups in the overall frequency of thoughts or images per week. However, the groups did differ in the precise nature of these thoughts and images. There was a significant difference between groups for number of ‘real images’ (p<0.00). Post hoc comparisons between pairs of groups revealed that Group A had more ‘real’ images than Group B (p<0.01) or Group C (p<0.00). There was no significant difference between groups B and C (p<0.196), in the frequency of reported images from the video.

There was also a significant difference between groups in the number of thoughts about the victim (p<0.037). Post hoc comparisons between pairs of groups revealed that participants in Group B had significantly more victim-related thoughts that those in group A. (p<0.044). There was a strong trend towards the frequency of victim related thoughts being higher for group B than C (p<0.052), but this was not significant. Condition A did not have significantly more victim related thoughts than condition C (p<0.935).

The difference between groups for the number of ‘constructed’ images was just short of significance (p<0.054), with Group A having the highest mean, followed by Group B and then Group C.
Table 10: Content of Intrusions (Diary descriptions)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (s.d.)</th>
<th>Mean (s.d.)</th>
<th>Mean (s.d.)</th>
<th>statistic</th>
<th>p&lt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A (n= 18)</td>
<td>B (n= 19)</td>
<td>C (n= 17)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thoughts per week (total) i (i.e. excluding images)</td>
<td>1.33 (2.33)</td>
<td>2.34 (2.87)</td>
<td>.88 (1.58)</td>
<td>$X^2 (2) = 2.891$</td>
<td>.236</td>
</tr>
<tr>
<td></td>
<td>median = 1</td>
<td>median = 2</td>
<td>median =0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visual Images per week (total) ii (i.e. excluding thoughts)</td>
<td>2.72 (4.09)</td>
<td>2.97 (6.83)</td>
<td>.82 (1.38)</td>
<td>$X^2 (2) = 2.827$</td>
<td>.243</td>
</tr>
<tr>
<td></td>
<td>median = 1</td>
<td>median = 0</td>
<td>median = 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visual (Real images) per week iii</td>
<td>2.47 (3.94)</td>
<td>.42 (.90)</td>
<td>.12 (.49)</td>
<td>$X^2 (2) = 2.827$</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>median = 1</td>
<td>median = 0</td>
<td>median = 0</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Visual (constructed images) per week iv</td>
<td>5.55 (.23)</td>
<td>2.21 (6.38)</td>
<td>.71 (1.26)</td>
<td>$X^2 (2) = .054$</td>
<td>.054</td>
</tr>
<tr>
<td></td>
<td>median = 0</td>
<td>median = 0</td>
<td>median = 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thoughts (about the Victim) per week v</td>
<td>.14 (.59)</td>
<td>.92 (2.00)</td>
<td>.24 (.91)</td>
<td>$X^2 (2) = 6.577$</td>
<td>.037</td>
</tr>
<tr>
<td></td>
<td>median = 0</td>
<td>median = 0</td>
<td>median = 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thoughts (cognitive challenge) per week vi</td>
<td>.25 (.49)</td>
<td>.95 (2.15)</td>
<td>.24 (.75)</td>
<td>$X^2 (2) = 2.265$</td>
<td>.322</td>
</tr>
<tr>
<td></td>
<td>median = 0</td>
<td>median = 0</td>
<td>median = 0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 11 shows the mean scores for the subtests on the Horowitz Impact of event scale (Horowitz, 1979). The means for all three groups fall within the mean ranges reported for a student sample in Horowitz, Witner, & Alvaras (1979). No significant differences between groups were revealed on either the intrusions or avoidance subtests.

Table 11: Impact of Event Scale (at one-week follow-up)

<table>
<thead>
<tr>
<th>Impact of Event Scale</th>
<th>Mean (s.d.)</th>
<th>Mean (s.d.)</th>
<th>Mean (s.d.)</th>
<th>Statistic</th>
<th>p&lt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subtests</td>
<td>A (n= 17)</td>
<td>B (n= 19)</td>
<td>C (n= 17)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrusions</td>
<td>3.29 (3.33)</td>
<td>3.53 (3.69)</td>
<td>4.59 (5.06)</td>
<td>$F(2,50) = .49$</td>
<td>.615</td>
</tr>
<tr>
<td>Avoidance</td>
<td>2.70 (3.12)</td>
<td>3.10 (4.71)</td>
<td>4.47 (4.14)</td>
<td>$F(2,50) = .88$</td>
<td>.420</td>
</tr>
</tbody>
</table>

Footnote: One case (from group A) was missing on this measure
Discussion

The results of the current study indicated that low levels of intrusions of a mildly distressing nature were elicited by way of traumatic video material. This replicates the findings of Murray (1997) and Davies and Clark (1998). Of particular interest was the finding that intrusive thoughts were elicited not only by seeing traumatic material, but also by hearing victim type accounts of traumatic material. In fact there was no significant difference between those who saw scenes versus those who heard accounts. This demonstrates that intrusions can be induced from hearing emotive material.

Interestingly, intrusive thoughts were also elicited by impersonal accounts of road traffic accidents, although to a slightly lesser degree. When designing the study, it had been anticipated that this condition would operate as a control group for hearing details of a traumatic event, but without the emotive content of traumatic scenes or victims themselves. Unexpectedly, these impersonal accounts elicited equivalent levels of distress and changes in mood to the other conditions. This highlights the need for future studies to compare seeing emotive scenes and hearing emotive accounts with completely neutral, non-emotive, material.

Although the groups did not differ in the frequency of intrusions, differences in the content of intrusions were found. Those who saw visual scenes of road traffic accidents had significantly more ‘real visual’ images (i.e. images of the car crashes they had actually seen on the video) than those who had heard victims’ accounts and impersonal accounts. In other words, people who had watched car crash scenes were more likely to experience flash-back type memories of the events they had actually seen. For example, one participant who watched the scenes reported having a "brief flashback to a dead guy slumped forward in (yellow) car". Another described a "flashback of a woman in pain, whilst medics put a tube down (her) throat". In contrast, those who watched victims’ accounts of road traffic accidents had significantly more ‘victim’ centered thoughts than
those who had watched the scenes. In other words, those who watched emotive personal accounts had more intrusive thoughts which focused on their concerns about the victim. For example, one participant described thinking about "the sadness of the persons reporting others' painful experiences". Another described how they "saw an accident...and it reminded me of how the people in the video must have felt". These findings make sense when considered in the context of the different experiences of the viewers of the two types of material. Those who watched visual scenes were provided with a range of images, but with little focus on individual victims. Those who heard emotive, personalised, accounts were given the opportunity to focus on the individual's distress.

Some methodological issues were raised. It should be noted that although the material elicited intrusions, they were only mildly distressing and rather short lived. This may explain why no differences were found at one week follow-up on the Horowitz Impact of Event Scale. Future studies may want to consider assessing more immediate intrusions following video material (i.e. in the subsequent hour). A possible difficulty with this study was the significant difference in credibility ratings between groups, with those seeing the real live footage of car crash scenes having higher credibility ratings than those hearing accounts of actors. This is difficult to control in that it is anticipated there would always be a degree of scepticism when actors are used. One possibility is to use real footage (e.g. from television material), although it may be difficult to obtain verbal accounts to match visual footage of the same event. However, there was no correlation between credibility ratings and the frequency and intensity of intrusions, suggesting that how much the participants believed the material to be 'real' did not effect the number and intensity of intrusions they experienced. However, it may be wise for further pilot work to be undertaken to keep this discrepancy to a minimum in future studies.

There are various limitations associated with analogue studies. For example, although the length of exposure for therapists is often longer than that of emergency workers, the intensity of exposure is commonly greater for emergency workers; which this study did
not control for. Video material also cannot provide multi-sensory stressors (such as smell) which may be significant. However, there are strong advantages for using such a design for this particular study. Bearing in mind the difficulty of controlling the 'stressor' when researching peoples' reactions to traumatic events, using such a design allowed for a direct comparison between seeing and hearing about similar incidents at the same level of distress. It is also acknowledged that the self-selection process limits the generalisability of this study to the general population. As well as the exclusion criteria, the author noted that it was a minority of those approached who were willing to volunteer to watch emotive material. This obviously limits the design. However, it is worth noting that both emergency workers and therapists are self-selected for their jobs.

Though the generalisability of this study, as yet, has to be viewed with caution, such findings may have meaningful clinical implications. It may be that those seeing emotive, impersonal, events (e.g. emergency workers) may be at risk for different types of intrusions compared to those hearing personal accounts of emotive events (e.g. therapists). This would have implications for clinical interventions, which would need to be targeted accordingly. Qualitative studies (e.g. McCann & Peralman, 1990) reflect consistent reports of PTSD symptomology in trauma therapists, though no studies have, as yet, discriminated between the types of intrusions experienced. However, Pearlman & Mac Ian (1995) have recently drawn attention to the importance of empathic engagement, a variable which may be significant to the development of vicarious traumatisation in those hearing traumatic material.

To conclude, this study supports descriptive studies which have found that therapists do report intrusions in relation to victim work by showing that hearing traumatic material can induce intrusions. It also showed that the nature of these intrusions experienced by those who hear victims accounts may differ from those seeing the traumatic material in that they have less visual and more victim-centered intrusions. Future research is needed to compare the nature and levels of intrusions in emergency workers and therapists attending similar incidents; qualitative research methods may be useful to investigate the
content of intrusions in these two groups. It would also be useful for future research to look at factors which make these intrusions particularly severe or long lasting amongst those hearing traumatic accounts. Such research is relevant to a variety of groups hearing traumatic information such as jurors, solicitors, helpline staff and social workers.
R 3: Bibliography


**EVALUATION QUESTIONNAIRE**

**STAI Form Y-2**

Name: ___________________________________________________________  Date: ______________________

**DIRECTIONS:** A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you generally feel. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. I feel pleasant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. I feel nervous and restless</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. I feel satisfied with myself</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. I wish I could be as happy as others seem to be</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. I feel like a failure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. I feel rested</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. I am &quot;calm, cool, and collected&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. I feel that difficulties are piling up so that I cannot overcome them</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. I worry too much over something that really doesn’t matter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. I am happy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. I have disturbing thoughts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. I lack self-confidence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. I feel secure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. I make decisions easily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. I feel inadequate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. I am content</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. Some unimportant thought runs through my mind and bothers me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. I take disappointments so keenly that I can’t put them out of my mind</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. I am a steady person</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40. I get in a state of tension or turmoil as I think over my recent concerns and interests</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix R3:2

Pre-study Mood Measure

1) How happy do you feel at the moment?
(Please circle the appropriate number) 0% 10 20 30 40 50 60 70 80 90 100%
Not at all  
Very

2) How anxious do you feel at the moment?
(Please circle the appropriate number) 0% 10 20 30 40 50 60 70 80 90 100%
Not at all  
Very

3) How sad do you feel at the moment?
(Please circle the appropriate number) 0% 10 20 30 40 50 60 70 80 90 100%
Not at all  
Very

4) How annoyed do you feel at the moment?
(Please circle the appropriate number) 0% 10 20 30 40 50 60 70 80 90 100%
Not at all  
Very
(Distress Rating Questionnaire)

Video Rating Questionnaire

Identification number..............................

On a scale from 0 (no distress) to 100 (intense distress), please rate how distressing you found watching each scene

<table>
<thead>
<tr>
<th>Scene</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix R3: 4

Post-study measure
When watching the video, please rate to what degree you did the following:

1. I empathised with the people I saw
2. I let my emotions come and go.
3. I put the people I saw out of my mind
4. I thought of something else
5. I visualised something else
6. I felt that they were not real
7. I numbed my emotions
8. I felt unreal
9. I felt distant from my emotions
10. I felt unable to think straight
11. I felt as if I was somehow remote from my body
12. I felt that time was passing faster or slower than it really did

For Question 13 to 17, please use the following key and circle the appropriate number:

13) How emotionally upset do you feel at the moment? 0% 1 2 3 4 5 6 7 8 9 10 100% Not at all Very
14) How happy do you feel at the moment? 0% 1 2 3 4 5 6 7 8 9 10 100%
15) How anxious do you feel at the moment? 0% 1 2 3 4 5 6 7 8 9 10 100%
16) How sad do you feel at the moment? 0% 1 2 3 4 5 6 7 8 9 10 100%
17) How annoyed do you feel at the moment? 0% 1 2 3 4 5 6 7 8 9 10 100%

If you have any concerns, please contact Jackie Allt, D. Phil Clin Psychol, Surrey University on 01483 259411 or To be confirmed
MONDAY

This diary sheet is to record any intrusive thoughts about the video material you have seen. Intrusive thoughts may be images, verbal thoughts, or memories that seem to “pop” into your mind. There is a diary sheet for each day for seven days.

Identification Number..........................

<table>
<thead>
<tr>
<th>Time</th>
<th>How many intrusive thoughts did you experience in this time span?</th>
<th>Please describe the content of these intrusive thoughts.</th>
<th>How much distress did the intrusive thought(s) give you, if any? Please rate from 0% (not distressing at all) to 100% (very distressing).</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-11 am</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11-2 pm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-5 pm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-8 pm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 p.m. until you go to sleep.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you have any concerns, please contact Jackie Allt, D. Phil Clin Psychol, Surrey University on 01483 259411 or To be confirmed
Horowitz's Impact of Event Scale

Below is a list of comments made by people after stressful life events. Please check each item indicating how frequently these comments were true for you during the past seven days. If they did not occur during that time, please mark the 'not at all' column.

<table>
<thead>
<tr>
<th></th>
<th>Not at all (0)</th>
<th>Rarely experienced (1)</th>
<th>Sometimes experienced (2)</th>
<th>Often experienced (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I thought about it when I didn't mean to.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I avoided letting myself get upset when I thought about it or was reminded of it.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I tried to remove it from memory.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>I had trouble falling asleep or staying asleep.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I had waves of strong feelings about it.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>I had dreams about it.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I stayed away from reminders of it.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I felt as if it hadn't happened or it wasn't real.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>I tried not to talk about it.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Pictures about it popped into my mind.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Other things kept making me think about it.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>I was aware that I still had a lot of feelings about it, but I didn't deal with them.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>I tried not to think about it.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Any reminder brought back feelings about it.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>My feelings about it were kind of numb.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Intrusion subset = 1, 4, 5, 6, 10, 11, 14; and avoidance subset = 2, 3, 7, 8, 9, 12, 13, 15.
Reproduced by permission of Professor Mardi J. Horowitz, from Horowitz (1986).
Appendix R3: 7

Credibility Rating

Group A: How much did you believe, when watching the video, that the car crash scenes were real and had really happened? (please circle the appropriate number)

0%  10%  20%  30%  40%  50%  60%  70%  80%  90%  100%

Not at all completely

Group B: How much did you believe, when watching the video, that the people were real clients/patients and that the events they described had really happened to them? (please circle the appropriate number)

0%  10%  20%  30%  40%  50%  60%  70%  80%  90%  100%

Not at all completely

Group C:

How much did you believe, when watching the video, that the person describing the events was a policeman and the events he described had occurred in real life. (Please circle the appropriate number)

0%  10%  20%  30%  40%  50%  60%  70%  80%  90%  100%

Not at all completely
Research Participants Required

Surrey university's department of clinical psychology is investigating the impact of road traffic accidents on the victims and those people working with them. One problem that road traffic victims have is that they suffer from distressing memories. We are aiming to conduct research that will help future victims overcome unpleasant memories.

To conduct this research we need the help of people who have NOT recently been involved in an accident or other traumatic event.

We are carrying out a study using video material to see how people deal with hearing or seeing potentially distressing material. The study is divided into two stages as follows:

Stage 1: The completion of a small number of questionnaires followed by a short video showing of potentially stressful material. The session will last approximately 30 minutes.

Stage 2: A 7-day period in which you will be asked to keep a brief record of your thoughts (taking approx. 5 minutes per day).

Stage 3: A short follow-up questionnaire (taking approx 5 minutes.)

We would be grateful if you would consider taking part in this study. We are looking for as wide a range of people as possible to take part.

If you do decide to take part and you find that you do not wish to continue for any reason, you may leave at any point, without having to give a reason for doing so.

All participants who complete the study will be included in the Prize Draw for a £20 gift voucher.

If you would like any further information about the study, then please leave a message for Jackie Allt on 01483 259441, and she will get back to you.

THANK YOU FOR YOUR TIME!
Appendix R3: 9

CONSENT FORM

Thank you for considering participating in this study.

This is a study about people’s reactions to emotive material. You will be asked to watch a short video regarding some recent road traffic accidents. You may find the material somewhat distressing.

If you are interested:

The study will involve you filling in a brief questionnaire before and after the video tape.

You will then be asked to fill in a recording chart for one week (taking approx. 5 minutes per day) regarding your experience of the video.

One week later, I will ask you for the recording chart and ask you to fill in another brief questionnaire (taking approx. 5 minutes).

As the material which you will see is emotional in nature, it’s recommended that you do not participate in this study if you have suffered a recent trauma such as road traffic accident or bereavement. It also recommended that you do not participate if you suffer from a severe depressive illness, have had treatment for depression, or if you, or an immediate family member, suffers from a severe psychiatric illness.

All participants who complete the study will be included in the Prize Draw for a £20 gift voucher!

If you would like to ask any further questions regarding the study before volunteering in this study, please contact Jackie Allt at the address/number below.

CONSENT

I have not recently experienced a trauma or loss, and am happy to participate in this study.
I understand that I may withdraw from the study at any stage without giving a reason for doing so.

Name: ............................................

Signature: ......................................

It’s essential that you do not discuss anything to do with this study with other participants until you have completed all the follow-up assessments.

There will be an opportunity for you to ask any questions about the study after the follow-up assessments have been completed.

THANK YOU FOR YOUR HELP

Jackie Allt
Psychologist in Clinical Training
Surrey University
Contact No: 01483 259441 or (to be confirmed)
Appendix R3: 10:

Ms Jackie Allt
School of Human Sciences
Psychology

Dear Ms Allt

An experimental investigation comparing the psychological impact of seeing versus hearing emotive material. (ACE/98/13/Psych).

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol, and has approved it on the understanding that the Ethics Guidelines are observed.

This letter of approval relates only to the study specified in your research protocol (ACE/98/13/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions and if the study is terminated earlier than expected (with reasons). I enclose a copy of the Ethics Guidelines for your information.

Yours sincerely

Helen Schuyleman (Mrs)
Secretary, University Advisory Committee on Ethics

cc Professor L J King, Chairman, ACE
Dr Emma Dunmore, Supervisor
Vicarious Trauma: A survey of clinical and counselling psychologists.

Major Research Project
Submitted: August 1999 (Year III)
Abstract

A survey design was used to investigate the phenomenology of vicarious trauma in a group of 141 clinical and counselling psychologists working with adults. Participants completed a questionnaire booklet consisting of measures of Post Traumatic Stress Disorder (PTSD) symptomology, compassion fatigue, trauma related beliefs, and burnout. Data was also obtained on background information including details regarding experience of trauma work. Further qualitative information was obtained regarding the therapist’s experience and interpretation of vicarious trauma symptomology.

The study revealed that a small proportion (9.3%) of therapists fulfilled DSM-IV criteria for PTSD. A minority of participants (12.2%) were also at high risk for compassion fatigue and burnout (22% for emotional exhaustion, 13% for depersonalisation and 24% for low personal accomplishment). There was some evidence to suggest that the sample, overall, had slightly higher levels of trauma-related beliefs when compared to normative data based on participants who have not experienced a traumatic event.

Those who had experienced a higher number of prior traumatic events were more likely to experience higher levels of compassion fatigue and negative beliefs about the world. In particular, a history of childhood abuse was found to be significantly related to higher levels negative beliefs about the world. There was also some evidence to suggest that burnout and vicarious trauma are not synonymous; some individuals who experienced high levels of PTSD symptomology but did not experience high burnout.

 Interestingly, the negative interpretation of intrusions was related to higher levels of PTSD symptomology. However, overall, therapists tended to interpret intrusions as a normal reaction to hearing distressing material, and would commonly seek to actively process the material when experiencing intrusions. A number of coping strategies were described, including decreasing the level of trauma work in their case load and the avoidance of certain types of trauma work, particularly work with victims of sexual abuse. A number of professional implications were discussed.
Introduction

General Background

The literature on the impact of traumatic events on individuals and their treatment has grown rapidly in the last twenty years. However, only recently has there been an increased awareness that people working with victims of trauma, who either witness or hear about the horror of traumatic events, may also be at risk for developing Post Traumatic Stress Symptomology. Figley (1995) argues that “it is time to consider the least studied and least understood aspect traumatic stress: secondary traumatic stress” (p7).

The concept of Post Traumatic Stress Disorder (PTSD) has a long history and has appeared in various guises (see Scott & Stradling, 1992, for a review). DSM-III (APA, 1980) was the first manual to include diagnostic criteria for PTSD. This has since been revised for DSM-III-R (APA, 1987) and DSM-IV (APA, 1994, appendix R4:10). The current diagnosis of Post Traumatic Stress Disorder (DSM-IV, APA, 1994) is usually applied to individuals who have directly experienced a traumatic event. It involves three clusters of symptoms, namely the re-experiencing of the event (including intrusive recollections and flashbacks), the persistent avoidance of stimuli with a numbing of general responsiveness, and persistent symptoms of increased arousal (including outbursts of anger and difficulty sleeping).

Interestingly, evidence has emerged to suggest that close family members who have heard about their relatives’ atrocities can also experience PTSD symptomology. Figley (1982, 1983 cited in Figley, 1995) has written extensively on this, reporting that family members can become “emotionally vulnerable” (p5) to the traumatic events which impacted on the relative because of the “emotional connection” (p5) they had with them. Figley called these responses “secondary catastrophic stress reactions” (p4). A recent study (Mikulincer, Florian & Solomon, 1995) also concluded that wives of war veterans living with husbands diagnosed with combat stress reaction experienced higher levels of
psychiatric and somatic symptoms compared to veterans' wives with spouses not diagnosed with combat stress reaction. It is noted that this study leaves open the question as to whether the wives had more psychiatric symptoms compared to spouses of those suffering other non-trauma related psychiatric illnesses, such as depression or psychosis. However, Mikulincer et al (1995) concluded from this study that such reactions were 'secondary traumatisation', though it is unclear how this matches with PTSD diagnostic criteria.

Such evidence has led to conceptual difficulties within the field. What constitutes a traumatic event (criterion A of DSM criteria) has now undergone some revision to accommodate these findings. Figley, (1995) highlights how it now includes “learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associates” (criterion A1, DSM-IV, APA, 1994, p424). In other words, an individual can be diagnosed with PTSD if they present with the relevant symptomology after hearing about the traumatic experience of a personal family member or acquaintance; no direct contact with the trauma itself is required.

It is unclear how important the closeness of the relationship to the victim is in the development of PTSD. However, the ability to diagnose PTSD after hearing about a trauma opens the way to consider whether therapists may develop post-traumatic responses after working with victims of trauma.

'Labels' for Therapist Trauma Reactions

The impact of working with trauma victims has been given various labels including 'secondary trauma' (Figley, 1995) ‘vicarious trauma’ (McCann & Pearlman, 1990; Pearlman & Mac Ian 1995),’countertransference’ and, more recently, ‘compassion fatigue’ (Figley, 1995). There is a lack of agreement in the field regarding their interchangeability. For example, it's been argued (Figley, 1995; MacCann & Pearlman, 1990) that ‘countertransference’ refers specifically to processes within a therapeutic relationship, and does not account for the significance of hearing distressing material. To
confuse matters further, the same terms have been applied to different types of ‘helping profession’ work. For example, Campbell (1994) applied the label ‘vicarious trauma’ to both rescue personnel and social workers, who generally may see and hear about the traumatic events respectively. In contrast, McCann & Pearlman (1990) use ‘vicarious trauma’ to refer specifically to therapists working with victims of trauma. As described above, Mickulincer, Florian, & Solomon (1995) used the term ‘secondary traumatization’ to refer to the emotional impact of living with a family member with combat stress reaction. However, Jones (1985) identifies personnel involved with body identification after a mass suicide event as ‘secondary disaster victims’.

Most of the research which has centered around workers who have seen the aftermath of traumatic events, such as the police and emergency workers (e.g. Alexander, 1993; Martin, McKean & Veltkamp, 1986 and Durham, 1985) have conceptualised individuals’ reactions according to PTSD diagnostic criteria. It is important to highlight that emergency workers may well fulfill criterion A (APA, 1994) for PTSD if they have experienced or witnessed a traumatic event. However, Figley now uses the label ‘compassion fatigue’ interchangeably with ‘secondary trauma’ to apply to a range of helpers (including emergency workers and therapists), who both hear about and/or see traumatic events. Such confusion in the literature reflects the relative lack of knowledge and theoretical understanding of such a phenomenon.

This study will examine the impact of hearing about traumatic events within a therapeutic relationship. This area poses significant questions, not only for the emotional well-being of the professional therapist, but also for the theoretical understanding of PTSD. Unless otherwise specified, the term ‘vicarious trauma’ will be used to label the impact of working with trauma victims on therapists.
Evidence for clinicians experiencing secondary trauma

There is relatively little empirical evidence to establish the phenomenology of ‘secondary trauma’ symptomology. We know little about the experiences of trauma clinicians, the potential prevalence of PTSD symptomology or the vulnerability and protective factors. There have been some descriptive reports of the emotional difficulties of this kind of work. For example, Figley (1995) has described the effects of trauma on relatives and the helping professions in terms of PTSD symptomology. He argues that ‘secondary trauma’ is a “syndrome of symptoms” (p8) which is nearly identical to PTSD, which he re-labels as ‘primary trauma’. Figley (1995) argues that the only difference between ‘primary’ and ‘secondary’ trauma is that secondary trauma involves exposure to hearing about a client’s traumatic event rather than experiencing, or witnessing, the traumatic event itself.

It is worth highlighting that an individual can be diagnosed with PTSD according to DSM-IV criteria (APA, 1994) if they have heard about a traumatic event happening to a close family member or associate. However, where Figley differs from DSM-IV (APA, 1994) is that he includes any individual who may have seen or heard about a traumatic event, whatever relationship they may have with the victim. So, for example, he includes the professional relationship of the helper and the victim which DSM-IV (APA, 1994) criteria would exclude. This conceptualisation has face validity, but lacks a large-scale empirical study to provide firm evidence that therapists actually experience PTSD symptomology directly as a result of their trauma work.

McCann and Pearlman (1990) discuss the impact of trauma work on the therapist. They identify this impact as ‘vicarious trauma’, which they place within psychoanalytic and constructivist self-development theory. They highlight both the significance of schemas, (complex cognitive structures which develop over time) and the nature of the traumatic material. McCann & Pearlman (1990) postulate that hearing distressing material can disrupt the therapist’s schemas and that “the therapist’s unique reactions will be determined by the centrality or salience of these schemas to himself or herself” (p137). They describe cases, with vivid examples of trauma work and its impact. Such work is
useful in providing a theoretical paradigm, but does not provide systematic evidence regarding the potential impact of trauma work.

Lyon (1993) goes a step further in gathering evidence on hospital staff’s reactions to accounts by survivors of childhood abuse. She collated reports from staff (number not reported) via ongoing supervision groups and training sessions. An “informal staff questionnaire” (p 411) was also used to collect further detail. No details of the qualitative measures or analysis were given. Three themes were identified: 1) the toxic, contaminating quality of the descriptions of abuse; 2) feelings of isolation; and 3) questioning of the “human potential for good and evil”. Although this study is useful in terms of providing data to support anecdotal evidence, the lack of rigorous methodology means that it is not possible to establish empirical evidence for the themes that emerged and the impact of these on psychological functioning. Furthermore, the study did not attempt to assess for potential PTSD symptomology.

The effects of trauma work on therapists are also discussed in the psychodynamic literature (e.g. Pearlman & Saakvitne, 1995; Kinzie & Boehlein, 1993; McCann & Pearlman, 1990), with particular attention to the significance of ‘counter-transference’. The literature on ‘countertransference’ conceptualises the therapists’ reactions to trauma work in terms of their own unresolved conflicts. Thus the emphasis within this literature is on the therapists’ own unique reaction to the characteristics of the trauma, rather than the nature of the traumatic material itself. These reactions may be conscious or non-conscious. More recently, this has been taken by Kinzie & Boehlein (1993) to include all emotional reactions a therapist has toward the client.

Kinzie & Boehlein (1993) identify some countertransference issues in psychotherapy with victims of chronic PTSD. The authors provide descriptive evidence based on the reports of individual case studies. They describe the strong impact of this work on therapists. During therapy, the therapists reported sadness, depression, anger, irritability hyperarousal, “excessive identification” (p91) and intolerance towards other clients who
have experienced less traumatic events. Outside of the therapeutic situation, the authors reported "intolerance of all violence" (p91), a personal "sense of vulnerability" (p91), and "a sense that a culture that allows such violence to occur anywhere has failed" (p91). The authors highlight how the therapist may have to struggle with such strong reactions. This is useful in terms of highlighting possible themes. Unfortunately, such evidence was based on reports of individual case studies, making it difficult to establish empirical evidence on the phenomenology of the psychological impact of working with trauma survivors.

**Empirical studies**

There are three studies (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995 and Arvay & Ulhemann, 1996) which examine the reactions of therapists working with trauma victims in the 'real world', which have made a significant contribution to the field. These will be described in more detail here.

Pearlman & Mac Ian (1995) offer one of the most convincing studies, in terms of its design and results. The study identifies the impact of working with victims of trauma within the framework of 'vicarious trauma' (McCann & Pearlman, 1990). They report on a postal survey design, based on 188 self-identified trauma therapists. Pearlman & Mac Ian (1995) found that therapists seemed to be functioning well psychologically when compared to the general population, despite indicating trauma histories which were more extensive. Some were experiencing intrusion and avoidance symptomology, assessed by the Horowitz Impact of Event Scale (IES, Horowitz, Wilner & Alvarez, 1979). Unfortunately, they did not report details of the scores on this measure nor did they give details regarding how many therapists were suffering more severe reactions.

However, they found that that those clinicians who had the least experience were suffering the most disrupted schemas, according to their scores on the Traumatic Stress Institute Scale belief scale (TSI, Pearlman, in press, cited in Pearlman & Mac Ian, 1995), which included items regarding self-trust, self-intimacy and self-esteem. They also had
higher symptom levels on the Symptom Checklist-90-Revised (Derogatis, 1977, cited in Pearlman & Mac Ian, 1995), a measure of psychiatric symptomology. The authors highlight how the younger therapists, newest to trauma work, were less likely to have been receiving supervision. This may have been a significant factor. It may also be that the initial changes identified decrease with subsequent experience. Another possibility is that the less experienced therapists, who were found to be coping less well, may go on to leave the field. This may mean that the more experienced therapists in this study may represent those who have always coped relatively well, and have chosen to stay in the field.

The authors also found the therapists' trauma history was relevant. Sixty percent of the sample answered 'yes' to the question 'do you have a trauma history?'. Those with a trauma history were found to have significantly higher scores on the TSI belief scales (Pearlman, in press, cited in Pearlman & Mac Ian, 1995), the SCL-90 (Derogatis, 1977, cited in Pearlman & Mac Ian, 1995), and the IES (Horowitz, 1980, cited in Pearlman & Mac Ian, 1995) than those without a trauma history. The authors suggest that this may mean that pre-existing schema are significant in how therapists respond to hearing clients' traumatic memories. However, there was no measure of pre-existing schema, and it is possible that those with a trauma history showed symptoms as a direct result of their trauma work. It is also worth noting that 'trauma history' was only measured by a single item, which gave no detail of the types of traumas people had experienced. For example, it is unclear whether this included bereavement.

Interestingly, against prediction, this study did not find that the percentage of trauma survivors in the therapist's case load was correlated with symptoms of vicarious trauma. An exception to this was the relationship between the percentage of trauma survivors in the clinician's case load and beliefs of self-trust, for which there was a negative correlation. It may be that the work has a negative impact on beliefs of self-trust. This result needs to be taken with caution, as the analysis was exploratory in nature.
Overall, this study was useful in that it had a relatively large sample of 188 therapists, albeit self-selected, who were revealed to be generally coping well. The study revealed some significant vulnerability factors, such as level of experience and trauma history, which warrant further investigation. However, it did not explore other PTSD symptomatology according to DSM-IV criteria, such as hyper-vigilance and hyper-arousal.

Schauben & Frazier (1995) found convincing evidence illustrating the negative impact of trauma work. Their study investigated the impact on 148 counsellors of working specifically with sexual violence survivors within a framework of ‘vicarious traumatisation’. The study used a survey design involving members of a women psychologist’s organisation and a group of sexual violence counsellors.

Schauben & Frazier (1995) found that the level of disruption to schemas, measured by the Traumatic Stress Belief Scale, (Pearlman & Mac Ian, 1993 cited in Schauben & Frazier, 1995) level of PTSD symptomology (according to a DSM-III-R criteria symptom checklist devised by the authors) and self-identified vicarious trauma was correlated with the percentage of trauma victims the therapists had in their case load. Unfortunately, the authors did not report details of the scores for the various PTSD symptomology, making it difficult to establish the severity of impact for those with a higher percentage of victims in their caseload.

In contrast to Pearlman & Mac Ian’s study (1995), they did not find that the counsellor’s own prior history of sexual victimisation was related to symptomology. Qualitative data revealed that the counsellors experienced emotional distress (such as anger at the perpetrator) and changes in beliefs, which corroborated with quantitative data. The five most common coping strategies established were active coping, emotional support, planning, instrumental support and humour. All five of these coping strategies were correlated with lower symptom levels.
This is a useful study in terms of duplicating Pearlman & Mac Ian's (1995) findings that most therapists cope well. Significantly, this study revealed that the impact of such work is likely to increase with the number of sexual violence victims they have in their caseload. In contrast, Pearlman & Mac Ian (1995) did not report such a relationship, highlighting the need for further clarification in this area of research. This different result may be partly accounted for by the fact that Shauben & Frazier's (1995) study was concerned with one type of trauma only. It may be that sexual abuse work has a specific impact, and that repeated exposure to accounts of the same type of trauma may also have a cumulative effect. Unfortunately, this study did not explore in detail the nature of intrusions and avoidance behaviour experienced, nor specific coping strategies for these. Neither did it report on the extent of other PTSD symptoms reported by the clinicians. Overall the authors concluded that the counsellors were experiencing relatively few symptoms, "perhaps because they have developed effective strategies to cope with the stresses of this work" (p63).

A recent study (Arvay & Uhlemann, 1996) investigated levels of general life stress, burnout and traumatic stress in 161 counsellors working primarily in the field of trauma. Again, they used a postal survey to target professionals specifically working in this field. The sample included certified clinical counsellors as well as social workers, child care workers, psychologists and psychiatrists.

The study revealed that 14% of participants were experiencing traumatic stress symptomology (measured by the IES, Horowitz, 1979) comparable to clients with PTSD (in line with Horowitz et al, 1979 study of 66 patients' with PTSD mean scores, cited by the authors). They concluded that working with trauma victims "can pose a serious threat to the well-being of the trauma counsellor" (p207). They also report that several demographic variables were significantly related to PTSD symptoms. Younger clinicians were found to experience more intrusions and avoidance symptomology, higher levels of stress, and scored more highly on the 'depersonalization' subscale (impersonal response to clients) of a 'burnout' measure (Maslach Burnout
Inventory, Maslach & Jackson, 1981). The number of years in practice was also found to correlate with intrusion and avoidance symptomology. The levels of stress, intrusions, ‘emotional exhaustion’ and personal accomplishment subscales of the ‘burnout’ measure were also correlated with the clinicians’ perception of the intensity and frequency of trauma clients on the case load.

This study reveals that clinicians working in this field have reported a range of symptoms, with 14% being identified as experiencing levels of symptoms comparable to clients with PTSD. The relatively high return rate (64%) from a large sample (430) adds particular weight to this finding. This study also revealed a number of potentially relevant relationships between variables. In particular, their finding that less experience is related to higher symptomology is backed up by McCann & Pearlman’s (1995) study, which found that younger clinicians, who are likely to have less experience, experienced higher levels of symptomology.

However, this study did not assess for the range of PTSD symptoms in a systematic way. Although the IES (Horowitz, 1979) is a widely used measure, it only assesses the level of intrusions and avoidance. This study also did not address any significant changes in beliefs, which has been highlighted as significant by a number of authors (e.g. McCann & Pearlman, 1990). A further methodological problem with this study is the range of professionals it involved in that different professional roles may effect how trauma work impacts on the individual. The authors did not compare the different professions in their analysis.

Other conceptualisations of work-related stress

‘Burnout’ has also been used to conceptualise the stress associated with the helping professions and is reviewed by Ackerly, et al. (1988). There are various definitions of ‘burnout’. Freudenberger (1982, cited in Farber & Heifetz, 1982) originally used the term to describe the physical and emotional exhaustion of staff members within health care institutions. Maslach & Jackson (1984) define burnout as "a syndrome of emotional

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exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who 'do people work' of some kind" (p189). Although there are differences in the definitions produced by various authors, it is generally acknowledged (e.g. Figley 1995; Ackerley, 1988; Farber, & Heifetz, 1988) that ‘burnout’ involves psychological and physiological exhaustion in response to working with those who are ‘troubled’.

There are few studies which look at ‘burnout’ specifically in therapists (acknowledged by Farber & Heifetz, 1982; and Ackerley, 1988). Farber & Heifetz (1992) undertook semi-structured interviews with 60 psychotherapists. They found that ‘burnout’ occurred “when psychotherapeutic work is particularly frustrating and only minimally successful” (p298). A large survey amongst psychologists was carried out by Ackerley et al (1988). Responses to a burnout inventory revealed that more than a third of participants were reported to be experiencing “high levels of both emotional exhaustion and depersonalisation” (p624, Ackerly, 1988).

Figley (1995) argues that ‘burnout’ emerges gradually, compared to secondary trauma, which can have a sudden onset. He also highlights how secondary trauma is associated with a sense of helplessness, confusion and sense of isolation, with the symptoms being “disconnected from real causes” (p 16) and having “a faster recovery rate” (p16) than that of ‘burnout’. However, it is unclear where Figley obtains the evidence for such a discrimination between the two. Arvay & Uhlemann (1996) postulate that “the difference between the two constructs seems to be a matter of the degree of intensity of many of the symptoms” (p195). However, Pearlman & Saakvitne (1995) argue that working with trauma survivors has unique effects, which are distinct from general psychotherapy work.

Schaube & Frazier (1995) investigated this in their survey described above. They hypothesised that the percentage of survivors that the therapists were seeing would be unrelated to the level of therapist burnout measured by the Maslach Burnout Inventory (MBI, Maslach & Jackson, 1981). This was confirmed. Furthermore, the percentage of
victims in the therapist’s caseload was associated with more disruptions in basic schemas, more PTSD symptoms and more self-reported vicarious trauma, but not correlated with ‘burnout’. This is clearly evidence to suggest that ‘vicarious trauma’ is a distinct concept, which is associated specifically with working with trauma victims.

However, Arvay & Uhlemann (1996) used the same burnout measure (MBI, Maslach & Jackson, 1981) on clinicians working with a range of trauma victims. They found that the emotional exhaustion subscale was related to the number of trauma victims seen per week, self-rating of having "too many in their caseload" and the self-rated frequency for the impact of traumatic material. The authors also reported that 52% of those participants who scored highly on the IES (Horowitz, 1979) were three times more likely to score highly on the emotional exhaustion scale of the MBI (Maslach & Jackson, 1981). Fifty percent of those who scored highly on the intrusions subscale of the IES (Horowitz, 1979) were 29% more likely to have low feelings of personal accomplishment. Ninety-two percent of those who scored highly on the avoidance subscale of the IES (Horowitz, 1979) were 83% more likely to score highly on the depersonalisation scale, and 37% of participants who scored highly on the avoidance subscale of the IES (Horowitz, 1979) were 52% more likely to have low scores on the personal accomplishment scale of the MBI (Maslach & Jackson, 1981). This, as the authors argue, would suggest that a proportion of those experiencing vicarious trauma symptoms are also more likely to be experiencing the emotional responses of ‘burnout’ symptoms. In particular, avoidance showed a strong link with depersonalisation. It could be that avoidance behaviour leads to depersonalisation and low personal accomplishment. Further research needs to investigate the relationship between ‘burnout’ and vicarious trauma, including the relationship between other vicarious trauma symptoms and aspects of ‘burnout’.

**Experimental Investigation**

The lack of empirical studies in this field led Allt & Dunmore (1998, small scale research project in current portfolio, p194) to undertake an experimental investigation to explore the frequency and nature of intrusions resulting from hearing, compared to seeing,
emotive material. This involved randomly assigning participants to watch either video material of car crash scenes, ‘clients’ (actors) describing their personal accounts of the same car crashes, or a policeman (actor) giving a neutral account of the same car crash scene. Of particular interest was whether intrusive thoughts were elicited by both seeing scenes of traumatic material and hearing ‘victims’ accounts. There was no significant difference in the frequency of intrusions experienced by these two groups. Furthermore, there were differences in the content of intrusions experienced. Those who watched the video material of victim’s accounts were more likely to experience intrusive thoughts about the victim (e.g. “the sadness of the other person’s experiences”), whereas those who had watched the car crash scenes were more likely to experience visual images (e.g. “a dead guy slumped forward in a yellow car”).

This study was significant in that it provides evidence that intrusions can be induced from hearing emotive material. It also raises interesting questions about the nature of intrusions therapists experience. However, these results need to be viewed with caution, as the study was undertaken under experimental conditions with limited relevance to the ‘real world’. It does not take into account, for example, the therapeutic relationship or the professional role of therapists.

**Summary and aims of current study**

A limited amount is known about the psychological impact on therapists of working with victims of trauma. Although the psychodynamic literature has provided a useful conceptualisation of the impact of this work in terms of ‘countertransference’, this is limited in what it can tell us empirically about its phenomenology. The constructivist self-development theory (e.g. McCann & Pearlman, 1990) of ‘vicarious trauma’ offers the most useful theoretical framework for the conceptualisation of the impact of trauma work on the clinician. However, more evidence is needed to establish the utility of this model.
Three studies in this review have been highlighted as the most significant in terms of the establishment of the phenomenology of vicarious trauma for therapists. Pearlman & Mac Ian’s study (1995) was useful in that it revealed risk factors (those with the least experience, and those with a trauma history) for experiencing negative psychological impact in terms of beliefs, intrusions and avoidance behaviour. However, this study did not establish any detail on the types of intrusions and avoidance, nor on the coping strategies used. Furthermore, it did not assess for other PTSD symptoms according to DSM-IV (APA, 1994) criteria. Schauben & Frazier (1995) also found some convincing evidence for vicarious trauma. Their main finding was that the disruption to schemas did correlate with the number of trauma victims the therapists had in their caseload, but did not correlate with therapist’s trauma history of sexual victimisation. The authors usefully assessed symptoms according to PTSD (DSM-III-R, APA, 1987) criteria, though unfortunately did not report the details of this. They also reported on a number of coping strategies used, and noted that this may account for the relatively low number of symptoms reported. Again, this study did not report in detail on the nature of any intrusions or avoidance behaviour. Arvay & Uhlemann’s (1996) study focused primarily on stress levels and intrusion and avoidance levels. They found that the number of years in practice was negatively correlated with the level of intrusions experienced. Again, they did not assess for any other PTSD symptoms. Neither did they explore the nature of intrusions/avoidance, or the impact of the work on beliefs. These studies provide significant evidence for the impact of trauma work, and highlight gaps where further work is needed.

There is still some confusion regarding how burnout overlaps, or differs from vicarious trauma. Schaube & Frazier (1995) confirmed that burnout was unrelated to the percentage of trauma victims in the therapists’ case load, whereas vicarious trauma symptoms were related to caseload. However, Arvay & Uhlemann’s (1996) study did not find such a discrimination, and it is not clear to what extent they differ and overlap.
Allt & Dunmore's study (1998) provides clear evidence that individuals can experience intrusions from hearing emotive material similar to that which a therapist would hear. Furthermore, they did not find that those who had heard distressing material experienced significantly fewer intrusions than those seeing visual scenes of the same scenario.

The current study aimed to address some of the gaps highlighted in the literature. A postal survey was undertaken based on a sample of 141 clinical and counselling psychologists. These were selected by way of geographical region. The sample consisted of clinicians who were undertaking varying amounts of trauma work with clients who had experienced a range of traumas.

The main aim was to establish data on the phenomenology of vicarious trauma, how it may be distinguished from 'burnout', and the risk factors for developing vicarious trauma. Included in this was a measure of the impact of this work on trauma-related beliefs. The second aim of this study was exploratory in nature. The literature revealed little knowledge regarding therapists' experiences of intrusions, avoidance behaviour and coping strategies. Qualitative methods were used to explore therapist's experiences of these.
Methodology

Pilot Interviews
Semi-structured interviews were undertaken with six clinical psychologists working across a range of adult mental health specialties. The clinicians were questioned, in confidence, about their experiences and responses to working with trauma victims. In particular, details were gathered regarding their experiences of intrusions, and how they felt such work had impacted on their beliefs and behaviour. These interviews confirmed the relevance of the study and contributed to the conceptualisation of the questionnaire design.

Design
This study used a postal survey design. Quantitative methods were used to assess the impact of trauma work using standardised measures. It was also appropriate to use qualitative methods to gather further exploratory data, bearing in mind the lack of research in the field.

Recruitment
The sample consisted of clinical and counselling psychologists working with adults within a specified geographical region. All 350 clinical and counselling psychologists working (at least some of the time) with adults who were listed in the South Thames Psychology Directory were included. A further 150 clinical and counselling psychologists were identified from the North Thames region, amounting to a total of 500. These names were obtained from the University College London directory of supervisors and departments in the region, with the kind permission of the course director. The first 150 names of those working with adults were identified from this directory, which listed NHS trust departments in alphabetical order. The accuracy of the information in the directory was clarified by phone calls to the relevant departments.

Due to the potentially sensitive nature of the questions, a crucial element in the design was that the survey was entirely anonymous. Because of this it was not possible to send
reminders to individual volunteers to return their questionnaires. However, a number of other measures were undertaken, recommended in the literature (e.g. Oppenheim, 1992), to encourage a high response rate. Care was taken to ensure that the layout of the questionnaire was clear, and that the wording of items on the non-standardised measures was clear and unambiguous. In addition, a clear rationale for the study was given and participants were informed that a summary of the research findings would be sent to each head of department for circulation.

Participants
143 volunteers completed and returned the questionnaire pack. Of these, two were discarded as the volunteers did not fulfill the criterion of working with adults, leaving. This left a total of 141. A further two questionnaires were returned, not known at the address. This gave an overall response rate of 28%.

Of these, 36 respondents (25.5%) were men, (103) and 72.3% were women. 86 (61%) of these worked in an adult mental health/primary care setting. 17 (12%) worked in the field of health psychology. The remaining 27% worked in a range of specialties: forensic (6.4%), neuropsychology (1.4%), rehabilitation (3.5%), physical disability (.7%), addiction (2.1%), or specialist/other services (2.8%).

They represented a range of ages. Sixty-three (44.7%) were between the ages of 31-40. 46 (32.6%) were between the ages of 41-50. 22 (15.6%) were between the ages of 20-30. 8 (5.7%) were between 51-60. One person (.7%) was aged 60 or above.

Procedure
A questionnaire pack was posted to each identified clinician. The pack contained a cover letter (appendix R4:1), a questionnaire booklet (appendix R4: 1-8), and a self-addressed envelope.
Clinicians were asked to volunteer to participate in the study, and were informed that their participation was entirely voluntary. They were also informed that the study would be entirely anonymous. It was made clear that no code numbers were being used to identify their responses. If individuals wished to volunteer, they were asked to complete the questionnaire booklet and return it in the self-addressed envelope.

**Measures**

**General Information**
This was a short measure, devised by the author, to obtain demographic information (appendix R4: 2). This included questions regarding age, experience, and the number of trauma victims they had worked with. Participants were also asked to indicate whether they received supervision when working with trauma victims.


This self-report measure (appendix R4:4) was chosen to assess for the level of PTSD symptomology according to DSM-IV criteria (APA, 1994). This measure also includes a question (8 point scale) regarding how disabling these reactions have been in the last month, and at their worst in the past, to assess criterion F.

The measure consists of 17 items which the respondent is asked to rate on an analogue scale (0-3) according to frequency during the last month. These scores give a measure of the severity of the symptoms. A further analogue scale was added, by the current authors, for respondents to rate their distress for each symptom. In addition to ratings for symptoms within the last month, the current author added the question of whether they had 'ever' experienced such symptoms.
To fulfill DSM-IV (APA, 1994) criteria, respondents must indicate they had experienced a total of at least one intrusive symptom, three avoidance symptoms and two arousal symptoms. In line with Dunmore, Clark & Ehler's study (1999) study, a score of <2 for impairment during the last month was taken as the cut-off point for those fulfilling criterion F of DSM-IV (APA, 1994) criterion.

The authors (Foa, Cashman & Jaycox, 1997) report satisfactory internal consistency, high test-retest reliability and good concurrent validity on a sample of 118 recent rape and non-sexual assault victims. This was also found to be both reliable and valid when administered to 248 participants who had experienced a wide variety of traumas. They provide norms based both on participants diagnosed with PTSD, and participants who have experienced a traumatic event but not diagnosed with PTSD.

For the purposes of this study, this measure was adapted so that it was appropriate for the clinician. Each item was re-worded to relate to the events (or related events) that the clients had described to them.

The Post Traumatic Cognitions Inventory (PTCI) (Foa, Ehlers; Clark; Tolin; Orsillo, in press)
This measure (R4:5) was chosen to assess for trauma-related thoughts and beliefs experienced by the clinician. There are three components to this scale: negative cognition's about the self, about the world and self-blame. The test consists of a series of statements or beliefs. Respondents are required to rate, according to their level of agreement or disagreement, according to 7 categories ranging from 1 (totally disagree) to 7 (totally agree).

Again, the wording for some of the items was adapted to be relevant to hearing about traumatic events, rather than experiencing a traumatic event directly. Two self-blame items were excluded as not relevant to the clinician. The authors report good reliability
and validity ratings. However, it is acknowledged that the use of these norms needs to be taken with caution due to the changed wording and omitted times from this test.

The authors also provide norms (median scores) based on three groups of participants: those who had not experienced a traumatic event, those who had experienced a traumatic event but had not been diagnosed with PTSD, and those who had experienced a traumatic event and had been diagnosed with PTSD.

**Intrusions Questionnaire**

This measure (R 4: 6) was devised by the author based on 6 pilot interviews undertaken with therapists who had worked with trauma victims. During its conceptualisation, the measure was completed by two clinical psychologists, and their feedback was incorporated into the questionnaire design. The measure was devised in order to obtain both qualitative and quantitative data on intrusions experienced, clinicians attitudes towards them and their coping strategies. Some of the items comprised of statements which participants were asked to rate according to 7 categories. Other items consisted of ‘open’ questions asking participants to describe their emotional reactions and strategies in more detail. This questionnaire was piloted on a number of psychologists. Although this measure has no established reliability or validity, the lack of knowledge regarding this area meant that it was an appropriate way to investigate these issues.

**Maslach Burnout Inventory** (Maslach & Jackson, 1981)

This measure (appendix R4: 7) was chosen as a well established measure of ‘burnout’ in people who work in human services settings. It comprises of 22 items which are written in the form of statements regarding personal feelings or attitudes. These correspond to three subscales: emotional exhaustion (9 items), depersonalization (5 items) and lack of personal accomplishment (8 items). Further details of these components is given in the introduction. Each of the statements are rated according to a frequency scale which extends from 0 (never) to 6 (every day). For the purposes of this study, the intensity scale was omitted, which, according to the authors (Maslach & Jackson, 1981) does not
compromise validity. The scores on the subscales are the sum of the relevant items. Burnout is indicated by high scores on the emotional exhaustion and depersonalisation scales, and low scores and the personal accomplishment subscale. The authors provide three ranges of scores for the categorisation of: low, moderate and high burnout. The authors report on both the measures reliability, with reliability coefficients for the subscales being .90, .79 and .71 for the three scales respectively. They also report on its convergent, and discriminant validity with normative data available based on 1384 participants across many occupational groups.

**Post Traumatic Experiences** (Dunmore, 1997)

This measure *(appendix R4: 7)* was selected as a tool for obtaining information on the ‘type’ and number of traumatic events participants may have experienced both as a child and adult. The total number of previous traumatic experiences was calculated as the sum of the first 11 items on this questionnaire. The sum of items 1-8 represent the number of traumatic incidents experienced other than childhood abuse. Items 9-11 assess for three types of childhood abuse. Unfortunately, due to an administrative error, an item regarding sexual abuse/assault was omitted from this measure. There is comparative data available, obtained from a group of clients diagnosed with PTSD.

**Compassion Fatigue Test for Helpers** (Figley, 1995, adapted by Stamm, 1995)

This ‘self-test’ measure *(appendix R4:3)* is the only measure available which has been devised specifically to assess compassion fatigue/secondary trauma in those working in the caring professions. The original measure is devised around three components: compassion fatigue, compassion satisfaction and burnout. The burnout component was excluded for the purposes of this study due to the inclusion of a widely used ‘burnout’ measure (Maslach & Jackson, 1981). The compassion fatigue (23 items) and compassion satisfaction (26 items) subtests consist of a series of statements. The respondent is required to rate each statement according to how frequently they have experienced each
characteristics in the last week according to a 5 point frequency scale ranging from 0 (never) to 5 (very often).

The authors provide norms for the three components based on a sample of 370 people from a range of professions. 16% of these were trauma professionals, 35% were business volunteers, 8% red cross and 27% were caregivers in training. Five risk categories have been identified by the authors for the interpretation of compassion fatigue scores ranging from extremely high risk to extremely low risk. Similarly, there are also five categories for compassion satisfaction potential, ranging from low potential to extremely high potential.

Statistical Analysis
Independent t-tests were used to make comparisons between gender where assumptions for the normal distribution of scores and homogeneity of variances were met. Otherwise, non-parametric tests were used. Chi-Square tests were used to analyse categorical data. Correlations were used to investigate the relationship between variables where appropriate. Analysis of variance was used to make group comparisons between those with no trauma history, those who had experienced at least one traumatic event (except childhood abuse) and those with a history of childhood abuse (with or without the experience of other trauma). Participant’s responses to open ended questions were analysed using content analysis. A kappa analysis was undertaken to establish inter-rater reliability.
Results

Part 1: Analysis of quantitative measures

Background characteristics
A total of 141 participants returned the questionnaires. Of these, 103 (73%) were women and 36 (25.5%) were men. Two participants (1%) did not reveal their gender.

Table 1 shows a summary of the background characteristics of the sample. There were no significant differences between male and female therapists on any of the background characteristics. 45% of participants were between the age of 31-40. One participant (3%) was aged 60 or over.

Most of the participants (64%) worked in the field of adult mental health/primary care (n=134). The rest of the sample was spread reasonably evenly between forensic/substance misuse (9%) health (15%) and other services (12%) which included neuropsychology, rehabilitation, and other specialist services. The mean number of years worked in the current specialty was 6.03 (5.29) and the mean number of years worked since qualifying was approximately two years longer than this.

Very few participants had worked with less than 10 trauma victims (5% of 138), with 38 (28%) indicating that they had worked with over 100. The percentage of trauma victims in the case load was high (including sexual abuse), with a mean score of 42.97%.

The large majority of the sample (85%) received supervision for their work with trauma victims.
Table 1: Background Characteristics of the Sample.

<table>
<thead>
<tr>
<th>Age (Years)</th>
<th>N (%)</th>
<th>Total</th>
<th>Statistic</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-30</td>
<td>3 (8)</td>
<td>19 (8.)</td>
<td>22 (16)</td>
<td>(\text{Chi}^2 (1,4) = 5.49) .241</td>
</tr>
<tr>
<td>31-40</td>
<td>18 (50)</td>
<td>44 (43)</td>
<td>62 (45)</td>
<td></td>
</tr>
<tr>
<td>41-50</td>
<td>11 (31)</td>
<td>34 (33)</td>
<td>45 (33)</td>
<td></td>
</tr>
<tr>
<td>51-60</td>
<td>3 (8)</td>
<td>5 (5)</td>
<td>8 (6)</td>
<td></td>
</tr>
<tr>
<td>60 and above</td>
<td>1 (3)</td>
<td>0 (0)</td>
<td>1 (1)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Job specialty</th>
<th>N (%)</th>
<th>AMH</th>
<th>Forensic/sub. Misuse</th>
<th>Health</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMH</td>
<td>22 (67)</td>
<td>64 (63)</td>
<td>86 (64)</td>
<td>(\text{Chi}^2 (1,3) = 1.42).701</td>
<td></td>
</tr>
<tr>
<td>Forensic/sub. Misuse</td>
<td>3 (9)</td>
<td>9 (9)</td>
<td>12 (9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td>3 (9)</td>
<td>17 (17)</td>
<td>20 (15)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>5 (15)</td>
<td>11 (11)</td>
<td>16 (12)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No. of years worked</th>
<th>mean (s.d)</th>
<th>(median)</th>
<th>No. of years worked</th>
<th>mean (s.d)</th>
<th>(median)</th>
</tr>
</thead>
<tbody>
<tr>
<td>in current specialty</td>
<td>5.94 (5.88)</td>
<td>6.14 (5.14)</td>
<td>6.03 (5.3)</td>
<td>U= 1737</td>
<td>.755</td>
</tr>
<tr>
<td>(median)</td>
<td>(6)</td>
<td>(6)</td>
<td>(6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>since qualifying</td>
<td>9.61 (8.90)</td>
<td>8.52 (6.64)</td>
<td>8.83 (7.24)</td>
<td>t(136)=.763</td>
<td>.447</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No. of clients</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 10</td>
<td>4 (11)</td>
</tr>
<tr>
<td>10-30</td>
<td>10 (27.8)</td>
</tr>
<tr>
<td>30-60</td>
<td>7 (19)</td>
</tr>
<tr>
<td>60-100</td>
<td>8 (22)</td>
</tr>
<tr>
<td>&gt;100</td>
<td>7 (19)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% of trauma victims</th>
<th>mean (s.d)</th>
<th>in case load</th>
</tr>
</thead>
<tbody>
<tr>
<td>37.63 (30.52)</td>
<td>45.17 (29.37)</td>
<td>42.97 (29.66)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supervision</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>31 (86)</td>
</tr>
<tr>
<td>No</td>
<td>5 (14)</td>
</tr>
</tbody>
</table>

Number of respondents:

* men = 26; women: = 74; total = 100  
* men = 25; women =75; total = 100  
* men = 101; total = 137  
* men = 35; women = 103; total = 138  
* men = 101; total = 136  
* men = 36; women = 101; total =137.

Table 2 shows data regarding the previous traumatic experiences of the participants. There was a significant difference between men and women in their mean score for previous traumatic experiences, with scores for men being significantly higher than for women for the total number of traumatic experiences and the number of traumatic events.
other than child abuse. Unfortunately, it is noted that 'other traumatic experiences' does
not include sexual assault as an adult due to an administrative error.

Table 2: Previous Traumatic Experience

<table>
<thead>
<tr>
<th></th>
<th>men</th>
<th>women</th>
<th>total</th>
<th>statistic</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous traumatic experiences</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>mean (s.d.)</td>
<td>2.56 (1.4)</td>
<td>1.80 (1.58)</td>
<td>1.9 (1.57)</td>
<td>t (134)=2.52</td>
<td>.013</td>
</tr>
<tr>
<td><strong>Child abuse</strong></td>
<td>.89 (.95)</td>
<td>.6 (.81)</td>
<td>.66 (.85)</td>
<td>t (136)=1.77</td>
<td>.080</td>
</tr>
<tr>
<td><strong>Other traumatic experiences</strong></td>
<td>1.67 (1.32)</td>
<td>1.2 (1.11)</td>
<td>1.99 (1.57)</td>
<td>t (135)=2.23</td>
<td>.027</td>
</tr>
</tbody>
</table>

number of respondents:
a: men = 36: women = 100: total = 136  
b: men = 36 women = 102: total = 138  
c: men = 36: women = 101: total = 137

Table 3 shows the data regarding how may respondents fulfilled DSM-IV criteria for PTSD during the last month and at any time in the past. 13 (9.3%) fulfilled PTSD criteria during the last month, with significant impairment of functioning (criteria F, DSM-IV, APA, 1994). Of these, 7 (53.85%) had experienced a previous traumatic event. 15.7% fulfilled DSM-IV criteria with the exception of Criterion F. Just over half of the sample (52.1%) had fulfilled PTSD criterion (including criterion F) at some point in the past. 65% had fulfilled PTSD criteria at some point, but had not experienced the symptoms with a significant level of impairment.
Table 3: Number of respondents who fulfilled DSM-IV criterion

<table>
<thead>
<tr>
<th>During last month</th>
<th>N.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSM-IV criteria (with impairment ≥ 2)</td>
<td>13</td>
<td>9.3</td>
</tr>
<tr>
<td>DSM-IV criteria (impairment &lt;2)</td>
<td>22</td>
<td>15.7</td>
</tr>
<tr>
<td>At any time in the past</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSM-IV criteria (impairment ≥2)</td>
<td>73</td>
<td>52.1</td>
</tr>
<tr>
<td>DSM-IV criteria (impairment &lt;2)</td>
<td>91</td>
<td>65.0</td>
</tr>
<tr>
<td>n=140</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4 shows a summary of the number of participants who indicated that they had experienced PTSD symptoms (on the PSS-SR) at some time in the past. The scores showed that, on average, participants had experienced 11.27 symptoms out of a possible 17. There were no significant differences between men and women and the number of symptoms they had ever experienced.

Table 4: Experience of PTSD symptoms at some point in the past

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
<th>total</th>
<th>statistic</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. indicated 'yes'</td>
<td>11.18 (2.87)</td>
<td>11.28 (2.69)</td>
<td>11.27 (2.70)</td>
<td>t (132) =-.191</td>
<td>.849</td>
</tr>
<tr>
<td>mean (s.d.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*: men = 34 : women = 100: total = 134
Table 5 shows the distribution, across gender, of scores for the PSS-SR. There were no significant differences between men and women.

Table 5: Impact of Trauma Work: PSS-SR

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
<th>Statistic</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSS (total severity)</td>
<td>5.91(4.57)</td>
<td>4.93 (4.93)</td>
<td>5.20 (4.15)</td>
<td>U=1716</td>
<td>.286</td>
</tr>
<tr>
<td>mean (s.d.) a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(median)</td>
<td>(5)</td>
<td>(4)</td>
<td>(4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSS (total distress)</td>
<td>5.10 (4.46)</td>
<td>5.10 (4.46)</td>
<td>5.13 (4.86)</td>
<td>U=1575.5</td>
<td>.894</td>
</tr>
<tr>
<td>mean (s.d.) b</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(median)</td>
<td>(2)</td>
<td>(1)</td>
<td>(1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>impairment (ever)</td>
<td>2.29 (1.75)</td>
<td>2.50 (1.99)</td>
<td>2.50 (1.87)</td>
<td>t (135) =-.848</td>
<td>.712</td>
</tr>
<tr>
<td>mean (s.d.) c</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(median)</td>
<td>(.71)</td>
<td>(.70)</td>
<td>(.70)</td>
<td>t (134) = .008</td>
<td>.994</td>
</tr>
</tbody>
</table>

Table 6 shows the distribution, across gender, of scores for compassion fatigue/satisfaction, the PTCI and the MBI. There were no significant differences between men and women on any measure of trauma impact. However, men scored significantly higher on personal accomplishment, indicating a slightly higher degree of self-rated personal accomplishment. Men also scored significantly higher on the depersonalisation scale of the MBI, indicating a higher degree of depersonalisation.
Table 6: Impact of Trauma Work: Compassion Fatigue, Beliefs and Burnout

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
<th>Statistic</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion Fatigue</td>
<td>24.66 (11.0)</td>
<td>23.65 (9.72)</td>
<td>24.0 (10.03)</td>
<td>U=1716</td>
<td>.733</td>
</tr>
<tr>
<td>mean (s.d.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(median)</td>
<td>24</td>
<td>23</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compassion Satisfaction</td>
<td>88.06 (14.42)</td>
<td>84.62 (13.51)</td>
<td>85.33 (13.83)</td>
<td>U=1590</td>
<td>.298</td>
</tr>
<tr>
<td>mean (s.d.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(median)</td>
<td>88</td>
<td>85</td>
<td>86.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTCI (beliefs about self)</td>
<td>1.63 (.53)</td>
<td>1.60 (.57)</td>
<td>1.61 (.55)</td>
<td>t (133) = .232</td>
<td>.81</td>
</tr>
<tr>
<td>mean (s.d.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTCI (beliefs about world)</td>
<td>2.52 (.93)</td>
<td>2.56 (.97)</td>
<td>2.5 (.96)</td>
<td>t (133) = -.147</td>
<td>.88</td>
</tr>
<tr>
<td>mean (s.d.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTCI (self-blame)</td>
<td>2.37 (.82)</td>
<td>2.24 (.91)</td>
<td>2.27 (.88)</td>
<td>t (128) = .737</td>
<td>.46</td>
</tr>
<tr>
<td>mean (s.d.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MBI (EE)</td>
<td>23.3 (9.4)</td>
<td>23.15 (10.12)</td>
<td>23.14 (9.83)</td>
<td>t (129) = .096</td>
<td>.93</td>
</tr>
<tr>
<td>mean (s.d.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MBI (DP)</td>
<td>7.8 (5.94)</td>
<td>5.52 (3.86)</td>
<td>6.13 (4.58)</td>
<td>U=1365.5</td>
<td>.05</td>
</tr>
<tr>
<td>mean (s.d.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MBI (PA)</td>
<td>39.06 (5.56)</td>
<td>36.066 (5.60)</td>
<td>36.83 (5.76)</td>
<td>t (123) = 2.66</td>
<td>.009</td>
</tr>
<tr>
<td>mean (s.d.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

number of respondents:
a: men = 35; women = 97; total = 132  b: men = 35; women = 103; total = 138  c: men = 35; women = 102; total = 137  d: men = 35; women = 103; total = 138  e: men = 35; women = 100; total = 135  f: men = 36; women = 95; total = 131  g: men = 36; women = 97; total = 133  h: men = 24; women = 91; total = 188.

Table 7 shows the total scores on the PSS-SR, compassion fatigue/satisfaction, PTCI and MBI, along with data from comparative studies. The mean PSS-R severity rating was lower than a comparison group of individuals who had experienced a traumatic event but had not been diagnosed with PTSD (Foa et al, 1997). Scores for each of the symptom clusters were also lower than the norms. The mean scores for the total distress rating were 5.13 (4.86). Unfortunately, no comparative data is available for this scale.
Mean scores for the current sample for compassion fatigue were 4.78 points lower than the comparison sample. This fell within the extremely low risk category for compassion fatigue although 17 (12.2%) respondents fell within the ‘high risk’ to ‘extremely high risk’ categories. Of these, 5 (83.3%) had experienced a previous traumatic event. Mean scores on the compassion satisfaction scale were also 6.8 points lower than the comparison sample. The mean fell within the ‘good potential’ range for compassion satisfaction although 9 (6.4%) fell within the ‘low potential’ range for compassion satisfaction. Of these, 5 (5.5%) had experienced a previous traumatic event.

With regards to the self-blame scale of the PTCI, the median score was over twice as high as the comparison sample who had not experienced any trauma (Foa et al, 1997). However, this difference needs to taken with caution as the scale consisted of only 3 items. None of the sample scored below the median in the comparative sample (Foa et al, 1997). Of these, 24 (20.5%) had not experienced at least one previous traumatic event. Median scores for the other two PTCI subscales (negative beliefs about the self and world) were also slightly higher than the those of a no trauma comparison group (Foa et al, in press). Of those who had scored above the norm for negative beliefs about the world, 11 (12.8%) had not experienced a prior traumatic event. For negative beliefs about the self, 21 (18.4% of 114) had not experienced a prior traumatic event.

Mean scores for the emotional exhaustion scale were slightly lower than Figely’s (1996) sample based on various helping professions. 30 (22.5%) respondents scored within the ‘high range’. Of these, 23 (76.6%) had experienced a previous traumatic event. With regard to the depersonalisation subcale of the MBI, the mean score was lower than the norm. 18 (13.3%) respondents scored within the ‘high’ range. Of these, 13 had experienced a previous traumatic event. Mean scores for the personal accomplishment scale were slightly higher than the norms. 31 (24.4%) scored within the ‘high range’ for burnout (i.e. had low ratings for personal accomplishment). Twenty-one (67.7%) of these had experienced a previous traumatic event.
### Table 7: Comparison of dependent variables with normative data.

<table>
<thead>
<tr>
<th></th>
<th>current</th>
<th>norms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pss-sr: severity (non-PTSD), mean (s.d.)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re-experiencing</td>
<td>5.20 (4.15)</td>
<td>12.54 (10.54)</td>
</tr>
<tr>
<td>Avoidance</td>
<td>1.11 (1.35)</td>
<td>3.64 (3.18)</td>
</tr>
<tr>
<td>Arousal</td>
<td>1.83 (2.03)</td>
<td>4.54 (4.83)</td>
</tr>
<tr>
<td></td>
<td>2.30 (2.10)</td>
<td>4.36 (3.97)</td>
</tr>
<tr>
<td><strong>Compassion fatigue mean (s.d.)</strong></td>
<td>24.0 (10.03)</td>
<td>28.78 (13.15)</td>
</tr>
<tr>
<td><strong>Compassion satisfaction</strong></td>
<td>85.33 (13.83)</td>
<td>92.10 (16.04)</td>
</tr>
<tr>
<td><strong>PTCI median (s.d.)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>negative beliefs</td>
<td>1.61 (.55)</td>
<td>1.08 (.76)</td>
</tr>
<tr>
<td>beliefs of self blame</td>
<td>2.27 (.88)</td>
<td>1.00 (1.4)</td>
</tr>
<tr>
<td>negative beliefs</td>
<td>2.50 (.96)</td>
<td>2.07 (1.43)</td>
</tr>
<tr>
<td>about the world</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MBI mean (s.d.)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>emotional exhaustion</td>
<td>23.14 (9.83)</td>
<td>24.08 (11.88)</td>
</tr>
<tr>
<td>depersonalisation</td>
<td>6.13 (4.53)</td>
<td>9.40 (6.90)</td>
</tr>
<tr>
<td>personal accomplishment</td>
<td>36.83 (5.76)</td>
<td>36.01 (6.93)</td>
</tr>
</tbody>
</table>

**Note:** Normative data based on: PSS-SR: based on participants who had experienced a trauma but had not been diagnosed with PTSD (Foa et al, 1997). PTCI: based on participants who had not experienced a trauma (Foa et al, in press). Compassion Fatigue/satisfaction: based on various helping professions (Figely, 1996). MBI: based on various helping professions (1981).

Table 8 shows the interrelationships between measures of impact of trauma work. The PSS-R was positively correlated with compassion fatigue (p≤0.05), which was not surprising as both measures aimed to measure PTSD symptomology. Both the PSS-SR and the compassion fatigue scale were also positively (p≤0.05) correlated with the PTCI, suggesting an association between trauma related beliefs and PTSD symptomology. The emotional exhaustion and depersonal scales of the MBI were also positively correlated with the PTSD measures, indicating that those who score highly on the PTSD measures are also more likely to score highly on the MBI. As expected, the personal accomplishment scale (MBI) and the compassion satisfaction scale were negatively correlated with most other measures.
| V10. MBI (post. accomp) | -0.9 | 0.4 | -2.21 | 1.6 |
| V9. MBI (depression) | | | | |
| V8. MBI (emotional exhaustion) | | | | |
| V7. PTCI (blame) | | | | |
| V6. PTCI (world) | | | | |
| V5. PTCI (self) | | | | |
| V4. PSS-SR (role intrusion) | 0.15 | 0.48 | -1.6 | 0.7 |
| V3. PSS-SR (role strain) | | | | |
| V2. Compassion satisfaction | | | | |
| V1. Compassion fatigue | | | | |

Table 8: Inter-relationships between Measures of Impact of Trauma Work
Table 9 and 10 shows the relationship between burnout and compassion fatigue/PTSD symptomology. Table 9 shows the relationship between those who were at risk of burnout and those who fulfilled DSM-IV criteria for PTSD. Of those who fulfilled PTSD criteria, 6 (50%) were also in the high risk group on the MBI for emotional exhaustion and 4 (31%) were in the high risk group for depersonalisation. Four (33%) of those who fulfilled PTSD criteria were at high risk for low personal accomplishment. There was a significant association between those who fulfilled PTSD criteria and those who were at high risk for emotional exhaustion, and with those at high risk for low levels of personal accomplishment.

Table 9: Relationship between those who were at risk for burnout and those who fulfilled DSM-IV criteria

<table>
<thead>
<tr>
<th></th>
<th>DSM (Yes)</th>
<th>DSM (No)</th>
<th>Total</th>
<th>Statistic</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Burnout N (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emotional exauna.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High risk</td>
<td>6 (50)</td>
<td>24 (20)</td>
<td>30 (23)</td>
<td>Chi² (1,1)=5.69</td>
<td>.017</td>
</tr>
<tr>
<td>Not high risk</td>
<td>6 (50)</td>
<td>97 (80)</td>
<td>103 (77)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Deperson N (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High risk</td>
<td>4 (31)</td>
<td>14 (12)</td>
<td>18 (13.3)</td>
<td>Chi² (1,1)=3.79</td>
<td>.052</td>
</tr>
<tr>
<td>Not high risk</td>
<td>9 (69)</td>
<td>108 (86)</td>
<td>117 (87)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pers. accomp. N (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High risk</td>
<td>4 (33)</td>
<td>28 (24)</td>
<td>32 (25)</td>
<td>Chi² (1,1)=.47</td>
<td>.027</td>
</tr>
<tr>
<td>Not high risk</td>
<td>8 (67)</td>
<td>87 (76)</td>
<td>95 (75)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>115</td>
<td>127</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a = Individuals who fulfilled DSM-IV criteria with an impairment score of ≥2.
b = Individuals who did not fulfill DSM-IV.
c = n=133 d = n=127

Table 10 shows the relationship between those who were identified as high risk for compassion fatigue (scored ≥36) and those identified as high risk for burnout. 6 (40%) of those identified at high risk for compassion fatigue were also at risk for emotional exhaustion and 5 (31%) for depersonalisation. 5 (31%) were identified as being at risk for both compassion fatigue and personal accomplishment. There was a significant association between those who were at high risk for compassion fatigue and
depersonalisation. These scores indicate that there were some individuals who scored highly on the measures of PTSD symptomology and compassion fatigue, but did not score highly on the subscales of ‘burnout’.

Table 10: Relationship between those who were at risk for burnout and those identified as at high risk for Compassion fatigue

<table>
<thead>
<tr>
<th></th>
<th>CF:Yes a</th>
<th>CF:No b</th>
<th>Total</th>
<th>statistic</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional exhau. N(%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High risk</td>
<td>6 (40)</td>
<td>24 (21)</td>
<td>30 (23)</td>
<td>Chi²(1,1)= 2.805</td>
<td>.094</td>
</tr>
<tr>
<td>Not high risk</td>
<td>9 (60)</td>
<td>92 (79)</td>
<td>101(77)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deperson. N (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High risk</td>
<td>5 (31)</td>
<td>13 (11)</td>
<td>18 (14)</td>
<td>Chi²(1,1)= 4.878</td>
<td>.043</td>
</tr>
<tr>
<td>Not high risk</td>
<td>11 (69)</td>
<td>104 (89)</td>
<td>115(87)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pers. accomp. N (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High risk</td>
<td>5 (31)</td>
<td>27 (25)</td>
<td>16 (100)</td>
<td>Chi²(1,1)= .331</td>
<td>.565</td>
</tr>
<tr>
<td>Not high risk</td>
<td>11 (69)</td>
<td>83 (76)</td>
<td>100</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a = individuals who were considered at high risk for compassion fatigue (scored ≥36)
b= individuals who were not considered at high risk for compassion fatigue (scored < 36)
c: n= 131
d: n=133
e: n= 126

Table 11 shows the relationships between impact of trauma work and background characteristics. There were no significant relationships between age, years worked since qualifying, number of trauma clients, years worked in current specialty, percentage of trauma victims in the clinician’s case load and any of the dependent measures. PTE (previous traumatic experiences) was positively correlated with compassion fatigue and, the beliefs about the world scale of the PTCI. Unexpectedly, the personal accomplishment scale of the MBI was correlated with previous traumatic experiences and the number of trauma clients in the clinicians caseload. These results need to be taken with caution as the large number of correlations calculated means that significant relationships may have been found by chance.
Table 11: Correlations between background characteristics and PTSD and 'burnout' measures

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Years worked since qualifying</th>
<th>No. of trauma clients</th>
<th>Years worked in current specialty</th>
<th>% of trauma victims</th>
<th>PTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>compassion fatigue</td>
<td>-0.72</td>
<td>.034</td>
<td>-0.018</td>
<td>0.060</td>
<td>0.078</td>
<td>0.287*</td>
</tr>
<tr>
<td>Compassion satisfaction</td>
<td>.062</td>
<td>.052</td>
<td>0.169*</td>
<td>0.056</td>
<td>0.038</td>
<td>0.038</td>
</tr>
<tr>
<td>PSS Freq.</td>
<td>-.105</td>
<td>.039</td>
<td>0.075</td>
<td>0.049</td>
<td>0.071</td>
<td>0.060</td>
</tr>
<tr>
<td>Pss Intensity</td>
<td>-.118</td>
<td>.003</td>
<td>0.086</td>
<td>0.088</td>
<td>0.082</td>
<td>0.019</td>
</tr>
<tr>
<td>PTCI self</td>
<td>-.041</td>
<td>-.064</td>
<td>-0.003</td>
<td>0.067</td>
<td>-0.011</td>
<td>0.008</td>
</tr>
<tr>
<td>PTCI world</td>
<td>0.058</td>
<td>-.020</td>
<td>0.080</td>
<td>0.011</td>
<td>0.014</td>
<td>0.293**</td>
</tr>
<tr>
<td>PTCI self-blame</td>
<td>0.007</td>
<td>0.099</td>
<td>0.073</td>
<td>0.063</td>
<td>-0.013</td>
<td>-0.049</td>
</tr>
<tr>
<td>MBI (EE)</td>
<td>-.153</td>
<td>-.098</td>
<td>-0.034</td>
<td>0.022</td>
<td>-0.062</td>
<td>-0.076</td>
</tr>
<tr>
<td>MBI (DP)</td>
<td>-.128</td>
<td>-.099</td>
<td>-0.023</td>
<td>0.037</td>
<td>-0.055</td>
<td>0.063</td>
</tr>
<tr>
<td>MBI (PA)</td>
<td>0.047</td>
<td>0.073</td>
<td>0.181*</td>
<td>0.061</td>
<td>-0.027</td>
<td>0.207*</td>
</tr>
</tbody>
</table>

* Correlation is significant at the .05 level (2-tailed)  ** Correlation is significant at the .01 level (2-tailed)

Some studies (Pearlman & Mac Ian (1995) and Arvay & Uhlemann, 1996) have found that there was a significant relationship between the number of years of experience and PTSD symptomology. However, those with less experience have been found to have lower levels of supervision (Pearlman & Mac Ian, 1995). Table 12 shows the relationship
between supervision and years worked since qualifying and years worked in current specialty. There was a significant relationship between the number of years worked since qualifying and supervision. Those with the least experience were more likely to be receiving supervision.

**Table 12: Relationship between supervision and years of experience.**

<table>
<thead>
<tr>
<th>Supervision</th>
<th>Yes</th>
<th>No</th>
<th>total</th>
<th>statistic</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years worked since qualified</td>
<td>8.23 (6.86)</td>
<td>12.74 (8.81)</td>
<td>8.85 (7.29)</td>
<td>t (136)=-2.55</td>
<td>.012</td>
</tr>
<tr>
<td>Years worked in current specialty</td>
<td>5.90 (4.50)</td>
<td>6.71 (4.23)</td>
<td>6.02 (5.32)</td>
<td>U=886.50</td>
<td>.157</td>
</tr>
<tr>
<td>(median)</td>
<td>4.50</td>
<td>6.00</td>
<td>5.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 13** shows the relationship between previous traumatic experiences and scores on the PSS-SR, compassion fatigue and PTCI. The participants were divided into three groups according to the type of traumatic experienced they had had. Group 1 represents those who had never experienced any traumatic events. Group 2 represents those who had experienced at least 1 or more traumatic events other than childhood abuse. Group 3 represents those who had experienced childhood abuse with or without other traumas as a child or adult. A significant relationship was found between trauma group and beliefs about the world.

A Tukey-HSD test was conducted on the scores for beliefs about the world. This revealed that scores for negative beliefs about the world were significantly higher (p ≤.026) for trauma group 3 than for trauma group 1. In other words, those who had experienced childhood abuse, had a significantly higher level of disrupted beliefs about the world than those who had no previous trauma history. Those who had experienced at least one traumatic experience (other than childhood abuse) did not show significantly
higher disruption in their beliefs about the world than those who had not experienced any prior traumatic events. Unexpectedly, there was a trend towards those with no trauma history having higher severity scores on the PSS-SR than those who had experienced previous traumatic events. This suggests that it is not just individuals with a trauma history who experience higher levels of PTSD symptomology.

Table 13: Relationship between Previous Traumatic Experiences and Vicarious Trauma

<table>
<thead>
<tr>
<th>Trauma Group</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>total</th>
<th>statistic</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSS-SR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(severity)</td>
<td>mean (s.d.)</td>
<td>median</td>
<td>mean (s.d.)</td>
<td>median</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.23 (4.55)</td>
<td>(4.75)</td>
<td>4.34 (4.18)</td>
<td>(3.00)</td>
<td>Chi $^2$ (2) = 5.89</td>
<td>.053</td>
</tr>
<tr>
<td>Compassion fatigue</td>
<td>mean (s.d.)</td>
<td>median</td>
<td>mean (s.d.)</td>
<td>median</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(median)</td>
<td>22.63 (11.80)</td>
<td>(21.00)</td>
<td>22.88 (9.66)</td>
<td>(22.00)</td>
<td>Chi $^2$ (2) = 3.54</td>
<td>.104</td>
</tr>
<tr>
<td>PTCI (beliefs about the self)</td>
<td>mean (s.d.)</td>
<td></td>
<td>mean (s.d.)</td>
<td></td>
<td>F(2, 131) = 2.19</td>
<td>.116</td>
</tr>
<tr>
<td>(self blame)</td>
<td>1.82 (.78)</td>
<td>(1.53)</td>
<td>1.53 (.51)</td>
<td>(1.61)</td>
<td>F(2, 131) = 1.17</td>
<td>.314</td>
</tr>
<tr>
<td>PTCI (beliefs about the world)</td>
<td>mean (s.d.)</td>
<td></td>
<td>mean (s.d.)</td>
<td></td>
<td>F(2, 131) = 4.05</td>
<td>.020</td>
</tr>
<tr>
<td>(median)</td>
<td>2.24 (.94)</td>
<td>(2.45)</td>
<td>2.45 (.89)</td>
<td>(2.82)</td>
<td>F(2, 131) = 1.17</td>
<td>.314</td>
</tr>
<tr>
<td></td>
<td>2.52 (.10)</td>
<td>(2.19)</td>
<td>2.25 (.81)</td>
<td>(2.28)</td>
<td>F(2, 126) = 1.17</td>
<td>.314</td>
</tr>
<tr>
<td></td>
<td>2.24 (.94)</td>
<td>(2.45)</td>
<td>2.45 (.89)</td>
<td>(2.82)</td>
<td>F(2, 131) = 4.05</td>
<td>.020</td>
</tr>
<tr>
<td></td>
<td>2.24 (.10)</td>
<td>(2.19)</td>
<td>2.25 (.81)</td>
<td>(2.28)</td>
<td>F(2, 126) = 1.17</td>
<td>.314</td>
</tr>
</tbody>
</table>
| Definition of Groups

Group 1 = no trauma Group 2 = ≥ 1 traumatic event (except childhood abuse). Group 3 = ≥ 1 childhood abuse with/without other trauma

Number of respondents: a: men = 24; women = 45; total = 69 b: men = 27; women = 48; total = 75 c: men = 25; women = 45; total = 70 d: men = 25; women = 45; total = 73.
Part 2: Analysis of data regarding therapist's experience of vicarious trauma.

Qualitative data

Cohen's Kappa (cited in Schweigert, 1994) was used to calculate inter-rater reliability of the categories of themes to the open questions on the intrusions questionnaire. A clinical psychologist selected 30 responses at random (every third response) and allocated participant responses to categories which had been established by the researcher. Cohen's Kappa \( k \) was calculated for each category (see appendix R4:9). All categories, with the exception of 7 (out of 46), had a \( k \) value of \( \geq .7 \), argued by Bakeman Gottman (1989, cited in Schweigert, 1994) to be an acceptable level of agreement. Those with a \( k \) value less than .7 included 'other' categories with regards to what intrusions meant to therapists (.43) and with regards to how the work had impacted on their perception of the likelihood of traumatic events happening to them (.58). In addition, the \( k \) value for the following categories were below an acceptable level: that 'intrusions are helpful' (.60), that 'intrusions are a warning' (.43), feeling 'under-trained' for trauma work (.6), being 'more aware' of the impact on therapist's perception of traumatic events (.58) and the 'negative impact of work' (.51).

Table 14 shows the relationship between negative items for intrusions and PSS-SR severity. The negative items were: 'Having intrusions means that I'm losing control', 'If I have intrusions, it means I am failing as a therapist' and 'intrusions are a normal reaction to hearing distressing material' (scoring was reversed for this item). The correlation was significant, showing that those who scored highly on the negative items for intrusions on the PSS-SR were more likely to score highly on the PSS-SR. This is evidence to suggest that the interpretation of intrusive symptoms may be important in the development and maintenance of PTSD. This supports findings in other studies (Ehlers & Steil, 1995; Dunmore & Steil, 1999).

Table 14: Relationship between negative intrusion rating and PSS-R severity.

<table>
<thead>
<tr>
<th>Negative intrusion rating</th>
<th>PSS-severity</th>
<th>r</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>.201</td>
<td>.032</td>
</tr>
</tbody>
</table>

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Table 15 shows a summary of the data, regarding clinician's intrusions, their emotional reactions to these and the meaning and interpretation ascribed to them. Regarding the experience of intrusions, only four participants (3 %) indicated that they had not experienced any type of intrusion. The most common intrusions were thoughts about the client (73.4%), followed by intrusive images of the client (46.04%) and thoughts about a traumatic event that clients had described (41.3%). The lowest number (13.7 %) indicated that that they had dreams about a traumatic event that a client had described, with (33.8%) having experienced dreams about the client.

Table 15 also shows a summary of the emotional reactions people indicated in response to the intrusions. The most commonly indicated emotions were anger (27.1%), fear (27.1%) and surprise (20.1%). The most common emotions suggested by respondents, in addition to those listed, were shock (9.3 %) sadness (8.5 %) and horror (6.2 %). The mean distress rating for a memorable intrusion the therapists were asked to consider was 42.5% (28.42), with ratings ranging between 0 to 100%.

A number of themes emerged regarding the meaning of intrusions for the therapists. The responses were coded according the categories listed in table 17. The most common response (40 respondents, 36 %) was that experiencing an intrusion or dream was an indication that the material they had heard needed to be actively processed. Thirty-four (30.6%) respondents indicated that they interpreted an intrusion/dream as a 'normal reaction'. Intrusions were interpreted as a warning by 15.3 % (17 respondents) and as a transference issue by 12.6 % (14).

In response to a number of statements regarding the interpretation of intrusions, the highest mean rating of agreement (5.36) was in response to the statement that intrusions are a normal reaction to hearing distressing material. The second mean highest rating (4.35) indicated slight agreement with the statement that intrusions meant that the material had not been processed fully. There was disagreement with the statement that
intrusions meant that they were failing as therapists (1.56) and that they were losing control (1.56). Other mean scores were close to a neutral rating.

**Table 15: Therapist Experience of Intrusions**

<table>
<thead>
<tr>
<th>Types of intrusions ever experienced</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrusive thought about client</td>
<td>102</td>
<td>73.4</td>
</tr>
<tr>
<td>Intrusive thought about a traumatic event that a client described</td>
<td>98</td>
<td>70.5</td>
</tr>
<tr>
<td>Intrusive images of the client</td>
<td>64</td>
<td>46.04</td>
</tr>
<tr>
<td>Intrusive image of a traumatic event that a client has described</td>
<td>78</td>
<td>41.30</td>
</tr>
<tr>
<td>Dreams about the client</td>
<td>47</td>
<td>33.8</td>
</tr>
<tr>
<td>Dreams about the traumatic event that a client has described to you</td>
<td>19</td>
<td>13.7</td>
</tr>
</tbody>
</table>

a: n = 139  b: n = 138

**Distress Caused by Intrusions**

<table>
<thead>
<tr>
<th>Emotional responses to intrusions</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guilt</td>
<td>9 (6.98)</td>
</tr>
<tr>
<td>Shame</td>
<td>7 (5.4)</td>
</tr>
<tr>
<td>Anger</td>
<td>35 (27.1)</td>
</tr>
<tr>
<td>Confusion</td>
<td>18 (13.95)</td>
</tr>
<tr>
<td>Fear</td>
<td>35 (27.13)</td>
</tr>
<tr>
<td>Surprise</td>
<td>26 (20.15)</td>
</tr>
</tbody>
</table>

**Meaning of Intrusions**

<table>
<thead>
<tr>
<th>Meaning of Intrusions</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>normal reaction</td>
<td>34</td>
<td>30.6</td>
</tr>
<tr>
<td>transference issue</td>
<td>14</td>
<td>12.6</td>
</tr>
<tr>
<td>intrusions are connected with empathy towards the client</td>
<td>12</td>
<td>10.8</td>
</tr>
<tr>
<td>indication that the material needs to be actively processed</td>
<td>40</td>
<td>36.0</td>
</tr>
<tr>
<td>intrusions are helpful to the therapist/therapy</td>
<td>7</td>
<td>6.3</td>
</tr>
<tr>
<td>intrusions are taken as a warning</td>
<td>17</td>
<td>15.31</td>
</tr>
<tr>
<td>other</td>
<td>7</td>
<td>6.3</td>
</tr>
</tbody>
</table>

n = 111

**Interpretations of Intrusions**

<table>
<thead>
<tr>
<th>Interpretations of Intrusions</th>
<th>Mean (s.d)</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>normal reaction</td>
<td>5.36 (1.32)</td>
<td>6</td>
</tr>
<tr>
<td>causes me concern</td>
<td>3.6 (1.54)</td>
<td>4</td>
</tr>
<tr>
<td>feel neutral</td>
<td>3.6 (1.7)</td>
<td>3</td>
</tr>
<tr>
<td>losing control</td>
<td>1.74 (1.08)</td>
<td>1</td>
</tr>
<tr>
<td>happen so quickly I hardly notice them</td>
<td>2.97 (1.53)</td>
<td>3</td>
</tr>
<tr>
<td>makes me think I haven’t process the info. properly</td>
<td>4.35 (1.77)</td>
<td>5</td>
</tr>
<tr>
<td>means I’m failing as a therapist</td>
<td>1.56 (0.91)</td>
<td>1</td>
</tr>
</tbody>
</table>

a: n = 121  b: n = 120  c: n = 119
Table 16 shows a summary of the data regarding participants' strategies for coping with the intrusions.

In response to an open question regarding coping strategies for intrusions, a number of coping strategies were described. Out of the 90 (63.8% of the whole sample) who responded to this item, 35 (38.8%) indicated that they took steps to actively process the material. 37 (41.1%) indicated that they would talk with a colleague. 33 (36.6%) reported that they would use supervision. A range of other strategies were reported by a small number of participants.

Overall, there was a low mean rate of endorsement to strategies that were suggested. There was evidence for slight endorsement to with the statement ‘I just let them come and go’ (4.9) and ‘I talk to someone about it’ (4.38). Overall, the sample indicated a low frequency of avoiding situations which might trigger intrusions, though 41 (21%) indicated that they used this strategy at least ‘quite often’. Interestingly, there was also a bi-modal distribution of scores for that statement ‘I distract myself’. 69 out 114 (59.5%) indicated that they would rarely, or never, distract themselves, although 32 (27.59%) indicated that they would.
Table 16: Strategies for Dealing with Intrusions

<table>
<thead>
<tr>
<th>Strategies for dealing with intrusions</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>actively process the information</td>
<td>35</td>
<td>38.8</td>
</tr>
<tr>
<td>write notes/process by writing thoughts/details</td>
<td>4</td>
<td>4.4</td>
</tr>
<tr>
<td>conceptualise in terms of transference issues</td>
<td>3</td>
<td>3.3</td>
</tr>
<tr>
<td>don’t do anything</td>
<td>4</td>
<td>4.4</td>
</tr>
<tr>
<td>talk about the event/reaction with friend/colleague</td>
<td>37</td>
<td>41.1</td>
</tr>
<tr>
<td>utilise supervision</td>
<td>33</td>
<td>36.6</td>
</tr>
<tr>
<td>think of it as a ‘normal’ reaction to hearing distressing material</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>utilise personal therapy</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>use a cognitive strategy</td>
<td>5</td>
<td>5.5</td>
</tr>
<tr>
<td>use distraction</td>
<td>15</td>
<td>16.6</td>
</tr>
<tr>
<td>other</td>
<td>16</td>
<td>17.7</td>
</tr>
</tbody>
</table>

N=90

Use of suggested strategies

<table>
<thead>
<tr>
<th>Use of suggested strategies</th>
<th>Mean (s.d)</th>
<th>median</th>
</tr>
</thead>
<tbody>
<tr>
<td>I just let them come and go *</td>
<td>4.9 (1.48)</td>
<td>5</td>
</tr>
<tr>
<td>I distract myself b</td>
<td>3.35 (1.54)</td>
<td>3</td>
</tr>
<tr>
<td>I talk to someone about it a</td>
<td>4.38 (1.74)</td>
<td>5</td>
</tr>
<tr>
<td>I ‘push’ the image thought out of my mind b</td>
<td>2.90 (1.42)</td>
<td>3</td>
</tr>
<tr>
<td>I ruminate about it b</td>
<td>2.71 (1.40)</td>
<td>2</td>
</tr>
<tr>
<td>I avoid situations which might trigger intrusions b</td>
<td>1.71 (1.15)</td>
<td>1</td>
</tr>
</tbody>
</table>

a:n = 115  b:n=116
Table 17 gives a summary of the data regarding avoidance.

Of the 136 (96.5 %) who indicated that they had tried to avoid working with any type of trauma work, 55 (40.4%) specified what type of work they had avoided. Sexual abuse work was the commonest type of trauma work avoided. In total, 28 (50.9%) indicated that they avoided work related to sexual abuse (including work with the perpetrator). 6 men (17% of the 35 men in the whole sample) said that they avoided working with females who had been sexually abused.

Two main reasons for avoidance of such work were given. 23 (82.1%) gave reasons connected to their emotional reaction to this work. 12 (42.9%) indicated that they felt under-trained.

22 (16.2% of 136) indicated that they had avoided asking a client the detail of a traumatic event. No main themes emerged from this.

23.4 % (45 out of 138) of respondents indicated that they had avoided telling colleagues details of the events that had been described to them. Of these, 14 (35.9%) had avoided this for fear of passing on intrusive thoughts/trauma to others.
Table 17: Summary of data regarding avoidance

<table>
<thead>
<tr>
<th>Avoidance of types of trauma work</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males indicating that they would avoid working with females who had been sexually abused</td>
<td>6</td>
<td>10.9</td>
</tr>
<tr>
<td>General sex abuse work</td>
<td>19</td>
<td>34.</td>
</tr>
<tr>
<td>Work with a perpetrator (sex abuse)</td>
<td>3</td>
<td>5.5</td>
</tr>
<tr>
<td>Referrals connected to therapists own previous traumatic experience</td>
<td>7</td>
<td>12.7</td>
</tr>
<tr>
<td>work with torture victims</td>
<td>7</td>
<td>12.7</td>
</tr>
<tr>
<td>other reasons not covered above</td>
<td>14</td>
<td>25.5</td>
</tr>
<tr>
<td>n = 55</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reasons for Avoiding such work</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling undertrained</td>
<td>12</td>
<td>42.9</td>
</tr>
<tr>
<td>reasons connected to emotional reaction to such work</td>
<td>23</td>
<td>82.1</td>
</tr>
<tr>
<td>n = 28</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respondents who indicated that they avoiding asking a client to describe details of a traumatic event</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>anticipating that will find it upsetting</td>
<td>6</td>
<td>27.2</td>
</tr>
<tr>
<td>fear of hearing the material</td>
<td>4</td>
<td>18.1</td>
</tr>
<tr>
<td>due to having experienced a similar event</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>for therapeutic reasons</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>fear of re-traumatising the client</td>
<td>2</td>
<td>9.0</td>
</tr>
<tr>
<td>other</td>
<td>8</td>
<td>36.4</td>
</tr>
<tr>
<td>n = 22</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respondents who indicated that they avoided telling colleagues the details of events</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons of confidentiality</td>
<td>9</td>
<td>23.1</td>
</tr>
<tr>
<td>Fear of passing on intrusive thoughts/trauma to others</td>
<td>14</td>
<td>35.1</td>
</tr>
<tr>
<td>Other</td>
<td>25</td>
<td>64.10</td>
</tr>
<tr>
<td>n = 39</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 18 shows the relationship between the negative items for avoidance (question 7, item b, d and f on the intrusions questionnaire) and PSS severity rating. No significant correlation emerged.

<table>
<thead>
<tr>
<th>Negative Avoidance rating</th>
<th>PSS-SR</th>
<th>r</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>.007</td>
<td>.941</td>
</tr>
</tbody>
</table>

Table 19 presents data regarding the impact of trauma work on therapist's beliefs. 65% (47.1%) indicated that trauma work had impacted on their beliefs. 49 (69.2%) indicated that their perception of risk had increased. 10 (15.4%) specifically indicated they were more aware of the risks to their own children.

40 (61.5%) of those who indicated that the work had had an impact on beliefs described strategies for coping. The most commonly reported coping strategies were cognitive (55.5%) and behavioural (53%) strategies.
Table 19: Impact of trauma work on Beliefs and General Impact of Trauma work

<table>
<thead>
<tr>
<th>Impact on perception of traumatic events happening to them</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>perception of risk is higher</td>
<td>45</td>
<td>69.2</td>
</tr>
<tr>
<td>vigilance has increased</td>
<td>8</td>
<td>12.3</td>
</tr>
<tr>
<td>more aware of risks to own children</td>
<td>10</td>
<td>36.2</td>
</tr>
<tr>
<td>other</td>
<td>14</td>
<td>21.5</td>
</tr>
</tbody>
</table>

n = 65

<table>
<thead>
<tr>
<th>Strategies used to cope with the impact of trauma work</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>utilise behavioural strategies</td>
<td>22</td>
<td>55.0</td>
</tr>
<tr>
<td>utilise cognitive strategies</td>
<td>21</td>
<td>52.5</td>
</tr>
<tr>
<td>utilise supervision</td>
<td>3</td>
<td>7.5</td>
</tr>
<tr>
<td>utilise personal therapy</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>other</td>
<td>10</td>
<td>.25</td>
</tr>
</tbody>
</table>

n = 40
Table 20 shows data regarding the clinician’s self-management regarding the level of trauma work in their case load. Of the 49 (out of 131) (37.4%) who had either increased or decreased their level of trauma work in their case load, 42 (85.7%) had decreased it. The main reason for this, indicated by 18 (37.5%) respondents, was connected with their emotional reaction to trauma work.

**Table 20: Management of Work Load**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of those who increased or decreased the level of trauma work in your case load.</td>
<td>49</td>
<td>37.4</td>
</tr>
<tr>
<td><strong>Decrease</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>42</td>
<td>32.0</td>
</tr>
<tr>
<td><strong>Increase</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>4.5</td>
</tr>
<tr>
<td>n = 131</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reason for increasing/decreasing work**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>increased level of trauma work due to skill/developing skills in this area</td>
<td>3</td>
<td>6.3</td>
</tr>
<tr>
<td>increased level due to other reason</td>
<td>5</td>
<td>10.4</td>
</tr>
<tr>
<td>decreased level of trauma work due to lack of skills in the field</td>
<td>4</td>
<td>8.3</td>
</tr>
<tr>
<td>decreased level of trauma work due to an emotional reaction to to this work</td>
<td>18</td>
<td>37.5</td>
</tr>
<tr>
<td>decrease in level of trauma work due to other reason</td>
<td>5</td>
<td>9.6</td>
</tr>
<tr>
<td>n = 48</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 21 shows a summary of the responses regarding the general impact this work. Both positive and negative aspects were identified to similar levels.

**Table 21: General impact of trauma work**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>feeling drained</td>
<td>10</td>
<td>10.98</td>
</tr>
<tr>
<td>positive aspect of trauma work identified</td>
<td>24</td>
<td>26.4</td>
</tr>
<tr>
<td>negative aspect of trauma work identified</td>
<td>22</td>
<td>24.2</td>
</tr>
<tr>
<td>neutral reaction to trauma work</td>
<td>14</td>
<td>15.4</td>
</tr>
<tr>
<td>n = 273</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Discussion

Impact of trauma work

The main aim of this study was to identify and describe the impact on therapists of working with people who have experienced traumatic events. This is the first study of its kind in the U.K. One of the main findings was that 9.3% of the sample fulfilled the symptom criteria for PTSD (DSM-IV, APA, 1994) for symptoms they had experienced during the last month. 53.9% of these had experienced at least one previous traumatic event. This left approximately half of those who fulfilled DSM criteria who had not experienced any other traumatic event other than hearing distressing accounts from victims of trauma. Interestingly, a higher proportion (78.7%) of the whole sample had experienced a previous traumatic event. It is acknowledged that this study did not attempt a comprehensive assessment of social and occupational impairment (criterion F, APA, 1994). However, this is evidence to suggest that the small number of participants who fulfilled DSM-IV criteria (APA, 1994) were experiencing PTSD symptomology as a result of their clinical trauma work.

Furthermore, 22% of the sample fulfilled DSM-IV (APA, 1994) criteria for PTSD for symptoms they had experienced during the last month, with the exception of criterion F (significant impairment). A larger proportion of the sample (52.1%) indicated that, at some point in the past, they had experienced the full range of PTSD symptoms. When at their worst, these symptoms were sufficiently disabling to meet DSM-IV criteria. The majority (65%) of the sample indicated that although they had experienced the full range of PTSD symptoms at some point in the past, they had not found them to be significantly disabling.

As predicted, none of the participants scored as highly for PTSD severity or for the severity of symptom clusters compared to individuals who had experienced a traumatic event but had not been diagnosed with PTSD in the comparison group (Foa et al, 1997). This is not surprising, as the comparison sample included participants from treatment
centers and emergency service centers who see as well as hear about traumatic events. Unfortunately, there is no comparison data available based on individuals who have not experienced a traumatic event, or based on therapists, which would be a useful comparison.

These results suggest that according to PTSD symptomology, most of the participants were not currently experiencing significant difficulties. However, the evidence raises concern for a minority (9.3%) who fulfilled DSM-IV criteria (APA, 1994). Furthermore, just over half the sample reported suffering distress from the full range of symptoms at some point during the past. This suggests that although most individuals cope well most of the time, there may be occasions when they experience higher levels of distress.

These results represent a significant finding. The evidence for vicarious trauma found in this study is backed up in the literature. Pearlman & Mac Ian (1995) found that it was a minority of clients who were experiencing intrusion and avoidance symptomology. Unfortunately, they do not report details of the levels of symptomology experienced by the sample, making it difficult to make a more specific comparison. Schauben & Frazier (1995) assessed symptomology according to DSM-III-R (APA, 1987) criterion, with a symptom checklist they devised themselves. Unfortunately, the authors do not report on the prevalence of each DSM symptom cluster experienced by the sample. However, they also concluded that it was a minority of clinicians who were experiencing problems. Arvay & Uhlemann (1996) found a higher level of participants (14%) were experiencing traumatic stress at levels comparable to clients with PTSD according to intrusion and avoidance symptomology measured by the Impact of Event Scale (IES, Horowitz, 1979). It is difficult to compare these results exactly, as the IES only measures two of the PTSD symptom clusters. Furthermore, this study represents therapists working solely with victims of trauma, compared to the current study which represents psychologists working generically with adults. It’s hypothesised that working solely with victims of trauma may have a cumulative effect and produce higher levels of symptomology. However, it is interesting that Arvay & Uhlemann (1996) also found that a minority of trauma clinicians
were experiencing high levels of PTSD symptomology. Overall it seems that this study is the first to report on the prevalence of the full range of PTSD symptoms, including arousal. It is also the first study which reports on exactly what proportion of therapists fulfill DSM-IV criteria.

The participants’ scores on the compassion fatigue scale were slightly lower than those found by Figley (1995). This, again, is not surprising as Figley’s (1995) norms included a range of helping professionals including ‘Redcross’ personnel (i.e. those seeing as well as hearing about traumatic events). It is worth highlighting the debate as to whether the experiences of emergency workers would be better conceptualised within a ‘primary’ rather than ‘secondary’ trauma framework.

However, within Figley’s categorisation system of risk, the sample’s mean score fell within the ‘low risk’ category for compassion fatigue and within the ‘good potential’ range for compassion satisfaction. However, 12.2% fell within the high to extremely high risk category for compassion fatigue, with 6.4% percent falling within the low potential range for compassion satisfaction. Of those who were classed as high risk for compassion fatigue, 82.3% had experienced at least one previous traumatic. This was slightly higher than the overall rate for the group which was 78.7%. This is further, albeit tentative, evidence to suggest that some individuals who have no prior experience of trauma experienced high levels of compassion fatigue. It is postulated that this may be as a result of their work with victims of trauma. In line with the samples scores for the PSS-SR, this highlights how most of the sample were coping well. However, for a significant few there was cause for concern.

As expected, the participants had higher scores on the PTCI for all three subscales (negative beliefs about the self, negative beliefs about the world and beliefs of self-blame) than those participants in the comparative sample who had not experienced a trauma (Foa et al, in press). In particular, beliefs of self-blame (2.27) were twice as high, but this finding needs to be taken with caution as there were only three items for this
scale. However, of those who scored higher than the norm for beliefs of self-blame, 20.5% had not experienced a prior traumatic event. This suggests that there may be some participants who have experienced changes in their beliefs of self-blame as a result of their trauma work. Of those who scored above the norm for negative beliefs about the self, 18.4% had not experienced a prior traumatic event. 12.8% of those who had scored above the norm for negative beliefs about the world had not experienced a prior traumatic event. These results suggest that there may have been some changes in clinicians trauma-related beliefs. As there were some individuals who scored above the no-trauma comparison group (Foa et al., in press) who had not experienced a prior traumatic event, it is tentatively postulated that these changes may have occurred for these individuals as a result of their clinical work with trauma victims.

Furthermore, negative beliefs about the world were correlated with the number of previous traumatic experiences. Interestingly, the impact of childhood abuse was revealed to be significant. Those who had experienced childhood abuse showed significantly higher disruption in their beliefs about the world than those who had no previous trauma history. This is evidence to suggest that the experience of childhood trauma has some significant role, or may be a significant risk factor, in the development of such beliefs. This will be discussed in more detail later.

The sample's scores on the burnout inventory (MBI, Maslach & Jackson, 1981) were comparable with those found in other studies based on a range of helping professions (Maslach & Jackson, 1981). Scores were slightly lower for emotional exhaustion (23.1) and depersonalisation (6.13) than the norms (24.08 and 9.40 respectively). Again, this would be expected, as previous studies have included professions which actually see the horror of the aftermath of accidents (e.g., nurses, police officers, and probation officers). According to Maslach & Jackson's (1981) categorisation system, the mean scores of the current sample for emotional exhaustion and depersonalisation were in the moderate range, whereas the scores for personal accomplishment were in the high burnout range (i.e., there was a low level of personal accomplishment in the sample). Moreover, 22%
scored within the high range for emotional exhaustion; 13% for depersonalisation and 24% for personal accomplishment (i.e. low personal accomplishment). Again, this suggests that for a minority, there is a risk of burnout, particularly emotional exhaustion.

These rates were lower than those reported by Ackerley et al (1988) who found that a third of a sample of psychologists working in non-specific human service settings were experiencing high levels of emotional exhaustion and depersonalisation assessed by the MBI (Maslach & Jackson, 1981). This is evidence to suggest that the participants in this sample were not experiencing high levels of burnout compared to a comparison sample of generic psychologists.

**Risk factors**

A further aim of the study was to identify any background factors which may be significant risk factors for developing secondary trauma symptomology. As highlighted earlier, there was evidence to suggest that prior traumatic experiences may be a significant risk factor. There was a positive correlation between previous traumatic experiences and scores on the compassion fatigue scale (Figley, 1995), suggesting an association between a high number of prior traumatic experiences and higher levels of compassion fatigue. However, there was no correlation between the PSS-SR (Foa et al, 1993) severity score and prior traumatic events. This may have been due to the limited variability on the PSS-SR (Foa et al, 1993) scores.

There was evidence to suggest that the experience of childhood abuse specifically may be a significant risk factor in the development of negative beliefs about the world, though it is impossible to establish this without assessing for beliefs prior to the clinician’s beginning work in the field. Foa et al (in press) hypothesis that such cognitions, or negative beliefs, underlie posttraumatic psychopathology. Pearlman & Mac Ian (1995) argue that one of the manifestations of the impact of trauma work may be disrupted schemas. However, McCann and Pearlman (1990) postulate that individuals develop
their own schemas over time. They argue that pre-existing schema are significant in how therapists respond to client’s traumatic material.

It may be that individuals who have experienced childhood trauma are more likely to have higher levels of negative schema about the world as a result of the trauma they have experienced. However, it may also be that individuals who have experienced childhood abuse are more at risk for experiencing the negative impact of trauma work on their beliefs. The fact that such beliefs are associated with PTSD symptomology, and that for some there was evidence that their beliefs were disrupted, emphasises the vulnerability of some participants in this study.

The literature also reflects a lack of clarity regarding the relationships between previous traumatic experiences and secondary trauma symptomology. Pearlman & Mac Ian’s study (1995) found that those with a trauma history were found to have significantly higher levels of intrusion and avoidance symptomology. However, this result needs to be taken with caution as they measured trauma history with only one item (‘do you have a trauma history?’). In contrast, Schauben & Frazier’s study (1995) found that counsellors’ prior history of sexual victimisation was not related to symptomology. This difference may relate to the fact that Schauben & Frazier (1995) were looking specifically at counsellors’ prior history of sexual victimisation and its association with the impact of working specifically with victims of sexual abuse. Pearlman & Mac Ian (1995) argue, that therapists may “contribute to their own healing as they share in their clients’ growth and change” (p563). The impact of this healing process may be more apparent in Schauben & Frazier’s (1995) sample which targeted clinicians with trauma histories which were related to that of their clients.

There was also a positive correlation between the number of prior traumatic experiences and the personal accomplishment scale of the Maslach Burnout Inventory. This was an unexpected result. This, again, may connect with Pearlman and Mac Ian’s (1995) argument that trauma therapists may contribute to their own development, and thus
increase their sense of personal achievement, by helping others. This is possibly at the cost of compassion fatigue. This result needs to be taken with caution as the large number of correlations calculated means that the significance of this relationship may have been found by chance.

With regards to other background characteristics (age, gender, years worked since qualifying, years worked in current specialty, number of trauma victims worked with and % of trauma victims) and impact of trauma work there were no significant relationships. This finding differs to that of the literature. Pearlman & Mac Ian (1995) found that those with the least experience were found to have the most disrupted schemas, and a higher symptom level on the SCL-90 (symptoms of psychopathology). Schauben & Frazier (1995) found that the percentage of trauma victims in the therapists case loads did correlate with levels of PTSD symptomology and level of disruptions to schemas. Arvay & Uhlemann (1996) found that being younger and having worked less years in practise was also associated with experiencing more intrusions and avoidance symptomology.

There are a number of reasons why this study may not have found the relationships reported in the literature. This study was based on the responses of qualified British clinical and counselling psychologists, many of whom will have trained for at least three years prior to qualifying. This may mean (the reported statistics in other studies make overall experience of clinicians difficult to compare) that the less experienced people in this sample are actually relatively more experienced than other samples. Pearlman & Mac Ian (1995) highlight that the less experienced clinicians in their study were less likely to have been receiving supervision and were more likely to be seeing more acutely distress clients. In this study, there was a significant relationship between the number of years since qualifying and supervision, with clinicians who had been qualified the least time being more likely to receive supervision. This may have counter-acted against any greater impact which may have occurred for less experienced clinicians if they had not had supervision. Furthermore, this study did not target trauma therapists specifically. The sample consisted of more generic clinicians working with adults, who were working with
varying numbers of trauma victims. This reflects the role of the psychologist in Britain and may mean that the specific impact of trauma work is more diffused in this study compared to other studies which have selected clinicians working specifically in the field of trauma.

**Relationship between 'burnout' and secondary trauma**

A further aim of the study was to investigate the relationship between 'burnout' and secondary trauma. The scores on the MBI were correlated with the scores on the compassion fatigue scale, the PSS-SR and the PTCI. There were also significant associations between those at high risk for compassion fatigue and depersonalisation. There were further significant associations between those who fulfilled PTSD criteria and those at high risk for emotional exhaustion and low levels of personal accomplishment. Thus the evidence suggests that if individuals are suffering from high levels of PTSD symptomology/compassion fatigue, they are also likely to be suffering from higher levels of burnout. However, it worth highlighting that there were some individuals who reported experiencing high levels of burnout, but were not experiencing high levels of vicarious trauma. Of those (13) who fulfilled DSM-IV criteria for PTSD symptomology, 50% were at high risk for emotional exhaustion, 31% for depersonalisation and 33% for low personal accomplishment. Furthermore, of those at high risk for compassion fatigue, only 40%, 31% and 31% were at risk for emotional exhaustion, depersonalisation and personal accomplishment respectively. This is evidence to suggest that individuals who score highly on measures of vicarious trauma do not necessarily experience high levels of burnout. Therefore, in some cases the traumatic impact associated with trauma victims is separable from general burnout. It appears that traumatic reactions after working with victims of trauma is not synonymous with burnout.

Schaube & Frazier (1995) found that secondary trauma was related to the percentage of trauma victims in the case load, whereas 'burnout' was not. As discussed above, in the current study, compassion fatigue was correlated with the number of prior traumatic experiences, but burnout was not. The number of traumatic experiences were also

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correlated with 'beliefs about the world' (PTCI), but not with 'burnout'. It is hypothesised, albeit tentatively, that previous traumatic experiences may be significant in the development of secondary trauma, but may not be a relevant risk factor for burnout. There were no other relationships between any of the background characteristics (including percentage of trauma victims in case load) and either 'burnout' or 'secondary trauma' measures. Such negative results makes it difficult to discriminate between whether there were actually no differences between burnout and secondary trauma, or whether there were other significant factors clouding the differences.

**Qualitative data regarding intrusions**

The qualitative part of the study also revealed some interesting and useful insights into the experience of the clinician regarding intrusions. One of the main findings was that there was a positive correlation between negative beliefs regarding intrusions and severity scores on the PSS-SR. This suggests an association between those who negatively interpret the intrusions they experience and higher levels of PTSD symptomology. This is backed up in the literature by Ehlers & Steil (1995) and Dunmore, Clark & Ehlers (1999) who also found such a relationship. Ehlers & Steil (1995) postulate that negative interpretations of symptomology is important in the development and maintenance of PTSD.

The intrusions questionnaire revealed that only 4 (3%) respondents had never experienced any form of intrusion. This is backed up by Allt & Dunmore's (1998) experimental study, which found that participants experienced intrusions from hearing victim’s accounts of traumatic events. Furthermore, the most common intrusions in the current study were intrusive thoughts about the client and intrusive thoughts about the traumatic event/s that clients had described. Allt & Dunmore (1998) also found that those who heard victim’s accounts were more likely to experience intrusive thoughts about the victim, whereas those who had watched car crash scenes were more likely to experience visual images. However, though it seems that clinicians most commonly experience intrusive thoughts, it is acknowledged that 41.3% of the participants also
reported experiencing intrusive images of the events that had been described to them. Participants described, in some detail, a range of examples which were memorable to them. These were often gruesome in nature, involving explicit details and images of torture, sexual assaults and other horrific scenarios. For some, the example they had chosen had been extremely distressing, with distress ratings ranged from 0 to 100% (mean score of 42.5%).

However, such memorable examples need to be considered within the context of the participants’ overall agreement with the statement that intrusions are a ‘normal reaction’ to hearing distressing material. There was also some agreement (mean score of 4.35 and median of 5) for the statement that experiencing an intrusion was an indication that they had not processed the information properly. These findings were also backed up by answers to open questions which revealed that 30.6% thought that intrusions were a normal reaction to hearing distressing material and 36% who thought that intrusions were an indication that material needed to be processed.

Participants identified a range of emotions which they experienced in response to intrusions. The most commonly expressed emotions were anger (27.1%) fear (27.13 %) and surprise (20.15 %). Shock, sadness and horror were also volunteered as other reactions they had experienced. Schauben & Frazier (1995) also reported counsellors’ emotional distress including anger at the perpetrator. Sadness, depression, anger, irritability and hyperarousal were also reported by therapists in Kinzie & Boehnlein’s study (1993). Such emotional reactions are also described by individuals who have experienced a traumatic event (Scott & Stradling, 1995).

The intrusions questionnaire also provided information regarding clinicians’ coping strategies for dealing with intrusions. In response to an open question regarding coping strategies, the commonest responses referred to actively processing the information (38.8%), talking to a friend/colleague (41.1 %) and utilising supervision (36.6%). They also gave a range of other strategies including distraction and cognitive (e.g. challenging
automatic thoughts) strategies. Interestingly, there seemed to be different opinions within the sample regarding the use of distraction, with a bimodal distribution of scores in response to the statement: ‘I distract myself’. 59.5% of participants reported rarely using distraction, though 27.6% reported using this strategy. It’s hypothesised that certain clinicians may interpret distraction as a subtle avoidance strategy which may contribute to the maintenance of intrusions. Others described how they use distraction until there is an appropriate time to process the intrusions. However, the sample indicated that they would rarely ‘push the image’ out their mind. This would constitute avoidance, within the cognitive-behavioural model of PTSD and it is hypothesised that clinicians would be aware of the negative consequences of this. However, 21% indicated that they avoided situations which might trigger intrusions that they used this strategy at least some of the time or more. This was surprising in that it is assumed that most clinicians would be aware that avoidance can be a maintenance factor of intrusions within a cognitive-behavioural model of trauma (e.g. Scott & Stradling, 1995).

Qualitative data regarding avoidance

Another interesting finding was that 40.4% of participants said that had avoided certain types of trauma work with 28 (50.9%) of these avoiding sexual abuse work. 6 men (16.6% of 36) said they avoided working with females who had been sexually abused. Overall, 82.1% of reasons for avoiding certain types of trauma work were connected to the emotional response to such work.

In line with this 42 (32%) indicated that they had sought to decrease the level of trauma work in their case load. 37.5% of these indicated that this was connected to self-identified emotional health issues to this work, compared to 8.3% who indicated that this was due to a lack of skills in this field. This is interesting in that it highlights how clinicians within this sample may be choosing to balance their work load as a coping strategy to deal with their emotional responses. Those who chose to decrease their work load for emotional reasons may in fact be more vulnerable than those who chose to
maintain or increase their level of trauma work. Thus, the presenting symptomology of the group may in fact have been higher if participants had not been able to choose to decrease their level of trauma work. This raises questions about the characteristics and experiences of certain individuals who identified themselves as possibly being at risk.

A low number (17%) indicated that they had avoided asking a client to describe details of traumatic events. The only theme to emerge from this was that some of these (27.2%) anticipated that the client would find it upsetting. However, there was an interesting response to the question of whether they had ever avoided telling colleagues the details of events. 23% said they had done this with 35% of these avoiding telling colleagues due to fears of passing on the trauma/intrusive thoughts to others. 23.1% of these indicated not telling colleagues due to reasons of confidentiality. Both these raise professional issues. A fear or resistance to telling colleagues the details of events that have been disturbing may have serious implications for the level of support people receive, and may constitute subtle avoidance. Furthermore, for some confidentiality would prevent them from telling their colleagues. Again, different perceptions of confidentiality between colleagues has implications for the support of individuals hearing distressing information. The implications of this for the profession will be discussed in more detail below.

Qualitative data regarding beliefs
47.1% indicated that that the trauma work had had an impact on their perception of traumatic events occurring to them, with 69.2% indicating that their perception of risk was higher. This is backed up by the scores on the PTCI ‘beliefs about the world’ scale (Foa et al, in press), for which the sample scores were slightly higher than comparative data based on individuals who had not experienced a traumatic event (Foa et al, in press). Increased wariness was not necessarily described as a negative consequence of trauma work. It was described in both a positive and negative light. A number of strategies were described to cope with this including, most commonly, cognitive (52.5%, e.g. “cognitive re-structuring”) and behavioral strategies (52.5%, e.g. “going on long journeys to desensitise myself”).
Qualitative data regarding general response to trauma work

In terms of an overall response to the work, negative and positive aspects were equally acknowledged. For example, one individual stated that the work had put them “in touch with the dark side of political life”. Another that “it has taken its toll on me emotionally”. Positive comments included that the work had “opened horizons” and that it “promotes (self) review, doubt, reflexivity and learning”.

Critique

A strength of this study was the sample size (141). Although this represented a response to the original mail out of only 28 %, this was a relatively high response rate considering the anonymity of the study which made it impossible to make second requests to individuals to return questionnaires. The return rate was comparable with Arvay & Uhlemann’s (1996) 28% return rate and Pearlman & Mac Ian’s (1995) 24% return rate after the initial mailing.

It is hypothesised that the anonymity of the survey would encourage the participants to be open and honest in their answers. The impression, from the highly personal nature of the answers to open questions in the qualitative part of the survey, was that people did feel comfortable divulging personal information.

This study is the only survey of British clinical and counselling psychologists investigating the impact of trauma work on therapists; thus it is significant in that it presents a picture of the impact of such work within the context of British culture and within an national health service (NHS) setting. The sample represented a typical picture of clinicians working in the NHS incorporating varying amounts of trauma work into their case load, rather than working in specialist trauma clinicians. This gave the study an advantage in that it allowed insight in to the experience of those who have chosen to decrease as well as increase their trauma case load. It would be useful for future research
projects to investigate the experiences, in more detail, of those who had chosen to decrease their level of trauma work due to their emotional experience of such work. This could be achieved via a screening measure.

However, the disadvantage of having a ‘mix’ of clinicians undertaking varying amounts of trauma work is that it makes it more difficult to establish the specific impact of trauma work. It is noted that there was no correlation between the number of trauma clients in the therapist’s case load and vicarious trauma, which differed to other studies (e.g. Schauben & Frazier, 1995). However, this may be due to the fact that clinicians who work full-time with victims of trauma (as in Schauben & Frazier’s study) experience a higher level of intensity which leads to a cumulative impact. Future research could identify those with a particularly high current trauma case load (i.e. a high number of trauma client’s per week) and explore the relationship between them and those with a low and infrequent (or non-existent) contact with victims of trauma. This would give useful comparative data and hopefully provide useful information on the specific impact of trauma work.

It is acknowledged that although the sample was a reasonable size, there was a large proportion (72%) which were not represented. There was no evidence to suggest that there were any systematic difference between the those who completed the study and those who didn’t. The sample represented a good range of specialties (within the field of adult mental health), experience and proportion of trauma work undertaken. A number of participants commented that the questionnaire was long, which may have contributed to the low response rate to the intrusions questionnaire. The return rate may have improved if it had taken less time to complete. The response rate may also have been improved if, costs permitting, a general reminder letter was sent to each participant.

Furthermore, it needs to acknowledged that the findings were based on self-report measures of symptomology and background information. These may not have always been accurate, which may have clouded any potential results. It is acknowledged that the
specificity of the measures, particularly when used with clinicians undertaking other non-trauma work, may be questionable. Clinicians may have found it difficult to isolate the impact of trauma victim work from other work. This is a difficult to issue to overcome, but the use of a control group with particularly low-levels of trauma work would elicit clearer evidence for vicarious trauma.

A final limitation is concerned with the assumptions of this study. The questionnaire was conceptualised according to DSM-IV (APA, 1994) criterion and within a cognitive-behavioral understanding of PTSD. Some participants commented that they did not conceptualize their trauma work in this way and felt limited in the responses they could give. It is acknowledged that this study did not attempt to take account of other conceptualisations such as counter-transference.

**Professional Issues**

The findings of this study have significant implications for the professional support of clinicians working with trauma victims. The results suggest that clinicians are using coping strategies (including decreasing their level of trauma work) and their knowledge of trauma to cope well with such work. However, a minority were experiencing significant levels of symptomology. This raises questions about how therapists are supported and what therapies and support should be offered to such clinicians. One pertinent issue with regards to this is that some clinicians are avoiding telling colleagues the details of intrusions due both to reasons of confidentiality and due to fear of ‘passing on the trauma’. If clinicians are reluctant, or prevented, from telling colleagues, it poses serious questions for how professionals are supported at work. This is an issue which clearly needs to be addressed within teams undertaking such work. Furthermore, when clinicians undertake ‘exposure’ work with clients, they often encourage them to discuss their traumatic experiences in detail. This may pose a risk for vicarious traumatisation for the clinician, and so raises a dilemma.
The impact of working with trauma victims, even if slight, raises ethical issues. It raises the question of whether clinicians should be warned of the likely impact of such work, and the pertinent risk factors - which are still unclear. It also raises issues for service managers who may need to be active in ensuring that trauma work is not 'off-loaded' on to one individual. It also raises the question of whether clinicians should be encouraged to balance their work load and not target a high caseload of trauma victims from the onset of their career. This could have serious implications for the setting up of specialist trauma services.

We know relatively little about how to support clinicians in such work. The intervention of critical debriefing (e.g. Talbot, Manton & Dunn, 1992), which has been applied to work with various 'helping professions' is surrounded in controversy. More research is needed to establish what sort of interventions and preventative strategies would be useful for clinicians. Many of the therapists report using personal therapy to help them. There is a lack of research on the most effective ways of supporting therapists specifically with trauma work.

Summary
In summary, this study supports previous research in confirming that a minority of therapists working with trauma victims may be risk for developing vicarious trauma. A small proportion of the participants were experiencing PTSD symptomology which fulfilled DSM-IV criterion. There was also a minority of participants who were at high risk for compassion fatigue and burnout. The study also indicated that the participants' had a higher level of trauma related beliefs compared to individuals who had not experienced a traumatic event.

It may be that trauma work has had some impact on the therapists' beliefs. However, there was tentative evidence to suggest that there may be an association between a higher number of previous traumatic events compassion fatigue and negative beliefs about the world. Furthermore, there was a significant relationship between those who had
experienced childhood abuse and higher levels of negative beliefs about the world. It is not possible to establish whether this was because they already had higher pre-existing levels of negative beliefs, or whether they had schema which were more sensitised to the impact of clinical work. There was also an unexpected association between prior traumatic experiences and personal accomplishment. It may be that some therapists who have experienced prior traumatic events find some meaning and sense of accomplishment in their work, though at some cost to themselves. Overall, fewer risk factors were identified than were described in the literature. This may have been related to the generic role of the psychologist in Britain.

There was evidence to suggest that burnout and vicarious trauma are not synonymous. Although it was clear that those who had burnout were more likely to experience symptoms of vicarious trauma, there were some individuals who scored within high ranges for PTSD symptomology, but did not score highly on the subscales of burnout. Furthermore, prior traumatic experiences seem to be a significant background factor for vicarious trauma but not for burnout.

Finally, some useful data was elicited regarding the experience and interpretation of symptoms of vicarious trauma. Particularly interesting was the finding that the negative interpretation of intrusions was related to a higher level of PTSD symptomology. Clinicians most commonly tended to interpret intrusions as a normal reaction, and would attempt to process the material in response to experiencing it. They experienced a range of emotions similar to that experienced by trauma victims. Furthermore, they indicated how they had become more aware of risk and more vigilant. The therapists described a number of coping strategies, including reducing the number of clients in their work load and avoiding certain types of trauma work. They also described how they avoided telling colleagues the details of the material for fear of passing on the trauma. A number of professional issues were raised and discussed.
R4: Bibliography


Dear Sir/Madam,

Psychologists at the University of Surrey are conducting an investigation of therapists’ reactions to working with clients who have experienced trauma. As part of this research, we are carrying out a questionnaire study of clinical and counselling psychologists working with adults in the South Thames region.

We would be most grateful if you would consider volunteering to participate in this study. It involves completing the enclosed questionnaire pack, which should take only 15 to 20 minutes, and returning it in the self-addressed envelope provided by the 23rd April 1999. There are a small number of questions about yourself and your current position. You will then be asked to fill in some questions regarding traumatic stress reactions and general stress related to your job. There is also a questionnaire asking you about your beliefs since undertaking clinical work. Finally, there are some questions of a personal nature regarding whether you have experienced any traumatic events yourself. It is emphasised that all questions are optional, and participation is entirely voluntary. The survey is completely anonymous, so you do not need to write your name anywhere on the questionnaires.

In this study we hope to include responses from a range of psychologists working with adults - both those who work primarily with traumatised clients and those who carry out less trauma work. It is hoped that the findings of this study will help us to understand the impact of working with clients who have experienced traumatic events, and may contribute to designing ways to support clinicians undertaking this type of work.

A summary of the results of the project will be sent to each head of department for circulation.

Thank you for your help.

Yours faithfully,

Jackie Allt
Psychologist in Clinical Training

Contact Address: Psychologist in Clinical Training, Psych D. Clin. Psychol. Surrey University Guildford, Surrey. GU2 5XH. Contact phone number: 01483 259441

If you have any concerns regarding the issues raised in this study, and would like to discuss these with a clinical psychologist in confidence, please contact:
Dr Emma Dunmore (Clinical Psychologist), Psych D Clin. Psychol, Surrey University, Guildford
Surrey. Contact number: 01483 876863
Appendix R4:2

University of Surrey
Survey of clinical and counselling psychologists in Adult Mental Health

Part 1: General Information

Please omit any information which may identify you

1. Age Band (please underline)  
   20-30  41-50  60 and above  
   31-40  51-60

2. Gender (please underline)  
   Male/Female

3. Brief job description (e.g. health psychology, primary care)

4. Approximately how many years have you worked as a therapist since qualifying?  
   .................... years.

5. How many years have you worked in your current specialty?  
   .................... years.

6. Approximately what percentage of your current case load involves working with clients who have experienced traumatic events (including sexual and physical abuse)?  
   ....................%

7. How many clients (approx.) have you worked with who have experienced traumatic events? (please underline)  
   Fewer than 10  
   Between 10 and 30  
   Between 30 and 60  
   Between 60 and 100  
   More than 100.

8. Do you currently have supervision when working with clients who have experienced traumatic events?  
   Yes/No
Appendix R4:3

Part 2: Compassion Fatigue Test for Helpers

Figley, 1995 adapted by Stamm, 1995

0 = Never  1 = Rarely  2 = A few times  3 = Somewhat often  4 = Often  5 = Very often
Write in the number that honestly reflects how frequently you have experienced these characteristics in the last week.

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 outbursts 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 have flashbacks connected to those I help.  
18. I have had good peer support when I need to work through a highly stressful experience.  
19. I have had first-hand experience with traumatic events in my adult life.  
20. I have had first-hand experience with traumatic events in my childhood.  
21. I think I need to “work through” a traumatic experience in my life.  
22. Working with those I help brings me a great deal of satisfaction.  
23. I feel invigorated after working with those I help.  
24. I am frightened of things a person I helped has said or done to me.  
25. I experience troubling dreams similar to those I help.  
26. I have happy thoughts about those I help and how I could help them.  
27. I have experienced intrusive thoughts of times with especially difficult people I helped.  
28. I have suddenly and involuntarily recalled a frightening experience while working with a person I helped.  
29. I am preoccupied with more than one person I help.  
30. I am losing sleep over a person I help’s traumatic experiences.  
31. I have joyful feelings about how I can help the victims I work with.  
32. I think that I might be “infected” by the traumatic stress of those I help.  
33. I think that I might be positively “innoculated” by the traumatic stress of those I help.  
34. I remind myself to be less concerned about the wellbeing of those I help.  
35. I have felt trapped by my work as a helper.  
36. I have a sense of hopelessness associated with working with those I help.  
37. Some people I help are particularly enjoyable to work with.  
38. I have been in danger working with people I help.  
39. I like my work as a helper.  
40. I feel like I have the tools and resources that I need to do my work as a helper. (298)
Appendix R4:4

41. I have thoughts that I am a “success” as a helper. ( )
42. I enjoy my co-workers. ( )
43. I depend upon my co-workers to help me when I need it. ( )
44. My co-workers can depend on me for help when they need it. ( )
45. I trust my co-workers. ( )
46. I am pleased with how I am able to keep up with helping technology. ( )
47. Although I have to do paperwork that I don’t like, I still have time to work with those I help. ( )
48. I am pleased with how I am able to keep up with helping techniques and protocols. ( )
49. I plan to be a helper for a long time. ( )

Part 3: PSS-SR
(Adapted from Foa, 1993)
This questionnaire has been adapted to assess secondary trauma reactions in clinicians. For part ‘a’, please indicate whether you’ve ever had each of the reactions by underlining either ‘Yes’ or ‘No’. For part ‘b’, please rate your experiences of each of these reactions during the last 4 weeks using the scales described below. First, rate how frequently you have had each of the experiences during the last 4 weeks using this 0-3 scale.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Once per week/</td>
<td>2-4 times/</td>
<td>5 times per week/</td>
</tr>
<tr>
<td>a little bit/</td>
<td>somewhat/</td>
<td>very much/</td>
<td></td>
</tr>
<tr>
<td>once in a while</td>
<td>half the time</td>
<td>almost always</td>
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Next, rate how distressing each of the experiences has been in the last 4 weeks using this 0-3 scale.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
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<tbody>
<tr>
<td>Not at all</td>
<td>Very distressing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>distressing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1a. Have you ever had upsetting thoughts or images about events (or related events) that clients have described that come into your head when you do not want them to? Yes/No

1b. Have you experienced this in the past 4 weeks?

How frequently? 0 1 2 3
How distressing has this been? 0 1 2 3

2a. Have you ever had any bad dreams or nightmares about events (or related events) that clients have described to you.

Yes/ No

2b. Have you experienced this in the past 4 weeks?

How frequently? 0 1 2 3
How distressing has this been? 0 1 2 3

3a. Have you ever had the experience of reliving events (or related events) that clients have described to you, ie. acting or feeling as if it were happening again?

Yes/No

3b. Have you experienced this in the last 4 weeks?

How frequently? 0 1 2 3
How distressing has this been? 0 1 2 3
1a. Have you ever been very EMOTIONALLY upset when reminded of events that your clients have described to you (includes becoming very scared, angry or sad etc.)? Yes/No

4b. Have you experienced this in the last 4 weeks?
How frequently? 0 1 2 3 How distressing has this been? 0 1 2 3

5a. Have you ever had any PHYSICAL reactions (e.g. breaking out into a sweat, heart beating fast) when reminded of events that your clients have described to you? Yes/No

5b. Have you experienced this in the last 4 weeks?
How frequently? 0 1 2 3 How distressing has this been? 0 1 2 3

6a. Have you ever tried not to think about or have feelings associated with the events that your clients have described to you? Yes/No

6b. Have you experienced this in the last 4 weeks?
How frequently? 0 1 2 3 How distressing has this been? 0 1 2 3

7a. Have you ever made efforts to avoid activities, situations, or places which remind you of events, or related events, that your clients have told you about? Yes/No

7b. Have you experienced this in the last 4 weeks?
How frequently? 0 1 2 3 How distressing has this been? 0 1 2 3

8a. Do you have any unexpected gaps in your memory of events which your clients have described to you? Yes/No

8b. Have you experienced this in the last 4 weeks?
How frequently? 0 1 2 3 How distressing has this been? 0 1 2 3

9a. Have you ever found that you are not interested in things you used to enjoy doing? Yes/No

9b. Have you experienced this in the last 4 weeks?
How frequently? 0 1 2 3 How distressing has this been? 0 1 2 3

10a. Have you ever felt distant or cut off from others around you? Yes/No

10b. Have you experienced this in the last 4 weeks?
How frequently? 0 1 2 3 How distressing has this been? 0 1 2 3

11a. Have you ever felt emotionally numb (for eg., feel sad but can't cry, unable to have loving feelings)? Yes/No

11b. Have you experienced this in the last 4 weeks?
How frequently? 0 1 2 3 How distressing has this been? 0 1 2 3
12a. Have you ever felt that any future plans or hopes have changed because of events your clients have described to you (for example, will have no career, marriage, children or life-long ambitions)? DO NOT INCLUDE MOVING. 

Yes /No

12b. Have you experienced this in the last four weeks?

How frequently? 0 1 2 3

How distressing has this been? 0 1 2 3

13a. Ever you ever had difficulty falling asleep or staying asleep? 

Yes/ No

13b. Have you experienced this in the last 4 weeks?

How frequently? 0 1 2 3

How distressing has this been? 0 1 2 3

14a. Have you ever been more irritable or had outbursts of anger? 

Yes/No

14b. Have you experienced this in the last 4 weeks?

How frequently? 0 1 2 3

How distressing has this been? 0 1 2 3

15a. Have you ever had difficulty concentrating (for example, drift in and out of conversations, lose track of a story or television programme, difficulty remembering what you have read?) 

Yes/No

15b. Have you experienced this in the last 4 weeks?

How frequently? 0 1 2 3

How distressing has this been? 0 1 2 3

16a. Have you ever been overly alert (for example, checking to see who is around you, uncomfortable with your back to a door, etc.)? 

Yes/No

16b. Have you experienced this in the last 4 weeks?

How frequently? 0 1 2 3

How distressing has this been? 0 1 2 3

17a. Have you ever been jumpier, or more easily startled? 

Yes/No

17b. Have you experienced this in the last 4 weeks?

How frequently? 0 1 2 3

How distressing has this been? 0 1 2 3

18. At their worst, how disabling have these reactions been to you in the past?

(please circle the number which best applies to you)

0 1 2 3 4 5 6 7 8

Not at all disabling slightly definitely markedly severely disabling

19. How disabling have these reactions been to you in the last month?

(please circle the number which best applies to you)

0 1 2 3 4 5 6 7 8

Not at all disabling slightly definitely markedly severely disabling
Appendix R4:5

Part 4: The Post-Traumatic Cognitions Inventory (PTCI)
Foa et al (in press)

We are interested in the kind of thoughts which you may have had after working as a therapist with clients who have experienced traumatic events. Below are a number of statements that may or may not be representative of your thinking.

Please read each statement carefully and tell us how much you AGREE or DISAGREE with each statement by placing a number within each set of brackets. People react to hearing traumatic events in various ways. There are no right or wrong answers to these statements.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Totally Disagree</td>
<td>Disagree slightly</td>
<td>Disagree slightly</td>
<td>Neutral</td>
<td>Agree slightly</td>
<td>Agree very much</td>
<td>Totally agree</td>
</tr>
</tbody>
</table>

1. I can't trust that I will do the right thing. ( )
2. I am a weak person. ( )
3. I will not be able to control my anger and will do something terrible. ( )
4. I can't deal with even the slightest upset. ( )
5. I used to be a happy person but now I am always miserable. ( )
6. People can't be trusted. ( )
7. I have to be on guard all the time. ( )
8. I feel dead inside. ( )
9. You can never know who will harm you. ( )
10. I have to be especially careful because you never know what can happen next. ( )
11. I am inadequate. ( )
12. I will not be able to control my emotions, and something terrible will happen. ( )
13. If I think about the events described to me, I will not be able to handle it. ( )
14. My reactions since hearing about the events mean that I am going crazy. ( )
15. I will never be able to feel normal emotions again. ( )
16. The world is a dangerous place. ( )
17. Somebody else would have been able to help more. ( )
18. I have permanently changed for the worse. ( )
19. I feel like an object, not like a person. ( )
20. Somebody else would not have got into this situation. ( )
21. I can't rely on other people. ( )
22. I feel isolated and set apart from others. ( )
23. I have no future. ( )
24. I can't stop bad things from happening to me. ( )
25. People are not what they seem. ( )
26. My life has been destroyed by hearing about the traumatic events. ( )
27. There is something wrong with me as a person. ( )
28. My reactions since hearing about the traumatic events show that I am a lousy coper. ( )
29. I will not be able to tolerate my thoughts about the events described to me, and I will fall apart. ( )
30. I feel like I don’t know myself anymore. ( )
31. You never know when something terrible will happen. ( )
32. I can’t rely on myself. ( )
33. Nothing good can happen to me anymore. ( )
Part 5: Intrusions questionnaire

These questions relate to your work with clients who have experienced trauma. For the purpose of this questionnaire, intrusions are defined as thoughts, images or memories that seem to ‘pop’ into your mind. Dreams are also included as intrusions. These may include intrusions related to, but not exact replicas of, events described to you by clients.

Q1. Have you ever experienced any of the following? (Please underline):
- Intrusive thoughts about the client
- Intrusive thoughts about a traumatic event that a client described to you
- Intrusive images of the client
- Intrusive images of a traumatic event that a client described to you
- Dreams about the client
- Dreams about the traumatic events that a client described to you

Other (please describe below).

Q2. If you have answered ‘yes’ to any of the above, please think of a memorable example and describe in detail the intrusion or dream (if not, please go to question 8).

Q2b. How distressing was this intrusion/dream? 0 10 20 30 40 50 60 70 90 100
(Please mark the line)

Not at all extremely

Q3. What was your emotional reaction to this when it happened?
(Please underline which emotion/s you experienced)

- Guilt
- Anger
- Fear
- Shame
- Confusion
- Surprise
- Other (please state)

Q4. When you experience intrusions or dreams, what does this mean to you as a therapist? (Please describe below):
Q5. Please use the following scale to rate how much you agree with the following statements:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>totally disagree</td>
<td>disagree slightly</td>
<td>disagree slightly</td>
<td>neutral</td>
<td>agree slightly</td>
<td>agree very much</td>
<td>totally agree</td>
</tr>
</tbody>
</table>

(Please put a number in the bracket for each statement)

a) Intrusions are a normal reaction to hearing distressing material. ( )
b) When I experience an intrusion, it causes me concern. ( )
c) I feel pretty neutral about the intrusions I experience. ( )
d) Having intrusions means that I'm losing control. ( )
e) When I experience intrusions, they happen so quickly that I hardly notice them. ( )
f) When I experience an intrusion, it makes me think that I have not processed the distressing information fully. ( )
g) If I have intrusions, it means I am failing as a therapist. ( )

Q6. Please describe in more detail any strategies you use to deal with intrusions, when they occur.

Q7. Please indicate how often you use the following strategies to deal with intrusions when they occur using the following scale:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>none of the time</td>
<td>very occasionally</td>
<td>occasionally</td>
<td>not aware of doing this</td>
<td>quite often</td>
<td>often</td>
<td>all the time</td>
</tr>
</tbody>
</table>

a) I just let them 'come and go'. ( )
b) I distract myself. ( )
c) I talk to someone about it. ( )
d) I 'push' the image or thought out of my mind. ( )
e) I ruminate about it. ( )
f) I avoid situations which might trigger intrusions. ( )
Q8. Have you ever tried to avoid working with any ‘types’ of trauma work?  
(Please underline)  
Yes/No  
If yes, please describe what ‘types’ you have avoided and why:

Q9. Have you ever purposely avoided asking a client to describe details of a traumatic event because you did not want to hear it?  
Yes/No  
If yes, please explain, in more detail, why you did this:

Q10. Have you ever avoided telling colleagues details of the events that have been described to you?  
Yes/No  
If yes, please describe, in more detail, why you did this:

Q11. Has your work with trauma victims had any impact on your perception of the likelihood of traumatic events happening to you?  
Yes/No  
If yes, please describe in more detail, how:
Q12. Please describe any strategies, if any, that you use to deal with the impact this work has had on your perception of the likelihood of traumatic events happening to you: (if you do not use any strategies, please go to Q13).

Q 13. Please use the following scale to rate how much you agree with the following statements:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>none of the time</td>
<td>very occasionally</td>
<td>occasionally</td>
<td>not aware of doing this</td>
<td>quite often</td>
<td>often</td>
<td>all the time</td>
</tr>
</tbody>
</table>

a) I am more wary now, but that’s a good thing. ( )
b) I feel my sense of danger is getting distorted, and this is concerning me. ( )
c) I am more wary now, and I’m concerned about the long-term effects of this. ( )
d) I don’t feel my sense of danger has really changed. ( )

Q14. Please describe how you feel about the impact this work has or has not had on you generally?

Q15a. Have you ever sought to increase or decrease the level of trauma work in your case load? If no, please go to question 16. Yes/No

Q15b. If yes, did you seek to increase or decrease your level of trauma work? Please underline Increase/decrease

Q15c. Why was this? (please describe):

Q16) Any other comments:
Appendix R4:7

**Part 6: MBI** (Maslach & Jackson, 1981)

Below are some questions about your reactions to your work in general. Please read the following questions carefully and circle those numbers that most represent your opinion now. Do not spend too much time on each question, your first response is probably the best one for you.

**How often:**

- **0** never
- **1** a few times a year or less
- **2** once a month or less
- **3** a few times a month
- **4** once a week
- **5** a few times a week
- **6** every day

1. I feel emotionally drained from my work. 0 1 2 3 4 5 6
2. I feel used up at the end of the work day. 0 1 2 3 4 5 6
3. I feel fatigued when I get up in the morning and have to face another day on the job. 0 1 2 3 4 5 6
4. I can easily understand how my patients feel about things. 0 1 2 3 4 5 6
5. I feel I sometimes treat patients as if they were impersonal objects. 0 1 2 3 4 5 6
6. Working with people all day is really a strain for me. 0 1 2 3 4 5 6
7. I deal effectively with the problems of my patients. 0 1 2 3 4 5 6
8. I feel burned out from my work. 0 1 2 3 4 5 6
9. I feel I am positively influencing other people's lives through my work. 0 1 2 3 4 5 6
10. I've become more callous towards people since I took this job. 0 1 2 3 4 5 6
11. I worry that this job is hardening me emotionally. 0 1 2 3 4 5 6
12. I feel very energetic. 0 1 2 3 4 5 6
13. I feel frustrated by my job. 0 1 2 3 4 5 6
14. I feel I'm working too hard on my job. 0 1 2 3 4 5 6
15. I don't really care what happens to some patients. 0 1 2 3 4 5 6
16. Working with people directly puts too much stress on me. 0 1 2 3 4 5 6
17. I can easily create a relaxed atmosphere with my patients. 0 1 2 3 4 5 6
18. I feel exhilarated after working closely with my patients. 0 1 2 3 4 5 6
19. I have accomplished many worthwhile things in this job. 0 1 2 3 4 5 6
20. I feel like I'm at the end of my tether. 0 1 2 3 4 5 6
21. In my work, I deal with emotional problems very calmly. 0 1 2 3 4 5 6
22. I feel patients blame me for some of their problems.
Part 7: Previous Traumatic Experiences (Dunmore, 1998)

The following questions ask about any traumatic events which you may have experienced either as a child or as an adult. It is important for us to obtain this information as we are trying to establish if previous traumatic experiences have an impact on therapists' experience of working with trauma victims.

Sometimes people have experienced more than one traumatic event in their life. We appreciate that it may be difficult to think about these events, but we would be extremely grateful if you could answer the following brief questions. For each of the traumatic events listed below, please indicate (by underlining the answer 'yes' or 'no') whether or not you have experienced the traumatic event/s.

- Natural or man-made disaster (e.g. landslide, flood, plane crash, explosion)
- Serious Accident
- Military combat
- Murder of a close friend/family
- Unexpected death of a close friend / family
- Being seriously burned
- Being physically assaulted or mugged as an adult
- Being present during a robbery
- As a child were you ever beaten by a parent or caretaker?
- As a child did you ever see or hear violence take place between members of your family? (This might include things such as seeing your brothers or sisters beaten, or seeing your father hit your mother)?
- Before you were 16, did anyone five years or more older than you have sexual contact with you?
- Have you ever had any psychological difficulties (e.g. anxiety, depression, eating disorders, alcohol/drug misuse)?
- If yes, have you ever received any help for them (e.g. from a psychiatrist, psychologist or counsellor)?

Thank you for your help with this study!

If you have any concerns regarding the issues raised in this study, and would like to discuss these with a clinical psychologist in confidence, please contact:

Dr. Emma Dunmore: Psych D Clin. Psychol, Surrey University, Guildford Surrey
Appendices R4: 9

Kappa analyses (for random selection of 30 responses) for each category identified for each item.

Q4: When you experience intrusions of dreams, what does this mean to you as a therapist?

<table>
<thead>
<tr>
<th>Category</th>
<th>Kappa</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>normal reaction (to hearing difficult material)</td>
<td>.84</td>
<td>.00</td>
</tr>
<tr>
<td>a transference issue/some mention of transference</td>
<td>1.00</td>
<td>.00</td>
</tr>
<tr>
<td>intrusions are indicative of empathy towards the client</td>
<td>.9</td>
<td>.00</td>
</tr>
<tr>
<td>indication that therapist needs to actively process the information/or</td>
<td>.76</td>
<td>.00</td>
</tr>
<tr>
<td>that the material has not been processed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>that intrusions help/are helpful to the therapist/therapy in some way.</td>
<td>.60</td>
<td>.00</td>
</tr>
<tr>
<td>that intrusions are a warning of some sort</td>
<td>.44</td>
<td>.01</td>
</tr>
<tr>
<td>Other</td>
<td>.66</td>
<td>.00</td>
</tr>
</tbody>
</table>

Questions 6: Please describe any strategies you use to deal with intrusions when they

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Kappa</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>actively process the information</td>
<td>.90</td>
<td>.00</td>
</tr>
<tr>
<td>write it down</td>
<td>1.00</td>
<td>.00</td>
</tr>
<tr>
<td>talk with colleague or friend</td>
<td>.78</td>
<td>.00</td>
</tr>
<tr>
<td>discuss in supervision</td>
<td>.73</td>
<td>.00</td>
</tr>
<tr>
<td>consider it as a normal reaction</td>
<td>1.00</td>
<td>.00</td>
</tr>
<tr>
<td>explore in therapy</td>
<td>1.00</td>
<td>.00</td>
</tr>
<tr>
<td>conceptualise in terms of transference issues</td>
<td>1.00</td>
<td>.00</td>
</tr>
<tr>
<td>don’t do anything</td>
<td>1.00</td>
<td>.00</td>
</tr>
<tr>
<td>use a cognitive strategy</td>
<td>1.00</td>
<td>.00</td>
</tr>
<tr>
<td>distract oneself when experience intrusion</td>
<td>.83</td>
<td>.00</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q8: Have you ever tried to avoid working with any types of trauma work? IF yes, please describe what ‘types’ you have avoided and why.

<table>
<thead>
<tr>
<th>Type</th>
<th>Kappa</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>males indicating that they would avoid working with females who had been sexually abused</td>
<td>1.00</td>
<td>.00</td>
</tr>
<tr>
<td>sex abuse work (general)</td>
<td>1.00</td>
<td>.05</td>
</tr>
<tr>
<td>working with a perpetrator sexual abuse</td>
<td>1.00</td>
<td>.00</td>
</tr>
<tr>
<td>referrals connected to their own previous traumatic experience</td>
<td>1.00</td>
<td>.00</td>
</tr>
<tr>
<td>work with torture victims</td>
<td>1.00</td>
<td>.00</td>
</tr>
<tr>
<td>other</td>
<td>.61</td>
<td>.05</td>
</tr>
</tbody>
</table>
Q8 Why (have you avoided working with certain types of trauma work?)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Kappa</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>felt under-trained</td>
<td>.60</td>
<td>.04</td>
</tr>
<tr>
<td>due to emotional response to this type of trauma work</td>
<td>.80</td>
<td>.01</td>
</tr>
</tbody>
</table>

Question 9. Have you ever purposefully avoided asking a client to describe details of a traumatic event because you did not want to hear it?

For the 30 responses randomly selected to rate for inter-reliability, there were ≤ 5 responses for this item. Therefore, it was considered invalid to undertake Kappa analysis with so few numbers.

Question 10. Have you ever purposefully avoided telling colleagues details of the events that have been described to you (please describe).

Similarly, for question 10 there were ≤ 5 responses for this item. Therefore, it was considered invalid to undertake Kappa analysis with so few numbers.

Question 11. Has your work had any impact on your perception of the likelihood of traumatic events happening to you?

<table>
<thead>
<tr>
<th>Impact</th>
<th>Kappa</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>vigilance has increased</td>
<td>.79</td>
<td>.00</td>
</tr>
<tr>
<td>feel that have a more realistic sense of risk.</td>
<td>1.00</td>
<td>.00</td>
</tr>
<tr>
<td>have a more ‘take it day by day’ approach to life</td>
<td>1.00</td>
<td>.00</td>
</tr>
<tr>
<td>more aware</td>
<td>.58</td>
<td>.00</td>
</tr>
<tr>
<td>more aware of risks of regarding their own children</td>
<td>1.00</td>
<td>.00</td>
</tr>
<tr>
<td>other</td>
<td>.77</td>
<td>.00</td>
</tr>
</tbody>
</table>

Question 12: Please describe any strategies, if any, you use to deal with the impact this work has had on your perception of the likelihood of traumatic events happening to you.

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Kappa</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>behavioural strategies</td>
<td>.71</td>
<td>.00</td>
</tr>
<tr>
<td>cognitive strategies</td>
<td>.81</td>
<td>.00</td>
</tr>
<tr>
<td>supervision</td>
<td>.77</td>
<td>.00</td>
</tr>
<tr>
<td>use therapy</td>
<td>1.00</td>
<td>.00</td>
</tr>
<tr>
<td>other</td>
<td>.44</td>
<td>.05</td>
</tr>
</tbody>
</table>

Question 13 Please describe how you feel about the impact this work has or has not had on you generally.

<table>
<thead>
<tr>
<th>Feeling</th>
<th>Kappa</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>feeling drained</td>
<td>1.00</td>
<td>.00</td>
</tr>
<tr>
<td>a positive aspect of this work being listed</td>
<td>.73</td>
<td>.00</td>
</tr>
<tr>
<td>a negative aspect of this work listed.</td>
<td>.51</td>
<td>.3</td>
</tr>
<tr>
<td>neutral reaction.</td>
<td>.70</td>
<td>.01</td>
</tr>
<tr>
<td>other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Question 15b: why did you seek to increase/decrease your level of trauma work?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Kappa</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>increased level of trauma work due to skill/developing skills in this area</td>
<td>1.00</td>
<td>.00</td>
</tr>
<tr>
<td>increased level due to other reason.</td>
<td>1.00</td>
<td>.00</td>
</tr>
<tr>
<td>decreased level of trauma work due to lack of skills in the area</td>
<td>1.00</td>
<td>.00</td>
</tr>
<tr>
<td>decreased level of trauma work due to an emotional reaction to this work</td>
<td>.74</td>
<td>.02</td>
</tr>
<tr>
<td>decreased level of trauma work to 'balance' caseload.</td>
<td>1.00</td>
<td>.00</td>
</tr>
</tbody>
</table>
Appendix R4:10

Diagnostic Criteria (DSM-IV, APA, 1994) for Post Traumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

1) the person experienced, witnessed, or was confronted with and event of events that involved actual or threatened death or serious injury, or a threat to the physical integrity of others.

2) the person’s response involved intense fear, helplessness, or horror. Note. In children, this may be expressed instead by disorganized or agitated behaviour.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

2) recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content.

3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific re-enactment may occur.

4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three of the following:

1) efforts to avoid thoughts, feelings, or conversations associated with the trauma.

2) efforts to avoid activities, places or people that arouse recollections of the trauma.

3) inability to recall and important aspect of the trauma.

4) markedly diminished interest or participation in significant activities

5) feeling of detachment or estrangement from others

6) restricted range of affect (e.g. unable to have loving feelings)

7) sense of foreshortened future (e.g. does not expect to have a career, marriage, children or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1) difficulty falling or staying asleep

2) irritability or outbursts of anger

3) difficulty concentrating

4) hypervigilance

5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

with Delayed Onset: If onset of symptoms is at least 6 months after the stressor

Extracted from American Psychiatric Association (1994), *DSM-IV* p 427-8
1 March 1999

Ms Jackie Alt
Flat C
166 Springfield Road
Brighton
BN1 6DG

Dear Ms Alt

Do therapists experience intrusions? A survey of therapists in the South Thames and London region. (ACE/98/49/Psych)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol and the subsequent information supplied, and has approved it on the understanding that the Ethics Guidelines are observed.

This letter of approval relates only to the study specified in your research protocol (ACE/98/49/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions and if the study is terminated earlier than expected (with reasons). I enclose a copy of the Ethics Guidelines for your information.

Yours sincerely

Helen Schuyleman (Mrs)
Secretary, University Advisory Committee on Ethics

cc: Professor L J King, Chairman, ACE
Dr E Dunmore, Supervisor, Psychology

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