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DISCUSS THE IMPLICATIONS OF THE NICE GUIDELINES FOR THE TREATMENT OF DEPRESSION FOR THE FUTURE OF PSYCHODYNAMIC PSYCHOTHERAPY IN THE NHS.

Is talk cheap?
Nice headlines:

National Institute for Health and Clinical Excellence (NICE) guidelines feature regularly in the media, often when decisions made at a national level conflict with the interests of an individual. Few could argue against some rationing in the NHS but the Institute's widely-reported decisions on beta-interferon for multiple sclerosis, the insulin inhaler Exubera and, more recently, the Alzheimer's disease treatment Aricept have, fairly or not, led to them being cast as a bureaucratic Goliath obstructing patient David's access to essential medication.

To tease out any links between the guidelines and the future of psychodynamic psychotherapy, I will take a historical, cultural and vocational view of the NICE recommendations on treatment for depression. In my experience as a trainee clinical psychologist, depression is a spectrum disorder with recognisable symptoms but precise definition is elusive. Similarly, the different therapeutic models used by clinicians do not appear discrete in practice. If, during a cognitive behavioural therapy (CBT) session focussed on thought, feeling and behaviour, I ask about the patient's childhood, am I switching to the psychodynamic model with its emphasis on relating early experiences to adult behaviour? And if I then ask about the patient's family, am I taking a systemic view? Clinical judgement is accommodated in the guidelines but NICE is fairly unequivocal in its preference for CBT and pharmacological intervention over psychodynamic or other therapies. The guidelines apply to NHS services in England and Wales and are recommendations, not rules, but as the vast majority of therapeutic work is done within the NHS, this hierarchical view of therapeutic models, with CBT at the apex, could have substantial implications for the future of psychodynamic therapy.

The costs of depression

Given the complexities and size of a publicly funded national health service, some form of structure to clinical practice seems desirable for disabling and enduring
conditions such as depression. Lepine et al (2005) found employees with major depression took an average of 13 days off work due to illness, compared with 2.5 days for those without depression, and Andrews et al (2005) found recurrence rates after one significant episode are around 50 per cent. Layard (2006) reports that among adults with long term mental health issues, fewer than one in four have jobs - the lowest employment rate for any of the main groups of disabled people – while Monk (1987) found suicide rates in patients with depression were eight times higher than that of the general population. But the costs of depression are not only borne by those who are diagnosed. The stigma associated with mental illness may lead to undiagnosed sufferers presenting to primary care with physical symptoms, tying up resources in investigations and treatment.

Although the diagnosis and treatment of depression is still evolving, the economic costs have been known for some time. Kind and Sorensen (1993) estimated the annual cost of depression at £420 million in direct terms (hospital admissions, GP costs and drugs) and nearly £3 billion in indirect (lost earnings). Layard (2006) estimates depression now costs the economy some £17 billion a year and cites mental illness as today's greatest social problem. Globally, the World Health Organisation (Ustun 2000) estimates that mental health accounts for over 15 per cent of the burden of disease in Western economies (greater than that caused by all cancers). Nor is the future bright, Murray and Lopez (1997) estimate that by 2020 depression will be second only to heart disease as the leading cause of disability adjusted life-years.

**Nice guidelines**

To chart the implications of the guidelines, it may be helpful to examine their provenance. Until NICE was established in 1999, each medical speciality produced its own guidelines but this had prompted concerns about their quality, reliability, and independence (Grilli et al 2000). There was also some debate about the so-called "postcode lottery" of health provision, where the availability of treatments appeared dependent upon the NHS Trust area in which the patient happened to live, and it was in this climate that NICE came into existence charged with assessing treatment options in England and Wales on the basis of cost-effectiveness.
According to NICE’s online mission statement, the process starts with an independent academic centre drawing together and analysing the published information on a topic and producing an assessment report. Input is then invited from patient groups, health care professionals and, if appropriate, pharmaceutical or medical equipment manufacturers. After successive rounds of consultation and feedback, the final appraisal determination is submitted to NICE for approval. The process is based on "clinical and cost effectiveness" according to the Institute and takes into account both desired medical outcomes and economic arguments.

**Treatment of choice**

Psychodynamic therapy may not sit easily within the medically-modelled NHS. Psychotherapists use a process of formulation that may appear similar to diagnosis, with its emphasis on summarisation and prediction, but there are subtle and significant differences. Diagnosis is generally thought of as a summary label, such as paranoid schizophrenia or Parkinson's disease, and in practice rarely takes into account social, situational or personality factors. This is useful for categorisation but any quantitative statistical function restricts diagnosis to a limited menu of standardised terms. By identifying what a patient has in common with others, diagnosis may be reduced to a functional naming role which, while essential for the management of resources, fails to identify what is unique about the patient's presentation in the way formulation does.

In the hierarchy of NICE options, the treatment of choice for moderate, severe and treatment-resistant depression is CBT while psychodynamic psychotherapy may be considered a potential intervention if there are complex co-morbidities as well as depression. Electro-convulsive therapy (ECT) may be prescribed for immediate relief of severe symptoms in those with severe depression if alternative interventions have not worked and if there is a potentially fatal risk to the patient’s health.

Healthcare staff are expected to take full account of the guidelines when utilising clinical judgement. However, health professionals are still responsible for making decisions germane to the individual patient’s situation, after discussion with the patient, guardian or carer. But why is CBT the preferred treatment for depression?
NICE (2004) defines depressive symptoms as low mood or loss of interest, usually accompanied by diminished energy; changes in appetite, body mass or sleeping patterns; reduced capacity for concentration, feelings of guilt or low self-worth and suicidal ideation and recommends patients suffering from depression receive CBT treatment in 16-20 sessions over 6 to 9 months. CBT is also recommended for patients who refuse anti-depressants or for whom the avoidance of side effects is a clinical priority; in situations where brief intervention has failed and for recurrent, chronic and treatment-resistant depression.

**Degrees of depression**

For mild depression, the guidelines recommend low-level interventions such as sleep and anxiety management, watchful waiting, exercise and guided self-help or brief psychological intervention. But for moderate to severe depression, CBT is a mere hand-maiden to the cheapest, simplest alternative: medication. The guideline is unequivocal: "Antidepressants are as effective as psychological interventions, widely available and cost less." (NICE, 2004, p18). But this rings alarm bells with me. By determining the availability of therapeutic interventions on the basis of availability and cost, NICE may be sleep-walking into the arms of the pharmaceutical companies, for whom availability and cost are foot soldiers in the market-share war. And given the widespread and ongoing debate over the mechanism of neurotransmitters and antidepressants, NICE's emphasis on medical models and medication is open to question. Lacasse and Leo (2005) challenge the hypothesis that depression is caused by low levels of serotonin by illuminating the problematic nature of "reasoning 'backwards' to make assumptions about disease causation based on the response of the disease to a treatment" (Lacasse & Leo, 2005, p1212, authors' italics). "If aspirin cures headaches that does not prove that headaches are due to low levels of aspirin in the brain" (Lacasse & Leo, 2005, p1212) but that would appear to be the assumption behind the application of selective serotonin re-uptake inhibitors (SSRIs). Roggenback et al (2002) found confounding evidence over the link between behaviour and levels of serotonin and Heninger et al (1996) suggest the monoamine systems merely modulate other neurobiological systems which have a more primary role in depression. Demands for more investigation of monoamine systems such as the
serotonergic are insistent but appear to be unheard over the roar of the SSRI juggernaut. The top 5 best-selling SSRIs notch up annual sales totalling $7billion for pharmaceutical companies that spend more on marketing than on research and development according to Grabowski et al (2004).

**CBT: a good fit?**

So why chose a CBT/pharmacological intervention over any of the other talking therapies? CBT focuses on the relationship between thoughts, feelings and behaviours, the premise being that psychological problems are the products of thinking errors. It would be difficult to sum up psychodynamic or systemic approaches in a dozen or so words. And it is not only CBT's transparency and apparent simplicity which makes it attractive to health authorities and government departments. CBT may be popular among policy makers because of its apparently rational and logical basis which resonates with a committee culture and its agendas, rules and quests for order. Psychodynamic models do not offer the certainty of CBT either. Howard (2006) highlights the discomfort many may feel in the psychodynamic paradigm where actions are driven by attempts to keep uncomfortable - and unconscious - truths from our conscious awareness, a proposition that may be challenging to people more used to exercising almost unhindered control over their environment.

Therapies, like celebrities, also depend on reputation and CBT is developing a peerless media profile. Typical of some broadsheet newspaper coverage is the Guardian's breathless article (Pidd 2006) on CBT's reputation as a "cure for just about everything, from depression and phobias to schizophrenia, ME, obsessive compulsive disorder and obesity". It also refers to an obscure pilot study of women who had not had a period for at least six months, in which CBT appeared to kick-start ovulation.

Media coverage appears to have contributed to CBT's popularity, sustaining it as a powerful brand which can make it appear more contemporary than psychodynamic psychotherapies. In the age of MP3s, PCs and SUVs, CBT even sounds more up-to-date than a multi-syllable Greek-derived name. CBT is also a quick-fix that appeals to our consumer instincts for speedy results and easy answers. Depression, with its symptoms of inactivity and isolation, disables people in terms of their ability to
contribute to an individualist, consumer-focussed society. In capitalist countries, a quick fix can be a welcome means to reintegrating a 'lost' consumer.

There is, however, a contemporary cultural trend that, at first glance, seems to favour a psychodynamic approach over CBT. It is the culture of revelation in which individuals, unfettered by modesty, feel compelled to reveal to strangers their inner emotional world in a reality TV-type scenario. On examination though, this trend has an ambivalent impact on any debate over therapeutic models because central to this culture is the idea that nothing should be tolerated which would prevent an individual from attending to his or her emotional needs. Certainly not hard work, sacrifice, altruism and commitment. These values are devalued and presented as being antithetical to the individual quest for happiness whereas psychodynamic therapy places them at the heart of its culture. It also seems that CBT might be an easier cultural fit for the bureaucratic mindset. Williams (2001) describes a simple cognitive-behavioural model of mood disorder with social dimensions (marital or occupational), cognition dimensions (helplessness and self-blame), behavioural dimensions (alcohol or drug abuse, risk-taking behaviour) and physical dimensions (appetite and fatigue). This model of CBT can be seen as a microcosm of target-setting and diktat, much favoured by governments and exemplified in the drives against alcohol consumption and anti-social behaviour. Prime Minister Tony Blair even has his own "happiness guru", economist Professor Richard Layard, who wants to make CBT available for the one million people who receive incapacity benefit because of mental illness. Layard (2006) claims that after fewer than 16 meetings with a therapist (costing some £750 to the public purse), at least half of those with depression or clinical anxiety could be cured. (And all this from a structured conversation and maybe a little homework. So is CBT a cure-all or snake oil?)

The new coca-cola?
A Maudsley Debate at the Institute of Psychiatry in London last year (IOP 2006) was provisionally entitled: "CBT is the new global coca-cola - this house believes that CBT is sugary, sweet and bad for you" although ultimately it was re-titled "CBT is the New Coca-Cola: This house believes that cognitive behavioural therapy is superficially appealing but over marketed and has few beneficial ingredients". This
scepticism appears to be justified as the evidence base for CBT is mixed. McPherson et al (2005) call for trials of psychological interventions for treatment-resistant depression which have larger samples, test a greater range of treatments (such as novel CBT or psychodynamic treatments), use a greater range of outcome measures and have follow-up periods of longer duration.

Westen and Morrison (2001) suggest the question is not whether practice should be evidence-based but what kind of evidence should be the basis of practice but it cannot be denied that CBT maps onto a structured political system in a way that psychodynamic cannot. The psychodynamic approach is a paradigm rather than a discrete method, modelling the mind in terms of unconscious processes which by definition are difficult to measure or manage. In psychodynamic therapy, it is assumed the unconscious elements are dynamic, hence purposeful, acting as motivators for behaviour feelings and fantasies (Morriss 2006). In psychodynamic formulations, the mind contains representations of the self and the external world, including other people, referred to as objects. Psychodynamic risk factors for depression include low actual self-representation (distorted body image, little achievement), unmodulated, primitive superego or unrealistic and over grandiose ego ideal. However, the government has never launched a Christmas campaign to improve low actual self-representation and there is no Ministry of the Id or amendment to the Superego Act.

**Structural flaws**

NICE guidelines acknowledge "significant limitations to the current evidence base" but the flaws may be structural. Is the evidence-based model (EBM), which may privilege certain kinds of econometrically derived types of studies over others, appropriate as a tool to separate therapies? Evidence based intervention sets the randomised controlled trial as the gold standard but there are plainly areas where such trials would be simply unethical such as in open-heart surgery.

According to the Centre for Evidence-based Medicine (CEBM 2006): EBM is the "conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients". This involves integrating individual clinical expertise with the best available external clinical evidence from systematic research so
that health professionals can use individual clinical expertise and the best available external evidence as neither alone is enough.

Availability of evidence may be the first hurdle and failure to publish negative trials is problematic. Positive trials present different issues. Reports of treatment effectiveness in clinical studies may be higher than that achieved in routine clinical practice because closer patient monitoring during the trials could lead to higher compliance rates. Haynes et al (1996) reported adherence rates for prescriptions of around 50%, unlikely to be tolerated in any clinical trial.

It could also be argued that lack of evidence is not the same as lack of benefit. The more data are collected, the more problematic is a comparison between patients in the studies with patients in the clinic as EBM applies to populations but not necessarily to individuals. Tonelli (2001) is quite emphatic that "the type of knowledge gained from clinical research ...is itself insufficient to provide for optimal clinical care. A gap exists between empirical evidence and clinical practice."

Financial considerations have an impact even at this stage. Randomised double-blind placebo-controlled trials are expensive to run; both public health bodies and pharmaceutical companies have powerful, if contradictory, financial incentives so public authorities may be inclined to fund preventive medicine studies to improve public health as a whole, while pharmaceutical companies fund studies intended to demonstrate the efficacy and safety of specific drugs.

Nor do evidence-based guidelines remove the problem of induction. Scepticism about results may invade areas not explicitly covered: a drug may influence blood pressure, glucose, or cholesterol levels but lack the power to demonstrate an overall decrease in mortality in a population. That gives sceptics ammunition to argue that the treatment not be used until it can be shown to save lives because crucial evidence is lacking. This makes for a cumbersome approval process which may slow or even stall the delivery of interventions.

Ramiﬁcations
A process skewed toward a structured evidence-based model is unlikely to favour a psychodynamic approach. Given NICE’s bailiwick, the ramifications for patients, the NHS, psychodynamic therapists and the broader clinical professions are multifarious.

For patients, NICE may mean there is less access to psychodynamic therapies (as there will be fewer of them and spread further apart) and there could be fewer therapies that are meaningful to them. If psychodynamic and other therapies are allowed to wither, CBT could be over-prescribed to ubiquity like antibiotics. Also, it appears that CBT is designed to treat relatively healthy individuals with discrete problems, for which the client willingly cooperates on one goal at a time. Most of the clients I’ve seen have chaotic lives and while the session may be structured it does not run to an agenda. However, if CBT is to be the predominant model, economies of scale may make training and delivery cheaper within the NHS and that, while chiming with the target culture, may reduce the tax burden as a whole.

For therapists who work both privately and within the NHS, a diminution of psychodynamic availability in the public sector could increase demand in the private sector but within the NHS there may be less scope to exercise clinical judgement. In terms of work culture, a focus on CBT could exacerbate a sense of isolation which I have observed among psychodynamic therapists and which, to an outsider, may be misconstrued as elitism. It seems inevitable though that it would dilute the expertise of clinicians if CBT were the only model to survive in a profession which previously prided itself on its capacity as a broad church.

Learning and developing new skills and modalities is very important for staff motivation so the NICE guidelines could eventually disincentivise the profession as a whole. The guidelines may also be another step down the road toward regulation. The provision of CBT is currently unregulated and anyone can set themselves up as a therapist despite the existence of an accrediting body, the British Association for Behavioural and Cognitive Psychotherapies.
To sum up I should concede that I may have been lured into a reductionist argument between CBT and psychodynamic but a hierarchical view may mean therapists lose a useful tool because it's not the most useful tool. If changing our thoughts had a direct mechanical impact on feelings and behaviour, I should be able to memorise new beliefs and be done but it plainly is not that simple.

Could the lasting impact of the guidelines be to galvanise a notoriously fragmented profession? Because while politicians, and political culture, may prefer a quick fix, public policy is not fixed. CBT's cheapness may be inseparable from its short-term action but the government has shown, in its attitude to climate change, that it can embrace an aspiration for long-term goals.
References


WHAT ARE SOME OF THE STRENGTHS AND WEAKNESSES OF MULTIDISCIPLINARY TEAMS FROM THE PERSPECTIVES OF STAFF AND SERVICE-USERS?

HOW CAN YOU AS A PSYCHOLOGIST CONTRIBUTE TO TEAMS FUNCTIONING OPTIMALLY?
Introduction
A truly solitary human existence is so rare as to be almost unknown. Dunbar’s (1993) ethnographic investigation suggests that for the last 250,000 years man has lived in groups as small as 30 or as many as 150 but very rarely outside these parameters. Dunbar argues that the size of the group is a direct consequence of a primate’s neocortical capacity for social interaction which raises questions about whether man has a hard-wired need to live in a group. In the developed world it would be almost impossible to live entirely without human contact. Even the planet’s most inhospitable environments are populated to some degree, several dozen scientists are permanently stationed at the South Pole and a handful circle the earth in the International Space Station – none of them alone. In biological terms, the demands of sexual reproduction mean isolation is a guaranteed route to the extinction of your gene code and it is evident from natural history that animals which live in packs are often successful species. Packs of dogs, colonies of ants and schools of fish offer a greater chance of survival to the individuals and those that live apart from the pack may more easily end up alone, under-resourced or eaten. But while man has long been a social animal, the nature of that sociability is changing, especially in the developed world. We rarely eat what we kill. Instead, we may eat what someone on another continent has killed and rely on a complex infrastructure involving dozens of other people to bring it to our door. Technological innovation has also influenced our social interactions. On the fringes of living memory, it may have been possible to enact a social life almost entirely via face-to-face contact. Not anymore. The postal service, mobile phone and internet have facilitated anything but face-to-face contact while new technology has also fuelled our reliance on groups. Our homes are commonly littered with machines and systems of which we have little understanding and which require someone else’s expertise to maintain. So, in the developed world, hunting and gathering now demand the collaboration of thousands meaning that team-work is not a new thing but a familiar human experience.

Inevitably, our working lives are enacted in teams. Mechanisation and urbanisation have increased the prevalence of the group experience and the different forms those groups may take are myriad. ‘Teams’ can play football, carry out surgery, topple governments and put men into space. Britain’s 1.3 million-strong National Health
Service could be seen as one of the largest teams on the planet and the focus of this essay will fall on multidisciplinary teams comprising clinical psychologists and other mental health professionals.

Collaboration

While collaboration may be a common human experience, it brings with it certain complications, not least the increased demands made on language skills. Communication is necessary to co-ordinate effort and the clarity required appears proportionate to the consequences of failure. Consider the pilot and air traffic controller involved in flying an aircraft. If their common goal of flight safety is compromised the results could be catastrophic, so very strict rules of communication have evolved. Individual letters are spoken with a universal phonetic alphabet, terminology is specifically prescribed and crucial information is repeated for clarity. But for pilots and air traffic controllers, their common goal appears discrete and quantifiable: they want to fly from A-B without crashing. What if the common goal is more complex, as in the case of a multidisciplinary team? Is success measured in financial terms, service-user satisfaction or clinical outcome? Is the effectiveness of service-user care, for instance, measured by mortality rates, quality of life measures or the length of time service-users must wait for treatment. For multidisciplinary teams, goals are difficult to quantify and maybe mutually exclusive; their interpretation and enactment mean goals requires choices and choices can bring conflict.

Free will may be one of the defining elements of humanity but human responses are often contextual. Lives are shaped by choices made for us and about us, from where we live and who we live with to what brand of toothpaste we use. Given the exponential permutations of those choices, it would seem extremely unlikely that many people will make the same sequence of choices over a single day so, as soon as two people collaborate, there is an inevitable tension between their preferred choices. Extrapolate those tensions into a multidisciplinary team with a dozen members and it would seem unlikely that any two will agree on every aspect of the service on offer.

The mental health context
Multidisciplinary teams have long been part of the National Health Service but their increased use in mental health settings can be traced to ‘New Ways of Working’, an initiative implemented by the National Institute for Mental Health in England on behalf of the Care Services Improvement Partnership, in turn commissioned by the Department of Health (Ruhstaller 2006). In order to explore the practical ramifications of team-working, this essay will focus on Community Mental Health Teams and Child and Adolescent Mental Health Services, as they lie within the experience of the author.

Communication

It seems inevitable that each discipline involved in a multidisciplinary team will have its own style of communication. Nurses’ and doctors’ communications each exhibit their own distinct features (Collins 2005) as do pathologists and radiologists (Kane et al 2007) but for a team to be effective, all participants must share a common understanding of the terms of reference. This may put the service-users and carers at a disadvantage as their communication will be vernacular and the multidisciplinary teams’ quite specialised. Also, Magnus and Turkington (2007) found that familiarity with the health professional was significantly associated with service-users’ satisfaction, in terms of their communication. If the service-user-professional relationship is diluted in a multidisciplinary team – when compared with a one-to-one relationship – there may be some danger that communication between service-users and professionals will suffer.

Inter-team communication could also lead to jargon and abbreviation as familiar phrases are rendered in linguistic shorthand for brevity and this may be problematic. Hamilton et al (2006) found that the use of jargon excluded service-users from participating in their own healthcare and the tendency to abbreviate can also be counter-productive. Doctors’ use of abbreviations in medical notes has put service-users’ lives at risk (BBC 2007) and the UK’s Medical Defence Union said some service-users have had the wrong limb removed and others have been given deadly drug doses.
Communication can also contribute to the formation of stereotypes (Karasawa et al. 2007) as remarks may both form and maintain collectively shared representations. Consequently, stereotypical beliefs around social groups and categories are often highly consistent due to the concordant influence of social learning from parents, peers, and mass media. Methodologically, however, it is difficult to extrapolate from this study to a real-life multidisciplinary team process as the questions—which were used to elicit ratings of stereotypical behaviour—were in a forced-choice format whereas established clinical teams may have an ongoing debate about the possible solutions to a problem before they even get to decide which solution to adopt.

Conflict

If it is accepted that, from an evolutionary perspective, operating within groups has advantages, then the corollary must be that to be outside the group is disadvantaged. One of the most common ways of categorising groups is to model them as social identities or in-group and out-group (Tajfel 1981). In-group could be a family, favourite football team or religion while out-group would be everyone outside the family, the opposing team in a match or anyone of a different religion. It could be postulated that in a multidisciplinary team colleagues in the same discipline are more readily identifiable as in-group than colleagues from other disciplines in the same team. For example, clinical psychologists are likely to have followed very similar training paths or even attended the same institutions and this may lead to a stronger in-group identity for fellow clinical psychologists than for other members of the multidisciplinary team such as occupational therapists or social workers. So a multidisciplinary team may foster a dyad which turns professional loyalty into team antagonism but, in practice, the dimensions of the in-group/out-group paradigm appear infinitely complex. Each individual within a team may see others as in-group by virtue of their age, gender or race rather than out-group by virtue of their discipline while the career path followed by different team members may have engendered a sense of distinctiveness and differentiation which may also make team-work problematic.

De Dreu and Weingart (2003) suggest that conflicts are concerned with either relationship or task issues. Relational conflicts centre on “personal taste, political
preferences, values, and interpersonal style” (De Dreu & Weingart, 2003, p.741) while task conflicts are concerned with the “distribution of resources, procedures and policies, and judgments and interpretation of facts” (De Dreu & Weingart, 2003, p.741). In multidisciplinary teams, the financial climate may provoke a higher number of task conflicts as New Ways of Working is seen as the necessary tool to achieve or maintain financial balance (CSIP/NIMHE (2007) while more than half of the English mental health providers reported being requested to reduce the number of personnel in clinical positions without adversely affecting service delivery. If choices available are not entirely positive or negative, then a process of dissonance may lead to a polarisation of views (Aronson 2004). A team trying to reconcile the provision of care with a desire to reduce waiting lists face just such a ‘shades of grey’ choice. Those team-members preferring to focus on the provision of care are exposed to the dissonance of static waiting lists. In order to reduce such dissonance, team members who supported the decision might seek out exclusively positive information about the provision of care and so increase the polarisation of views within the team and create fault lines which will shape their allegiances in future decisions. This could foster ideological rigidity within the team and so lock them in endless debate; however, Kee (2004) demonstrated that team discussion did not improve the quality of decision-making overall.

Power
As well as fomenting task conflicts, New Ways of Working may have perpetuated a perceived hierarchy in multidisciplinary teams as it initially focussed only on consultant psychiatrists - to the exclusion of the rest of the mental health team. If it is accepted that power is a relational property which describes the extent to which one person can influence or control the behaviour of another then its role in multidisciplinary teams is evident. What is less transparent is how power is attributed and manifested. A clinical psychologist in an multidisciplinary team is answerable to several colleagues including a supervising clinician, professional lead, team lead and team manager but, outside this structural hierarchy, power is also sustained by status and status by pay. Unfortunately, the NHS’s Agenda for Change appears to have missed an opportunity to address this issue for all its employees despite describing the Agenda as a radical shake-up of the pay structure within the NHS.
For the first time staff are now paid on the basis of the jobs they are doing and the skills and knowledge they apply to these jobs.

(NHS Employers 2007)

While this is a laudable aspiration it may have fossilised a power imbalance between doctors and the rest of the workforce because the Agenda – although it applies to over one million NHS staff – does not apply to doctors, dentists and the most senior managers. In the most recent progress report, (CSIP/NiMHE 2007), NWW promotes the distribution of responsibility among team members rather than assigned by an individual member of staff such as a consultant but it is difficult to see how this change in responsibilities can be enacted among colleagues who are subject to different pay scales.

Accountability may also be a factor in the attribution of power but new legislation may enable a broader range of disciplines to take clinical responsibility. The Mental Health Act 2007 changes the roles available to clinicians in carrying out responsibilities described in the Mental Health Act 1983. The 1983 Act establishes the circumstances in which people with mental disorders can be detained for treatment without their consent and sets out the procedures professionals must follow to ensure that service-users are not inappropriately detained or treated without their consent (Mental Health Act 1983). The role of Responsible Medical Officer was enshrined in the 1983 Act as a clinician with overall responsibility for someone receiving compulsory treatment who decides when service-users can be discharged or allowed out on leave - a role only open to doctors. Under the 2007 Act, the role of RMO will be replaced with that of Responsible Clinician, which will be open to a range of trained and competent mental health professionals, in addition to doctors, and will liaise with multidisciplinary teams (CSIP/NIMHE 2007). Similarly, the role of Approved Social Worker will be replaced by Approved Mental Health Professional (AMHP) and opened up to a wider group of mental health professionals, with appropriate training and qualifications, in addition to social workers.

Alternate perspectives
Staff may benefit from the alternate perspectives engendered in a multidisciplinary team. For a psychologist with a background in psychodynamic therapy - with its emphasis on motivations and drives buried deep in the service-user’s past – the input of a family therapist may allow a broader perspective of the service-user’s situation. Similarly, a family therapist may find a psychodynamic formulation a useful counterbalance. But for service-users – without the familiar ground of a well-known model of therapy – the alternate perspectives could be bewildering. Is their anxiety the manifestation of a deeply buried murderous impulse or the result of a negative core belief? Is it possible that by blending the inputs of various disciplines the resulting service offered by a multidisciplinary team is bland and mediocre with staff using diluted skill sets as opposed to specific tools?

Also, if a mental health professional is the only representative of their discipline in a team, that isolation may foster a sense of vulnerability. If a team is dominated by proponents of a medical model of therapy, then the dissonance which fractured the decision-making process could also lead to a proponent of a bio-psychological-social model ultimately disengaging from the team rather than spending their working day in a state of tension with their colleagues.

Diversity
As most of the information and decision-making is vested in the health care professionals, service-users and carers may feel disempowered – a sentiment which can only be exacerbated if there are issues of diversity in that power-imbalance too. By increasing the number of staff involved in a service-user’s care, multidisciplinary teams may be more representative in terms of race, age or ethnicity.

Organisational costs and benefits
Multidisciplinary teams may offer advantages to the management of service-user care which benefit both team members and, indirectly, service-users and carers. As new technology plays an expanding role in caseload management, multidisciplinary teams support the standardisation of management tools so improving their efficiency. However, multidisciplinary teams may also require more resources. If clinical assessments are to reflect the aspirations of multidisciplinary teams then more than
one professional should be involved in the process so more staff will be needed to carry out assessments. For service-users, there may be organisational benefits in that the one-stop-shop nature of multidisciplinary teams may mean they have to make fewer visits to the clinic.

A psychological contribution
In the wider context of the NHS and restructuring clinical teams has been shown to contribute to higher rates of dissatisfaction, burnout and absenteeism Kuokkanen (2007). If conflict is an unavoidable consequence of interprofessional working, are psychologists better equipped for conflict resolution? (?) Understanding: all of these can be factors in therapy: psychologists should bring skills of empathetic listening, reflection and language to discuss human behaviour

Bamford (2007) found emotional intelligence of team members influenced team effectiveness, the quality of client care, staff retention and job satisfaction. Particularly difficult for psychologists as everyone can have a psychological understanding. So, must maintain specialist knowledge without crossing in to insularity and argot.

Reflection
While recognising the aspirational nature of the Agenda for Change and New Ways of Working, my experience of multidisciplinary teams is that they fall short of addressing some fundamental needs of service-users, clinicians and the service. Respectively, the areas that appear most important to me are that the discipline is not very diverse; consultant psychiatrists appear unwilling to share their historically inherited power and team discussion can lead to team inertia. The issue of diversity may be best addressed from a training perspective and more investigation is needed to understand why white women appear over-represented among trainee clinical psychologists. Among the many factors which may influence attributed power in multidisciplinary teams, I recognise the pragmatic attraction of the ‘certainty’ of the medical model compared with the ‘continuum’ paradigm in psychological approaches. Continuing professional development may be one route to improving
multidisciplinary team functioning but if different disciplines are to work together, surely they should learn together. Halfway through post-graduate training in clinical psychology I have had no contact with occupational therapists, psychiatrists, community psychiatric nurses or social workers to specifically address their different perspectives in an academic environment. Is this omission sustaining professional tribalism? Lastly, in my own team-working experience prior to clinical psychology I found those most productive where a balance was struck between sharing opinions and making decisions. Endless polishing of fundamentally sound objectives can lead to inaction and I have come to prefer a good plan which can be enacted today over a perfect plan which cannot be enacted until tomorrow.

Conclusion

The involvement of service-users and diverse professions in multidisciplinary teams appears a commendable process of democratisation but notwithstanding the implementation of the Mental Health Act 2007 in October 2008, it appears largely unachieved. This failure may be traced to the poorly defined objectives of the institutional changes. The Care Services Improvement Partnership (CSIP) offers no definition of clinical or professional leadership and while the mission statement refers to “strategic vision and driving service improvement and effective team working to provide excellence in service-user/client care” it also concedes that further work needs to be done. This lack of focus is revealed by the CSIP objectives:

- making the best use of the current workforce
- providing job satisfaction and career development for staff
- providing services that meet the needs of service users and their carers
- providing services that make efficient use of resources.

(CSIP/NiMHE, 2007, p20)
Has anyone argued for making the worst "use of the current workforce" (CSIP/NiMHE, 2007, p20)? Or proposed denying "job satisfaction" (CSIP/NiMHE, 2007, p20)? Providing services that don't "meet the needs of service users and their carers" (CSIP/NiMHE, 2007, p20) or are inefficient uses of resources? Nothing about how these objectives are achieved or how success could be measured. So bland it could have been thought up by a team.
References:


Year 1 PBL

The Relationship To Change

1,842 words
It seems impossible to trace the provenance of my relationship with other members of Case Discussion Group 2. I had met the whole year for the first time on the induction day but there was a pre-existing, nascent connection that had developed over several years. One early form of the relationship existed between being offered a place on the course and the start of term. We had got in touch with each other by e-mail and I, like everyone else I imagine, watched the exchange and tried to prise out clues to the character of my fellow trainees. Somebody asked about accommodation in Guildford. Someone else suggested meeting before the course started. The e-mails were straightforward and information-based, focussing on when and where to meet for lunch, but still I tried to wring some interpretation from them. Who were these two dozen strangers who would be, at the very least, my colleagues for the next three years? Their names gave some clues. Five men and 19 women. Slightly higher proportion of males than I expected. When studying for my undergraduate degree, only 10 per cent of the students were male but the one third/two third ratio was similar to that found in journalism, my previous career. There was also a projection of characteristics based on the familiarity of surnames; unconscious but probably unavoidable. Lots of British family names but also a few that might originate elsewhere in Europe or Asia. I had lived in Amsterdam, Sarajevo and Hong Kong, maybe that would give me some common experience that would be useful for those first anxious conversations. And what would they make of ‘Martyn Bignold’?

But I must go back even further to find the source of my relationship with other trainees as, even in the summer of 2006, it was already criss-crossed with associations and projections. I had been imagining what my future colleagues would be like since 2002 when I first anticipated changing careers from journalism to psychology. I had found a path that went via Graduate Basis for Registration to a PsychD, who else would be making that journey? Were those daydreams the initial source of my relationship with CDG2? What had informed my daydreams? The trace before that point is faint but I have effectively had a relationship with CDG2 since 2002 even though I did not meet them until 2006.
Dateline: Lecture Theatre K, University of Surrey, Guildford, UK.

September 18, 2006

We introduce ourselves, give out our foil-wrapped mini-biographies and start replacing projection and extrapolation with experience and acquaintance. One perceptive tutor asks who in the group feels like a fraud. I raise my hand and it is some relief to find most of the rest of the class do too. I also find myself taking shorthand notes, unconsciously modelling myself as a correspondent and the induction day as a news conference. But there was a practical purpose too. I need to put names to faces and there are so many new faces. Fellow trainees, admin staff, tutors: too many to remember in the first few days so it came as some relief to move into the smaller case discussion groups.

A large part of my career as a journalist had focussed on problem-solving. Working in a foreign, and very often hostile, environment meant there were many obstacles to getting the story and I enjoyed logistical, initiative-based challenges. The pressure of deadlines and finite resources also meant I had developed a preference for a good plan which could be acted upon today over a perfect plan that couldn’t be enacted until tomorrow. So, to work in a small group on a problem-based learning programme seemed very attractive.

Then the title of the project was revealed. We must make a presentation to the rest of Year 1 on: “The relationship to change.” We weren’t going to bridge a 12-foot river with only 10-foot planks or talk our way past drunken, Serbian border guards. I was baffled. Reverting to type I challenged the language. “‘The relationship to change’ is surely no more than a fragment of a sentence,” I thought. Maybe not incorrect but certainly inelegant. And is it ‘change’ as in ‘exchange’? Are we to discuss which relationship we should swap, one for another? Or is it meant to suggest the relationship with change. I was reassured that the rest of the group seemed equally bemused. We looked to each other for clarification. (In hindsight, the facilitator was at that moment probably ticking box 1 on page 1 of the group log book: “Do the team members look to each other for support?”)
Tentatively, themes were explored including what 'change' had meant to each of us. We cast around for models of change. Someone suggested a cycle of change model involving precontemplation, contemplation, action and maintenance. We debated whether we should fit theory to our experience or the other way around but agreed some structure was needed. We set ourselves homework and the project took on a more familiar, academic shape. At one point we shared positive and negative examples of a relationship to change. For the positive example, I wrote what became the introduction to the presentation:

"Our hominid ancestors were rarely the strongest or fastest animals in their habitat. There were bigger, fiercer animals on the savannah. But we were adaptable. With our rapidly evolving frontal lobes we could accommodate change, plan for it and enact it. And that gave us a small but significant advantage over other animals. So we colonised every kind of climate and terrain. New environments did not defeat us. And now we don't just accommodate change, we embrace it. We measure ourselves according to how we have changed the world."

The example I used of a negative relationship was the resistance that some people have to a change in the accepted meaning of a word. I had heard a BBC Radio 4 presenter bemoan the use of "gay" to mean homosexual rather than "happy", as it had in his youth. I prefer to think of language as an organic, evolving form so to insist that a word cannot develop a new meaning seems Luddite. I also felt his view was predicated on some self-importance in that the process of linguistic evolution should be halted to coincide with one man's career.

In retrospect I can see that my choice of examples were both very language-based and emphasised a strategic, informed view of the world. Was I clinging to the comfort blanket of my previous life as a journalist? Looking beyond the manifest content I can see the introduction reflected the change I was experiencing. The adaptability I had shown to plan and enact a career change. I was also, in a way, testing the group to see what value would be put on language skills and communication.
By this point the group had really gelled and we could discuss sensitive ethical issues and agree how to deal with them. The conversation roamed across Plato, I Ching and Buddha but it was eventually decided the better platform for our presentation would be the TV makeover show Trinny and Susannah. On the day of the presentation I became aware that we had a more rigid structure than many of the other CGDs and the costs and benefits became evident. While it was reassuring to work from a script we were familiar with, there was also little room for spontaneity.

The feedback was very useful, among the critiques it was noted we had not explored other models and there was very little reflectivity within the presentation, both valid criticisms and I certainly contributed to a pragmatic approach which meant that as soon as we had decided on the format we focussed on production rather than further exploration of alternative models.

‘Change’ for service-users

As I gathered my thoughts for this essay I have reflected on the meaning of change for the patients I see on placement. What we offer as psychologists seems to be the potential for change. From anxious to relaxed. From depressed to engaged. My first experience of CDG2 involved changing my relationship with them from that of strangers to colleagues as I changed from a journalist to a psychologist. Just as I could not identify the particular day on which I decided to change careers so, notwithstanding a discrete onset due to trauma or disease, it may be difficult for a patient to identify on which particular day they became depressed or anxious or compulsive. It may be useful to identify the transition from contemplation to action but it shouldn’t overshadow the relationship that already exists. I know the date on which I enrolled for a BSc in psychology but my relationship with psychology was already latent, fuelled by media representations, my own reading, the view of family and friends. For a prospective patient, making an appointment with their GP is a significant step but their relationship with psychology will have already been informed by their experience, the received wisdom of others, how psychology is talked about by those around them. Some may look forward to a life without depression or a return to what they think of as normalcy. Eating without guilt.
Drinking without excess. Each presentation is unique but the desire for change ubiquitous.

So the patient-clinician relationship is formed long before they meet face to face. Patients have associations with the word “psychology”. Their relationship with the clinician will be informed by the views they hold about a clinician’s race, background and gender. I don’t feel it’s a new relationship that starts when a patient and clinician meet for the first time but a new phase of one person’s relationship with psychology. It is not so much a case of building a relationship in that first session as building on a relationship.

I have one patient I see in a secondary care setting. He is a middle-aged white male. We have age and gender in common but little else. He is gay, I am straight. He is Scottish, I am English. He had no formal education beyond 15, I am studying for a doctorate. I have found him quite difficult to engage. In the weeks or months that he considered asking his GP for help with his intrusive thoughts, he may have had some idea of what a psychologist would do. He may have been in therapy in the past or know of the experience of others. He may have seen psychologists portrayed in the media. Inevitably he will have built up a relationship with a psychologist long before he met me. It was a relationship with someone who doesn’t exist, who he has never met and will never meet. But I try to accommodate that relationship as I engage him in the therapy. By working with the idea that I am not building a new relationship with the patient, but instead building on a pre-existing one, I hope my own prejudices and associations won’t obstruct the path to an effective therapeutic relationship.
Child protection, domestic violence, parenting and learning disabilities
Task
The scenario we were presented with featured three generations of the Stride family: parents who were illiterate and had learning disabilities and special educational needs; paternal grandparents (who lived locally and were supportive) and three-year old twin girls who were in short-term foster care and on the child protection register under the categories of emotional abuse and neglect. The CDG’s task was to conduct a full risk assessment and develop a rehabilitation plan for the children against the background of the local authority’s desire to place the children for adoption and the parent’s commitment to have the children returned to their care. When the third Problem-Based Learning (PBL) exercise was set, the Case Discussion Groups (CDGs) had been running for over a year and while this engendered a sense of familiarity and trust within the group it may have also meant that the novelty of learning via the PBL route may have waned a little. This dynamic was apparent throughout the process of assessing the problem and delivering the presentation but ultimately proved a useful route to reflect on the impact of personal perspective on clinical work, especially on assessment.

The group decided to approach the task by fleshing out the characters with improvised scripts in order to expand our understanding of the relationships involved. Each member of the CDG was responsible for ‘scripting’ one character and I asked to work on the paternal grandfather role: Grandfather Stride. According to the brief, the grandparents buy clothes and toys for the children and occasionally buy food for the family. The only information specific to the grandfather was that he suffered from a painful rheumatic condition. On re-reading the script I created for Grandfather Stride, I feel I may have focussed quite heavily on the impact of the rheumatism and extrapolated some impatience and resentment on his part towards the world in general and his son in particular. For instance, according to the script I produced, when he refers to his son, Grandfather Stride says “he should pull himself together” and he was a “lazy little bugger” who “never stuck at anything”. I was not alone in this rather broad-brush characterisation and at the subsequent CDG meeting, it became apparent that we had all produced quite stereotypical characters with a rather jaundiced view of the world and we joked about how they would all be at home on a TV soap. We went
on to discuss how the CDG may be at quite a low point, in the second year of a three-year programme, and this may have coloured our characterisations of the Stride family. It seemed to be a common experience that the initial buzz of getting a place on a doctoral course had worn off while qualification was still more than 18 months' away. On reflection, it was also evident that we spent a lot of time talking about behaviour, not motivation. The original scenario was informative in a functional way - containing biographical details etc – but did not present fleshed out characters.

**Personal reflection**

As well as our group perspective, the scenario had a particular resonance for me as my partner is expecting our first child and the insecurities that I imagine all prospective fathers face may have coloured my framing of the Stride’s position. I had, and still have, many doubts about my own capacities as a father and found them almost overwhelming in the first few weeks of my partner’s pregnancy. As a way of de-fusing that cognitive dissonance, I realise I may have been quite hard-line on the Stride’s situation. My own fears about whether I would become a good father were projected into the scenario and the voice that I gave to Grandfather Stride may have had some echoes of my own internal dialogue as I anticipated the care of my own family. By having Grandfather Stride be very critical about his son’s ability, I was addressing my own anxiety about my paternal abilities. Other members of the CDG shared their personal perspectives on family and parental responsibility and we agreed that we needed some way of understanding the Stride family which would avoid stereotypical characterisation and/or our own projected anxieties.

One group member suggested we recruit some help from outside the group and produce a video of the Strides to assist us in establishing them as real people. Actors were recruited and, working from the original PBL scenario, they were filmed speaking in character about their situation. This proved to be a really useful way of developing the characters without simplifying them and after watching the video we ‘went back to the drawing board’ to produce new scripts for the different roles involved. I was then responsible for the characterisation of a Community Psychiatric Nurse involved in the case and this second round of scripting proved much more fruitful. When we returned to share our work it was evident that by having ‘met’ the
Strides – or at least seen them chatting on a video – we had all been able to produce more ‘rounded’ characters.

Having seen how useful it was to work with well-formed characters, I suggested to the group that we take this process a stage further. I felt the first scripts were the product of a rather insular process. We had taken the working brief and tried to build on it from our own assumptions and attributions. By having two people from outside the group role-play the characters we had gained a useful strategic perspective rather than rely on an internally generated tactical view. My suggestion was that when we made the presentation to the rest of the year – and our assessors - we should invite two people from the audience to play the roles of Mr and Mrs Stride. I anticipated that this would illuminate the confusion that the Strides must feel as they meet the various professionals involved in their case. In the original brief, it was stated that their solicitors would often ‘read the reports out loud to them, usually once, and sometimes on the morning of a court hearing’. The Strides are unable to read and write so this conjured up a picture of two people quite literally struggling to make sense of the world. I thought that by having two ‘naïve’ members of the audience take their role it would become an experiential presentation that might offer a useful perspective on what it is to be illiterate in a system that communicates almost entirely in the written form. (This may have also been an echo of my own frustrations with the original brief: that, while it was factually accurate, it didn’t communicate the intricacies and complexities of the case). However, on discussing my proposal within the group, some problems emerged. Firstly, we could not be sure that we would be able to recruit anyone from the audience to take the role and while we may rely on the good nature of our fellow trainees to help by contributing, many would be quite uncomfortable with the sense of ‘helplessness’ which we were hoping to expose them to. Secondly, uncertainty about the presentation’s success resting on audience participation might provoke some anxiety within the CDG. I know that in the past I may have championed an idea because it was ‘my’ idea and I have seen how counter-productive that can be as it leaves colleagues feeling rail-roaded so I was ready to accede to the group’s decision that we would not recruit from the audience but, instead, play the video of the Stride role-play as part of our presentation.
By having the central characters acted out by people from outside the group we did avoid the gross simplification that beset the original scripting process but there were still some problems. Both the Grandfather Stride of the first script and the CPN character I played in the actual presentation exhibited some resentment which may have been a projection of my own resentment at the diminishing returns from a third problem-based learning exercise. And there may be an inevitable tendency toward over-simplified characters because we are training as clinical psychologists not scriptwriters. Even after making the Strides much more real in the video, the four characters played by women wanted to keep the twins with the family while the two male characters were the only professionals who wanted to take the children into care. Did this reflect some gender-based thinking on our part around the role of women as protectors of children?

Learning outcome
It is evident now that the PBL model has both strengths and weaknesses. It is useful as a way of exposing the CDGs to several scenarios but it requires a creative use of resources to make it relevant. The process could be improved by having service-users involved but that would raise issues of confidentiality, ethics and resource allocation. Secondly, although the scenario may be based on a real-life case, in order to communicate it to the CDGs, an entire family must be summarised in 800 words then ‘reconstituted’ by the CDG team. While this leaves room for creativity and interpretation within the CDG, this process of ‘first simplify, then exaggerate’ does not easily reproduce the idiosyncrasies of face to face encounters.

Theory-practice
It became apparent however, that the very weakness of the 800-word scenario ultimately led to a powerful learning experience. It was apparent that we struggled as a group to avoid stereotyping a whole family because we had "just" 800 words to go on. Only when we had added 10 minutes of video – a kind of virtual face-to-face encounter - were we able to conceptualise the family in three dimensions. In my clinical experience however, an 800-word referral would be a rarity and few are more than one paragraph. The PBL exercise alerted me to the importance of not fabricating a soap-opera characterisation on the basis of a few fragments of information. I am
now mindful of not attaching too much importance to the surname, size of family or postcode of a patient and strive to keep an open mind until we meet face to face. I also try to keep in mind the stereotypes that clients may hold about psychologists and that part of the process of building rapport might involve addressing those issues. Of course, biographical detail is needed but I have tried to develop ways of adding more qualitative observations to my assessments. Instead of asking the parents their ages, I may ask the children how old they think their parents are. The interactions as they navigate the question can furnish very useful insight into how they relate. Does the child know how old the parents are? Are the parents comfortable allowing children to speak for them? Which child speaks first? When I have used this approach in clinical settings, it has often allowed the family to focus on each other briefly and can give a useful microcosm of home life. I also appreciate how quickly familiarity and its subsequent contempt can set in. I was a little resentful of completing a third PBL whereas in my professional life I may expect to see dozens of clients that are – at first glance – quite similar. This PBL has reminded me of the need for a thorough assessment in order to understand the individual from within the patient file.
Working with people in later life, their families and the professional network
The focus of this problem-based learning exercise was a case study of a Mr Nikolas, 69, who had been referred to a psychology department for assessment of his short-term memory problems and his needs for care. We were given some background information, a genogram and some suggested questions with the brief to prepare a presentation for the rest of the cohort.

I was allocated to a group with six other trainees: two third-years (who I knew well) and four second-years that I had not met before. It was not made clear whether the groups had been assigned randomly or to any design. The exercise coincided with my Older Adult placement which made a useful academic/clinical synchronicity and prompted me to explore some personal and professional issues including team work, self-disclosure and delegation. We met four times before the presentation and the pattern of our interactions seemed to become established fairly quickly. I attributed this to the fact that although we had not worked together as a group, we all knew some of the rest of the team from our year cohort. This could have divided the group along year-group lines but other allegiances within and between groups (age and gender for instance) may have blurred that distinction and it is a factor which I try to keep in mind in multidisciplinary teams. The overt demarcation between disciplines does not take into account the complex working history which colleagues may have had within the team and elsewhere. Groups may be categorised as social identities comprising in-group / out-group facets (Tajfel (1981)). In-group refers to a collection of individuals which have something in common; out-group refers to everyone outside those teams, families or departments. So there may be allegiances among professional in-groups such as psychiatrists or occupational therapists or social workers but in the same way we aspire to a holistic view of our clients, I have found it useful to remember that other in-groups may co-exist alongside the obvious demarcation of profession. In-group/out-group factors may include colleagues who are united – or divided – by ethnicity, outside interests or something as prosaic as sharing a bus route to work.

Within the PBL group, the pattern that became established was that we would all engage in a free-flowing exchange of ideas during meetings but I was aware that toward the end of the session I often took on the role of summing up and establishing deadlines for the tasks we had identified. The rest of the group may have acquiesced to this because of seniority (I was the oldest in the group by at least a decade) and I
recognise it is not a role everyone is comfortable with but I was also aware that decision-making within teams is an issue that has arisen since I began working in the NHS and, I imagine, will remain with me throughout my career. I had no clinical experience prior to training and had spent my entire working career (some thirty years) in the private sector. I encountered many forms of teamwork in that time – from both ends of the seniority range – and recognised that teams must strike a balance between discussion and decision-making. Discussion was valuable, and often the source of creative solutions, but - given the constraints of finite resources – I learned it had to be balanced with action. Decision-making is equally essential but, in the absence of discussion, can lead to dogmatism and the stifling of ideas. What I had found in the NHS was a tendency toward discussion with sometimes a marked absence of decision-making. I had attended Community Mental Health Team meetings during an earlier placement when most of the items on the agenda for the first team meeting were still on the agenda six months later. The allocation of office space, the possibility of extending the service hours, the point at which care co-ordinators assumed responsibility for clients newly-referred were all discussed but no decision on any of them was reached over the six-month period. The team in question did not have a team manager – and had not had one for some time – so it was apparent to me that the role of translating discussion into decision was not being taken by anybody. It reminded me of the value of a maxim I had learned in my pre-NHS career: a good plan which can be enacted today is preferable to a perfect plan which cannot be enacted until tomorrow. In psychological terms, Quey (2001) recognised the potential drawbacks of what could become an overpowering group imperative for constant consensus. While my earlier career was focussed on outcome, my clinical training had made me aware of the importance of process so I was careful to balance my need for decision-making with the group’s need for discussion. Before summing up I would look around to see if anyone was also waiting for a turn to speak. If someone had not spoken for a while I would ask if they had anything they could add and referred to decisions made by ‘us’ and ‘we’ not ‘I’. I hope I was able to manage this area effectively and I see the balancing of decisiveness with discussion as a useful skill to take into my career post-qualification.

Whereas my experience of team work within the NHS was very different to that in my earlier career, one issue has been a constant learning curve throughout my working
life: delegation. I have come to see the handing over of responsibility for one aspect of a task as a valuable skill which has the potential to enhance and optimise teamwork, or if handled badly, to undermine a colleague’s confidence and increase the workload without increasing output.

As a trainee I expected my work to be assessed and improved by a supervisor who was more experienced in that service but on one occasion I began to think the supervisor struggled with delegation per se. This was most evident in the process of drafting letters to clients after assessments or interventions. I would produce a draft copy and my supervisor made extensive changes to the style and substance. A re-draft met with the same response and by the third version it was evident that some changes made to the first copy were reversed by the second or third. This inconsistency puzzled me, and made it difficult to get letters out in a timely manner, but I came to see it was a question of confidence. Pfeffer (2004) examined the process of delegation and concluded that difficulty delegating work is consistent with difficulty attributing the same value to work produced by others as to work produced with one’s own direct intervention. This made it easier for me to accept the repeated revision of my work as it was not reflective of my skills at letter-writing as it was of my supervisor’s skills in delegation. Veronesi (2007) recognised the power of delegation and highlighted the crucial role of trust in that relationship. The advantage we may have had in the PBL group was that as our in-group status as clinical psychology trainees enabled sufficient trust for us to delegate work effectively.

The deadlines we established were mostly around producing character backgrounds and draft scripts for the exercise. While I was aware of managing my role regarding decision-making during the exercise, only in the process of reviewing our work some months later have I seen the full extent of how my personal circumstances influenced the work I produced. The first task we agreed on was to ‘flesh out’ each character by conjecturing a more complex personal history and then writing a script for them in which they were able to voice their concerns. We had a brief synopsis of the family but we wanted to get a better idea of a three-dimensional person by exploring their back story and imagining how they would describe their position. We all took one character and I chose to write a script for Alexander, one of Mr Nikolas’ sons. Alexander was a middle-aged male so we had some fundamental aspects in common, and I would expect any conjecture to be heavily informed by the writer’s own
perspective, but reading through the script in order to produce this essay, I am struck by the scenes from my own life which I wrote into Alexander’s.

Two examples stand out. In the script, but not mentioned in the original brief, Alexander referred to his brother’s emigration with the phrase “James has sodded off to Singa-bloody-pore”; and later he said of psychologists: “All they do is molly-coddle people”. Around the time I was writing this script there had been some tension in my own family as my brother had emigrated and, while I fully supported his decision, I was also resentful of the impact it had on the rest of the family. Secondly, on placement at that time I had met an experienced colleague who caricatured newly-qualified clinical psychologists as “frilly Victorias who think their job is to molly-coddle people until they feel better”. The phrase was said with such venom that it has stayed with me since – and prompted some unresolved questions of my own as to why he thought he could share such a divisive view with me – but I was surprised to see that it surfaced in Alexander’s view of the profession.

As psychology is my second career, age is a dimension that has influenced and informed many of my experiences with fellow trainees and on placement and my age gave the case in question a rather personal resonance. My parents are in their 70s and, while they are in very good health, they are in a similar age range to Mr Nikolas and therefore potentially vulnerable to the issues that he and his family are facing. Intelligent life choices have, of course, made a significant contribution to my parents’ circumstances but discussing Mr Nikolas sharpened my awareness that genetics and luck are factors in health and longevity and thinking about these two unwieldy forces in the context of one’s parents’ mortality can be uncomfortable. There is a transition of power in the family unit from Mr Nikolas to his sons as Mr Nikolas relinquishes his role as ‘carer’ and becomes ‘cared-for’. While it is not on the same scale, a similar handover is unfolding in my relationship with my parents. The process of becoming the “senior” member of the group is one I am ambivalent about – an unease which may be reflected in my earlier descriptions of summing up at the end of meetings and setting deadlines for the group. This change in roles within a family has been compounded by becoming a parent myself. This has reinforced to me the multifaceted nature of our systemic relationships and is a perspective I treasure in my clinical work.
References
My own experience with a patient I saw for weekly individual psychotherapy proved a microcosm of my involvement in the CDG process. The patient had been talking about her family and revealed that she felt she was very different to her sister and that they had been separated by their very different reactions to their father’s death. “I invited her to a peace rally, she invited me to a cosmetics party,” she said. I told the group how beneath the manifest content - that she was politically active and crusading, while her sister was cosy and suburban – was a clash of ideologies. She wanted to make peace, her sister wanted to cover up blemishes. I had not made that interpretation in the session, nor talking with my supervisor. But the longer perspective afforded by the CDG had allowed that interpretation to surface. Much later, I reflected that understanding back to the patient and it proved really useful.

I was also aware that my understanding of separateness had been enhanced by my experience of living abroad and that realisation was the first step to transferring my experience in the CDG to my practice. I had spent some time as an English speaker in countries where Arabic, Serbo-Croat or Cantonese were the lingua franca. Of course, being a psychodynamic therapist among CBT practitioners hardly qualifies me to speak about the meaning of minority but the process of the case discussion group gave me a useful perspective.
Within the case discussion group, there was a lot of rhetorical and circular questioning, slowly unpacking the different elements of our experiences on placement. After a first year placement in what seemed like the familiar territory of adult mental health (after all, I was an adult), I was now working with children and a little outside my comfort zone. In the process of discussing our cases and experience of placements, the CDG has become a very useful forum for reflecting on personal development. I was particularly struck by an observation by other group members that, two years on, I sounded less like a journalist. Yes, I had consciously moved away from journalism but had the members of the group become less threatened by a journalist in their midst? Curiosity and some hostility is a typical, understandable reaction to a journalist. But how are people reacting to my new status? For reasons I have not yet pinned down, people greet the news that I am a psychologist with a mixture of reserve and what seems like suspicion. I often find myself wondering: “How can they not be interested in human behaviour?” I think that they are, perhaps, interested in human behaviour but not to the extent of putting their own under the spotlight. It could also be quite intimidating to have your own amateur views scrutinised by an expert in human behaviour. Observations from the CDG about how I come across were very useful, providing a self-awareness that I took into clinical practice.
Placement overview

Adult placement (Nov 2006 – Sep 2007)

Springfield Dept of Psychotherapy:

I found this an especially challenging but rewarding experience. I worked with one patient for a year and found the transference relationship very useful therapeutically. This was my first experience of clinical work and of the psychodynamic model so I anticipated a steep learning curve. One of the most supportive aspects was the time invested in finding the right patient for a year-long intervention. My supervisor suggested that, as many of the patients on the waiting list had been diagnosed with a personality disorder they may be prone to a cycle of deification and denigration with their therapist which would be very challenging for a trainee.

We eventually settled on a young woman, Patient A, who presented with some obsessive compulsive behaviours and anxiety around the death of her father, which she had witnessed when she was a child. On my supervisor’s advice, I also engaged in my own psychodynamic therapy. As well as the opportunity to see another therapist at work, it gave me good insight into the patient’s perspective.

The work with Patient A progressed quite slowly at first. I found interpretation to be quite familiar as it is quite language-based and chimed with my previous career as a journalist. It took a little longer to tune into the transference relationship but after some 15 sessions, Patient A’s transference to me as a father figure became apparent. With hindsight, I now realise the combination of the safe place created in the sessions and the transference of her relationship with me allowed the patient to express her fears and so normalise and accommodate them.

My work with this patient remains among my most profound experiences of my clinical training, encompassing professional and personal development within a model which I found both challenging and rewarding.
Lavender Hill Practice Group
My work in primary care, using brief psychodynamic therapy, was complemented by engaging in my own psychoanalytic therapy for the duration of the placement. I found the greatest challenge to be finding a therapeutic space midway between the structured process of CBT and the more exploratory, undirected process of psychodynamic therapy.

Wandsworth Primary Care
I co-facilitated an Anxiety and Depression Group and implemented individual CBT with a diverse range of clients.

Tooting and Furzedown CMHT
As well as assessing patients for psychological intervention I used CBT and integrative models of therapy.

Child placement (Sep 2007 – April 2008)
Sutton CAMHS:
My experience in Child and Adolescent Services highlighted the importance of making a fully-rounded assessment, especially in terms of ensuring that behaviour is not unnecessarily pathologised. It also gave me some experience of working with different agencies such as social services and education authorities.

Learning Disability placement (April 2008 – Sep 2008)
Merton Learning Disability team
I worked with patients with moderate to severe learning disability and learned that in some cases the ‘safe space’ of the session room very useful whereas in others, I found home visits a good way to connect the intervention with the patient’s daily life.

Older adults placement (Sep 2008 – April 2009)
Epsom Older Adults CMHT
This placement illuminated how useful a psychometric battery can be in identifying strengths and so foster good coping strategies. I also had the opportunity to work with
narrative therapy which proved very useful given the rich life stories of the client base.

Adult competencies placement (April 2009 – Sep 2009)
Traumatic Stress Service, St Georges
I work with clients suffering complex and simple PTSD and have been able to refine my skills in uncovering the meaning people give to their experience. I have also developed my assessment, formulation and intervention skills within a well-defined model of CBT.
Using a behavioural experiment within a CBT framework for treating panic disorder and agoraphobia
Referral
After experiencing anxiety and agitation, John Edwards – a white British male in his early 20s - presented himself to the Accident and Emergency ward at a large hospital where he was admitted to a psychiatric ward for assessment. In his discharge summary, he said he had thought about suicide. On discharge, after a stay of five days, Mr Edwards was referred to a CMHT.

Assessment
I assessed Mr Edwards as an outpatient at a large metropolitan teaching hospital; the session was co-facilitated by a supervising Consultant Clinical Psychologist. Mr Edwards had been an undergraduate science student at university the previous summer when he took part in an investigation into sleep deprivation. It involved staying awake for 36 hours in a room with no daylight. After just a few hours, Mr Edwards said he felt consumed by an overwhelming dread and “just lost it”. He left immediately.
Since that experiment he has felt anxious quite often, sometimes in social situations but mostly in confined spaces. He has avoided using the underground and feels very uncomfortable travelling in a car on a motorway. He described physical symptoms of breathlessness, sweating and feeling he was about to pass out. His GP prescribed Citalopram and Diazepam and referred him to a psychotherapist but his anxiety did not diminish and he eventually reported to an A&E department. Mr Edwards was admitted to an acute ward and seen by a Consultant Psychiatrist attached to a CMHT. He was prescribed Zopiclone (a short-term hypnotic) and Diazepam (an anxiolytic) but after a few days said he did not feel staying on the ward would help. He was discharged with a referral to a CMHT for outpatient assessment.
During Mr Edwards’ assessment a week later he was emphatic that he had not had further suicidal thoughts since leaving hospital. My supervisor agreed there was no longer a risk of self-harm. He was offered eight weekly hour-long sessions, providing it did not impinge on his psychotherapy.

Formulation
I formulated that Mr Edwards was suffering agoraphobia with a panic disorder. His good social support, articulacy, learning ability and motivation suggested he had some useful protective factors that would respond well to a cognitive behavioural therapy
intervention (Johnstone & Dallos 2006). Exposure therapy and CBT are both effective in the treatment of panic disorder with agoraphobia (Salkovskis et al 2006) and as Mr Edwards’ learning style was science-based, I anticipated a behavioural experiment might prove especially relevant (Bennett-Levy et al 2004).

Intervention

At the first session I asked Mr Edwards to rate his anxiety levels. He said his background anxiety was 5 or 6 but peaked at 9 on some occasions such as preparing to go out to meet friends; starting a long car journey; and most profoundly, finding that a train was cancelled and having to wait a further period. I explained to Mr Edwards that it appeared in the anticipatory period of all three incidents he had been engaging in some selective attention (Mansell 2004) which led him to focus on his physical symptoms, so initiating and sustaining his anxiety.

In the second session, we agreed that the goal of therapy would be for Mr Edwards to travel on the Tube without feeling overwhelmed by anxiety. The importance of identifying safety behaviours is well known Salkovskis (1991). For Mr Edwards they included carrying Diazepam, listening to a personal music player and sitting in the emptiest carriage. If the safety behaviours were practised during the experiment, Mr Edwards may feel any success was due to the Diazepam or the choice of carriage.

In the third session, Mr Edwards brought in a written account of his ‘worst fears’, which I had requested. Using a model developed by Beck (1995), I contrived the first stage of a behavioural experiment that would test Mr Edwards’ catastrophic misinterpretation of symptoms.

A week later, we travelled on the tube together and I asked him to rate his anxiety, with 10 being the most anxious. It peaked at 9 while waiting for an approaching train and remained at 6 or 7 while travelling.

The following week I changed the parameters. We met at the same station but I gave him a one-day Travelcard so he would not have a specific destination and did not know how long we would be gone. I asked for his personal stereo and made sure he was not carrying the Diazepam - his safety behaviours. We travelled for 20 minutes or so on different lines before getting on a service which I knew was most likely to stop between stations. Once I stayed on the platform and asked Mr Edwards to travel ahead and wait at the next station, to ensure I did not become one of his safety behaviours.
Afterwards Mr Edwards reported that his worst fears had proved unfounded. He had not blacked out through anxiety when the train stopped between stations. While we were only stationary for a few seconds it was enough to show him he could cope. At the end of the journey he rated his anxiety at around 6, much lower than his first report.

At the following session, Mr Edwards said he found the behavioural experiment very useful and, together with his better understanding of anxiety, he felt his level of anxiety had diminished over the course of the treatment. He said he was still uncomfortable on the Underground but as he knew he would not black out he felt this would diminish over time. At the next team meeting it was agreed it would be appropriate to discharge him.

Outcome – final session

Mr Edwards reported background anxiety levels of 2 or 3, while his anxiety connected with the Underground now only peaked at 6 or 7. He had expanded his psychological understanding and seemed keen to continue his recovery independently.
"I don’t want to go to Coventry"
a psychodynamic intervention
in the case of a young woman
traumatised by grief.
For the purposes of anonymity and confidentiality, some details have been changed and all names are fictitious

Referral
Carol Harris is a white British female student in her mid-20s. She was referred to the psychotherapy service by her GP following bouts of depression, anxiety and obsessive behaviour. Age 6, Ms Harris witnessed her father drowning. Over the next few years there were other unrelated accidents and deaths.

Background, presenting problems and initial assessment
According to my supervisor's assessment, Ms Harris had two presenting problems: obsessive counting and scenario-creating. Ms Harris would add up different elements from her immediate environment such as the number of doors and hope to find the result was an even number. She also thought about how she would react to an accident involving close family. Her father died during a family holiday in France. Her mother and father had separated and her father, together with his new girlfriend, had taken Ms Harris and her older sister on holiday. He had gone for a swim, got into difficulties and drowned.

My supervisor's initial assessment was that Ms Harris was an anxious person from birth and that her father's traumatic death was a shocking experience from which she had not fully recovered.

Formulation: first meeting.

Risk assessment
She said she had not considered harming herself and had not thought about suicide. She said she did not take drugs or abuse alcohol. I considered Ms Harris to be at very low risk of self-harm and re-assessed her risk at regular intervals but never departed from my initial assessment.

Treatment plan
Ms Harris said she would not be able to start therapy (hour-long, weekly) until mid-January as she was going on holiday. I told my supervisor I did not fully understand her reasons for delay but had been too uncomfortable to explore it further at the time. Only later, I did I identify the source of my discomfort.
Intervention

In our first session, Ms Harris recounted a dream in which she was in a boat at sea which capsized. She then explained how she would go sailing with her step-father, (her mother later remarried) without telling him she found being at sea traumatic. In supervision later I realised I had failed to link her dream with her father's death. Back in the session, my insecurity at my performance as a therapist was apparent as I asked what kind of person she would like to confide in (ie “Who do you want me to be?).

Ms Harris’ on-off relationship with a man, Ilya, proved to be the source of a new understanding. There were many parallels with her father. Ilya was the same age, had a daughter the same age as Ms Harris and was unavailable as he lived some way away.

Ms Harris’ father had had several extra-marital relationships. At the time of his death, her father had just left her mother to be with a younger woman. For Carol, the romance of new relationships may be tied up with her feelings about her father’s infidelity and, ultimately, his death. She was angry with him for his infidelities but also felt guilty about having these feelings about her dead father. That was her internal world. Her external reality was her desire to visit her father’s grave in Kenilworth, a small town near Coventry.

“I have a problem in that I want to go to Kenilworth but the only thing that stops me is transport. I can only go as far as Coventry on the train and I don’t want to go to Coventry, (starts crying) I want to go to my father’s grave and the place we grew up.”

I understood she was trying to approach her relationship with her father but didn’t feel confident in her abilities to make the psychological journey unaided. My supervisor asked what going to the grave meant to her. I modified my formulation of Carol to include a state of complicated mourning that had never been resolved.

In session 13 we reached a significant understanding of her internal world – her fear of forgetting her father. I asked if she was afraid of forgetting her father – and she cried for some time.

Her tears seemed child-like and I found myself thinking about my own desire to be a father. This gave me a better understanding of transference and counter-transference. The age difference, her desire to change her relationship with her father and my desire to be a father myself coalesced into a powerful therapeutic force which was something
of a turning point in the therapy. In subsequent sessions, she cried less and said she felt she was no longer dominated by her father.

As we negotiated the end of the therapy she revealed she had not been able to start therapy immediately because she went into hospital to have breast implants. She said she thought something had gone wrong. My interpretation was that Ms Harris was concerned that the development and understanding she had gained during therapy would be lost when it ended. Recalling my discomfort at Carol’s reason for delaying the start of therapy. I was reacting to her discomfort at the subterfuge around a sex-related subject.

Critical evaluation

Ms Harris had built a father figure that was idealised, idolised and unsustainable. My supervisor said that by introducing an inexperienced therapist with some uncertainties and anxieties it might help Ms Harris build an internal object of an imperfect father which was more sustainable.

The Kleinian model provided a useful language with which to discuss the case (The collective writings of Melanie Klein volume 3 – envy and gratitude – 1975) but I identified most strongly with Lemma in Introduction to the Practice of Psychoanalytic Psychotherapy (2003) in viewing psychotherapeutic models as no more or less than metaphors to describe an understanding of a patient’s inner world, an understanding which always remained my goal.
worrying about worrying:
a metacognitive approach to generalised anxiety disorder
Referral
Charles is a 15-year-old white English-speaking male who attends a co-educational comprehensive in a metropolitan borough. He lives at home with his mother and 13-year-old sister (diagnosed with an autistic spectrum disorder in 2004). Charles' father died in July 2005. In September 2007, Charles was referred to a Child and Adolescent Mental Health Service by his GP for panic attacks and anxiety.

Presenting problems and initial assessment
Charles' preliminary assessment by CAMHS was completed in November 2007 over three 50-minute sessions, sometimes with Charles alone and occasionally with his mother present.

Charles' mother and father had divorced before his father was diagnosed with cancer in 2002. He died in 2005. According to his mother, Charles had once enjoyed challenging situations but now found them daunting. Charles recognised the onset of his panic attacks followed his father's death. He also said he had occasionally felt quite uncomfortable around strangers or in unboundaried situations such as leaving the house with no clear destination. Charles was reluctant to seek reassurance from his family as he 'did not want to burden them'.

Risk assessment
Charles said he had not considered harming himself and had not thought about suicide. He said he did not take drugs or abuse alcohol. I considered Charles to be at very low risk of self-harm. I reassessed the risk regularly but never departed from my initial assessment.

Formulation
Charles' predisposition to anxiety are suggested by his mother describing him as a clingy and highly strung child. Also, Charles' father abused alcohol and Charles recalls, aged 7, sleeping in his father's bedroom to ensure he did not drink during the night. Precipitating factors include his parents' divorce, the death of his father and his sister's diagnosis. Maintaining factors include Charles worrying about catching up when he returned to school after his father's death and then worrying about the impact of worrying.

Initial formulation
I formulated that Charles was suffering a generalised anxiety disorder (GAD) precipitated by his father’s death. This is consistent with the ICD 10 definition of GAD that is a “free-floating” anxiety not restricted to particular environmental circumstances, WHO (2007).

Treatment plan
After consultation with my supervisor, a Highly Specialist Team Clinical Psychologist, I offered Charles five fortnightly therapeutic sessions, starting in January 2008. In line with Trust policy, we also agreed to monitor Charles’ progress using several rating tools:

- Strengths and Difficulties Questionnaire (SDQ) (a brief behavioural screening questionnaire for 3-16 year olds completed online);
- self-rating measures;
- Wells’ (1997) Generalised Anxiety Disorder Scale (GADS);
- Beck’s Anxiety Inventory for Youth (BAI-Y) (a self-report inventory to assess symptoms of anxiety).

I chose to adopt a CBT model within an integrative framework. Linden et al (2005) found CBT to be an effective method of treatment for adolescents suffering GAD compared to a contact control group.

Intervention
Charles’ intellectual frame of reference was very science-based so I surmised that an emphasis on hypothesis-testing and behavioural experimentation within a CBT model would be most useful. Charles also described ‘worrying about worrying’; this chimed with Wells (2005) metacognitive model of GAD which identifies Type 1 (external daily events) and Type 2 worry (focussing on the nature of the thoughts themselves). As Wells’ model gives priority to the role of Type 2 worry in GAD it had a particular resonance with Charles’ situation so I used it as the backbone of my intervention.

In the first session Charles said his anxiety levels ranged from 2-8 (0 lowest/10 highest) and that his goal was to reduce the peaks to 7 or 7.5. I asked Charles what he would do if his smoke alarm at home went off three or four times a day. Would he consider taking the battery out? He said he would not as it may leave him vulnerable if
there was a house fire. I explained that anxiety was a warning system but just as we would not take the battery out of a smoke alarm nor should we aim to eradicate anxiety. Our aim was to ensure the alarm was only triggered appropriately. Charles referred to this analogy in later sessions as being very helpful in understanding of his situation.

In session two Charles returned a completed Generalised Anxiety Disorder scale which revealed he experienced moderate to extreme stress; that he had not asked for reassurance about his anxieties; that he had very little avoidant behaviour and that he believed worrying put his body under stress.

Within the metacognitive model, patients can challenge metabeliefs around perceived uncontrollability of worry if they are encouraged to experience some worry control Wells (2005). Charles agreed to schedule a 'worry time' and keep a diary to explore his anxiety. In the fourth session, Charles reported his general level of anxiety over the preceding fortnight had settled between 4 and 6 out of 10 which he attributed partly to his realisation that it was not necessary to be anxious. He reported finding it useful to set aside time for reflection.

There was a planned break of a month before the last session to give Charles the opportunity to implement his coping strategies. Charles had just taken two GCSE exams and had not been overwhelmed by anxiety. He also said he had become more confident that he could share his worries with his mother and sister.

We reviewed his initial referral which focussed on his growing difficulty with new situations and discussed how therapy was a new experience he had successfully addressed.

Outcome

Charles responded well to a CBT-oriented approach, in post-therapy measures self-reporting a significant diminishment in his anxiety. His SDQ scores of emotional stress decreased from “very high” to “close to average”. In his GADS assessment he rated his worries as less than moderately distressing and he no longer thought worrying would help him solve problems while T-score equivalents on the BAI-Y index fell from 72 – 63. Consequently, I discharged Charles back to the care of his GP.
Development as a clinical psychologist

I had no clinical experience when I began training but found I could relate to the first client groups I encountered (adults and children) by drawing on my own life experiences. However, when I started work with a learning-disabled client group, I was aware that I was moving outside my 'comfort zone'. My previous career in journalism meant my default position had been to work from a language-based perspective, to drill down via direct questioning to uncover some objective understanding. I came to see during this placement that working with learning-disabled clients, such as Tom, would challenge me in two ways. Firstly, I could not use complex language to explore Tom's experience because his comprehension and expression were compromised by his learning disability and he struggled to understand abstract concepts such as time and emotion. Secondly, direct questions did not reveal direct answers. From week to week, Tom's account of his life was almost entirely subjective. In one session, he told me he had got married. Yet no-one else in his family or among his carers had met or even seen his 'wife'. He reported meetings with her, relayed conversations and anticipated holidays but she did not exist in any accepted sense.

I was initially confounded by this fantasy and realised I would need to develop a new skill set. The tools that had served me as a journalist -- reductionism, dualism and pervasive cynicism -- did not produce transferable skills. Instead I learned to understand Tom's story by what it meant to him. Why had he created a wife and family? What lack in his own life was he expressing with this fabrication? Why did he confabulate elements of other people's lives into his own? How could I maintain a therapeutic relationship while neither colluding in his fantasy nor crushing it? It was the exploration of these questions that proved most useful in my work with Tom, especially in terms of fostering rapport. But it also revealed the third challenge I faced. How could I make a meaningful contribution in a six-month placement to someone with a pervasive and lifelong condition? I am not sure I have found the answer to this last question but am confident its exploration has been worthwhile.
Tom is 43, has a moderate learning disability and an autistic spectrum disorder. He lives at home with his mother, brother and sister. Tom’s brother Peter also has a learning disability and the two spend most of their time watching TV in the living room, often sleeping there too. The house is cluttered and chaotic but does not appear unhygienic. The family have been re-housed twice after harassment by neighbours.

Tom was referred to the Learning Disability team as his family reported he was losing his temper at home. They said he would often get angry, shout and throw his belongings around the room. Tom never acknowledged this behaviour to me.

Tom is a cheerful and personable man, who easily engaged in conversation about his family, activities and friends but it proved very difficult to talk to him about abstract concepts such as emotions or timescales.
Year 3 Case Report 5 summary

Using a psychometric assessment to investigate memory difficulties in a 59-year-old woman
Referral
Mary Coleman was referred by her GP in December 2008 after reporting concerns about apparent memory loss. Mrs Coleman was referred for an MRI brain scan and to a consultant clinical neuropsychologist working with a trainee clinical psychologist in the Community Mental Health Service for Older Adults team.

Presenting Problem
Mrs Coleman is a 59-year-old white woman living at home with her husband and youngest son. At the first meeting with psychologists, she reported: having to re-read information more than she did a year ago; difficulty in using appliances; forgetting previously-familiar information. Mrs Coleman denied any suicidal intent or ideation. No other risks were identified. Mrs Coleman’s husband David said he had noticed a change in his wife’s behaviour but not any change in his wife’s personality.

History of Presenting Problem
Mrs Coleman’s work involved producing an annual report for a large government department. She was first aware of feeling she could not rely on her memory in 2006 when ordinary clerical tasks were taking longer. Mrs Coleman retired in October 2007 as she found the job very stressful – she put it down to a change in her workload and insecurities around her memory. Mr Coleman said he had not noticed a sudden onset but there seemed more instances of Mary forgetting people’s names and dates over the last two years.

Mrs Coleman reported that her mother was diagnosed with Alzheimer’s dementia in her eighties. Her medical history revealed no relevant issues.

Hypothesis
Given Mrs Coleman’s age, the relatively sharp onset of memory difficulties (in the last two years) and the absence of vascular risk factors, personality changes or psychomotor issues, it was hypothesised that Mrs Coleman’s symptoms were most consistent with early onset dementia of the Alzheimer’s type. There is a significant caveat to this hypothesis in that definite diagnosis of early onset dementia is only sustainable after neuro-imaging (Mendez 2006).
Rationale

The examination of the relationship between measures of intellectual functioning and memory has become a routine analysis for many clinicians using the Wechsler scales (Wechsler, 1997). The WAIS-III is a widely used valid and reliable battery of tests which are sensitive to the functional consequences of brain damage and cognitive impairments (Groth-Marnet et al 2000).

Wefel et al (1999) found the prevalence of depression to be higher in patients with Alzheimer’s than with other types of dementia and, as depression and anxiety could also cause temporary cognitive deficits, which could be confused with early signs of dementia, (Crowe, 1998) the Hospital Anxiety and Depression Scale (HADS) would be administered (Cameron et al 2008).

Findings

The WAIS-III was administered over two sessions, totalling more than two hours. The HADS was also completed by Mrs Coleman.

General intellectual functioning (as measured by the WAIS-III)

The Wechsler Adult Intelligence Scale (WAIS-III) tests for assessment of verbal comprehension/working memory (Verbal IQ); and perceptual organisation/processing speed (Performance IQ). Verbal IQ relates to crystallised intelligence, such as vocabulary, facts and figures while Performance IQ relates to more fluid intelligence such as abstract thinking.

On the basis of Mary’s educational level and work history, her pre-morbid level of intellectual functioning could be expected to fall in the above average range.

<table>
<thead>
<tr>
<th>Summary of Verbal and Performance scores:</th>
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<tbody>
<tr>
<td>IQ</td>
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<tr>
<td>Full Scale</td>
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<tr>
<td>Verbal</td>
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<tr>
<td>Performance</td>
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</tbody>
</table>

Summary of Index scores
Within individual subtests, Mrs Coleman's strengths were in Vocabulary and Comprehension. Her significant weaknesses were in tasks related to processing speed and working memory.

Anxiety and depression (as measured by the HADS)

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<thead>
<tr>
<th>HADS</th>
<th>Score</th>
<th>Description</th>
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<tbody>
<tr>
<td>Anxiety</td>
<td>10</td>
<td>Borderline</td>
</tr>
<tr>
<td>Depression</td>
<td>2</td>
<td>Normal</td>
</tr>
</tbody>
</table>

Mrs Coleman’s score on the HADS was consistent with behaviour observed during testing and interview.

Discussion

Mrs Coleman’s WAIS profile – particularly the discrepancy between verbal and performance IQs - revealed deficits consistent with Golden et al’s (2005) criteria for diagnosis of dementia.

The following factors may have impeded her performance:

- anxiety: there is considerable overlap between symptoms of anxiety and dementia (Seignourel et al 2008) and several stressors – such as concern about her memory – may have impacted Mrs Coleman.
- dexterity - Mrs Coleman describes herself as “not very dextrous” - could have an impact on performance.
- perfectionism: her attention to detail could have slowed her performance.

Recommendations included:

- allowing more time for tasks requiring attention to detail
- writing down information which is only used occasionally
- attending an Anxiety Management Group

While psychometric assessment of Mrs Coleman’s cognitive abilities clearly indicates the possibility of early onset dementia, a more certain diagnosis requires supporting
evidence from neuro-imaging (NICE 2006) and treatment would then follow NICE guidelines for dementia including access to psychological therapies, an assessment of needs for carers and agreement for a combined care plan.

Critique

I believe the psychometric assessment went some way to addressing the referral question within the following constraints:

i. the need to balance an accurate appraisal of Mrs Coleman’s cognitive abilities with the learning needs of a trainee clinical psychologist.

ii. the particular role clinical psychologists have within the wider context of a multi-disciplinary team (MDT) assessment and

iii. the experience gap between trainees and Consultants.

After administering the WAIS-III, Mrs Coleman’s profile was sufficiently extreme for the consultant to rule out further psychometric assessment in the immediate future as they would not improve understanding proportionate to the potential distress to Mrs Coleman of taking and ‘failing’ more tests. As patient care is a higher priority than a trainee’s learning needs for familiarity with a wide range of tools, it was decided that no further psychometric assessment would be carried out until the diagnoses had been elaborated with an MRI scan which was not completed until after the trainee’s placement had finished.
How NICE are we?

An audit of advance directive provision
for patients diagnosed with schizophrenia
ABSTRACT

"How NICE are we?" is a quantitative clinical audit designed to assess implementation of National Institute for Health and Clinical Excellence (NICE) guidelines within a mental health trust. Auditors collected data from case notes of service-users using an audit tool (see Appendix 1) developed through a pilot study to assess NICE implementation within six diagnoses (schizophrenia; bipolar disorder; depression; post-traumatic stress disorder, eating disorders and obsessive compulsive disorders). This study examines only the data relating to service-users (n=70) with a diagnosis of schizophrenia. NICE guidelines require the provision of advance directives (ADs) - written instructions agreed between a service-user and health care professional in advance of treatment - for all patients diagnosed with schizophrenia whenever possible, (NICE 2002). Previous studies have shown that race (Degenholtz et al 2002) and organisational factors (Atkinson, Garner and Gilmour 2004) have significant impacts on the provision of advanced directives for patients suffering from schizophrenia and it was hypothesised that those findings would be replicated in this Trust. The null hypothesis prevailed and no correlation found. It was found, however, that only 23 (33%) of those service users audited had a documented advance directive. Implications for clinical practice and training are discussed.

INTRODUCTION

Schizophrenia is a mental illness characterised by impairments in the perception or expression of reality, onset typically occurs between ages 20-30 with diagnosis based on the patient's self-reported experiences and observed behaviour (Mental Health Foundation 2007). Until NICE was established in 1999, each medical speciality produced its own guidelines for treatment but this prompted concerns about their quality, reliability, and independence (Grilli et al 2000) and some debate about the so-called "postcode lottery" of health provision. In the Trust audited in this study, a strategic framework for the implementation of NICE guidance was developed in February 2006 and teams established to ensure strategy implementation. This study was charged with establishing a baseline audit for compliance by:

i. measuring current compliance against NICE guidelines;
Within the broader strategy of setting a benchmark for NICE compliance, this study focuses on the provision of advanced directives for patients diagnosed with schizophrenia. NICE guidelines on advance directives are an attempt to accommodate the alternating periods of competency which characterise mental illness as insight and judgment become impaired in times of crisis. Critical care choices are difficult decisions and an advance directive is a written document designed to inform those choices with the wishes of the patient made at a more reflective time. The impairments associated with schizophrenia mean the provision of advance directives is especially pertinent as, according to NICE’s full national clinical guideline for schizophrenia, when treatments are offered it is “essential to engage the service-user in a collaborative, trusting and caring working relationship at the earliest opportunity” (NICE 2002 p16). One aspect of that collaboration is facilitated by the use of advance directives with the recommendation that they are developed and documented in individuals’ care programmes whenever possible.

According to Campbell and Kisely (2006), the benefits of advance directives are:

i. enhanced autonomy and choice for patients, with subsequent benefits to physical and psychological well-being;

ii. improved family relationships through the reduction of conflict around treatment;

iii. increased acceptance by service providers of patient autonomy;

iv. reduced service use including hospital admissions, bed-days, use of mental health legislation and contact with the criminal justice system.
METHOD
The Trust's clinical governance department developed the audit tool following a pilot study in one community mental health team (CMHT) and one child and adolescent mental health Tier 3 service (CAMHS). The audit team comprised five first-year trainees from a PsychD clinical psychology course, supervised by two consultant clinical psychologists. Each member of the team was responsible for producing a study on one of the diagnoses. Supervising consultant clinicians established there were no ethical issues to consider. Data was recorded from new referrals and re-referrals accepted for care between 1st January 2006 and the 31st January 2006 of service-users who (a) have a diagnosis covered by NICE guidelines and (b) have received at least two to three months' care. Hard copies of the tool were used by auditors to record data from service-users' case notes. If the evidence could not be found, auditors were instructed to contact the service-user's care co-ordinator. Each member of the audit team was then allocated CMHTs and services to visit, collecting 20 notes per team/service and distributing appropriately. If there was any ambiguity in the case notes, a written record was made of the information available.

Patient records used in this study came from one of two Trust services. The majority of the records (n=47 67%) came from the Trust’s Community Mental Health Team, a secondary care service receiving most of their referrals from GPs. Records from the Early Intervention Service (EIS) - a tertiary care service accepting referrals from adult Community Mental Health Teams, Child and Adolescent Mental Health Services and Liaison Psychiatry – comprised 23 (33%) of cases audited.

The criterion for referral to the early intervention service are that the patient is 30 or younger, that three years has passed since the first psychotic episode and the patient has no previous mental health service contact. Patients with schizoaffective disorder were included in this study as this diagnosis, given to people suffering schizophrenia and a mood disorder, is still covered by NICE guidelines for schizophrenia. Those case notes included under the diagnosis ‘psychosis’ or ‘first episode psychosis’ were also included after discussion with care co-ordinators revealed that although there had been psychotic episodes subsequent to the initial diagnosis, the stigma attached to a
diagnosis of schizophrenia meant the initial formulation was retained on the case notes although the patient now met the criteria for schizophrenia. This is consistent with reported stigma attached to a diagnosis of schizophrenia, Mann and Himelein (2004).

The audit tool contained one summarising section, applicable to all case notes, in which it was recorded whether the care plan included an advance decision or contingency plan detailing the service user’s treatment of choice in the event of an acute episode of illness. In a later section, devoted specifically to those patients diagnosed with schizophrenia, the audit tool recorded whether the service users’ care plan contained an advance decision or a crisis contingency plan detailing the service user’s treatment choice in the event of an acute episode of illness which may require rapid tranquillisation. Categorical answers to this question were Met – (evidence in case notes); Met (following conversation with the care co-ordinator; Not met and Not applicable. As the advanced directive could only be implemented if it was recorded in the case notes – and therefore quickly and easily accessible to health care professionals – only those advanced directives which were recorded in case notes were counted as fulfilling the NICE requirements. The other three categories (Met following conversation; Not met and Not applicable) were audited as Not Met.

The audit tool has face validity as the NICE requirement is that the advance directive is documented within the individuals’ care programmes and all data was gathered from those care programmes. The importance of test reliability was acknowledged by having documented instructions for data collection to ensure uniformity and consistency, such as specific instructions for dealing with data which does not fit the categories on the audit tool, i.e. contacting the care co-ordinator. The five auditors met often to discuss their work and ensure inter-rater reliability.

Ethnicity was recorded using the Trust’s coding: WBR = White British, WI = White Irish, WO = White Other, B/BBA= Black/Black British African, B/BBC = Black/Black British Caribbean, B/BBO = Black/Black British Other, Asian = All Asian groups, Mixed = All Mixed Race groups and Other. If the study was to explore associations between categorical variables, the small sample size would necessitate a conservative view of the categorisation used in the audit tool. Consequently, ethnic categories were translated into racial categories. All Black ethnicities recorded in the
case notes were treated as Black (n=23) in this audit, all White ethnicities were treated as White (n=24) and Asian, Mixed, Other and Not Recorded treated as Other (n=23). This also facilitated comparison with Degenholtz et al (2002) which recorded race (Caucasian, African-American, Hispanic and Other) not ethnic background.

Statistical analysis
Descriptive statistics were used to explore the data and, in order to test for a significant association between two categorical variables, the $\chi^2$ test was used (Field 2005) using the convention that significance must be less than 0.05.

Hypotheses
The hypotheses of this study are:

i. Black patients will receive proportionately fewer advance directives than white patients

ii. Some services will record a higher proportion of advance directives than others

RESULTS
An advance directive was recorded in only 23 (33%) of the audited notes, falling short of NICE guidelines that require advance directives to be developed and documented ‘whenever possible’.

Among the 70 patients whose notes were audited, the age ranged from 18 – 73 (consistent with findings of the Mental Health Foundation 2007); 23 patients (33%) were treated in an early intervention service with the remainder treated in a CMHT; 51 (73%) were diagnosed with schizophrenia, 16 (23%) diagnosed with first episode psychosis and 3 (4%) with schizoaffective disorder. English was the mother tongue for 49 patients (70%), 10 (14%) did not have English as a mother tongue and for 11 patients (16%) language was not recorded.
Table 1: patient demographics

<table>
<thead>
<tr>
<th>Patients</th>
<th>Male</th>
<th>Female</th>
<th>Advance directives recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>n = 70</td>
<td>44 (62%)</td>
<td>26 (37%)</td>
<td>23 (33%)</td>
</tr>
</tbody>
</table>

Lifetime risk of schizophrenia shows no gender differences but the higher proportion of males in this study may be explained by a differential in presentation as men have a lower level of social development at illness onset and subsequently a greater impediment of their further development (Hafner 2003).

Inferential statistics (Race)

The percentage of patients that had recorded advance directives did not differ by race, $\chi^2 (2, N = 62) = 1.20, p > .05$.

Table 2 Distribution of Advance Directives by race

<table>
<thead>
<tr>
<th>Race</th>
<th>AD requirement met</th>
<th>AD requirement not met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black (n=23)</td>
<td>10 (43%)</td>
<td>13 (56%)</td>
</tr>
<tr>
<td>White (n=24)</td>
<td>8 (33%)</td>
<td>16 (67%)</td>
</tr>
</tbody>
</table>

A cross-tabulation of race and the provision of advanced directives revealed no significant relationship using the convention that significance must be less than 0.05. A Pearson $\chi^2$ calculation revealed no significant correlation between race and the provision of advanced directives ($p= 0.549$) therefore the null hypothesis was supported for the first hypothesis.

Inferential statistics (Service)

The percentage of patients that had recorded advance directives did not differ by service, $\chi^2 (1, N = 70) = 0.94, p > .05$. 

79
Table 3 Distribution of Advance Directives by service

<table>
<thead>
<tr>
<th>Service</th>
<th>AD requirement met</th>
<th>AD requirement not met</th>
</tr>
</thead>
<tbody>
<tr>
<td>EIS (n = 23)</td>
<td>9 (39%)</td>
<td>14 (61%)</td>
</tr>
<tr>
<td>CMHT (n = 47)</td>
<td>13 (28%)</td>
<td>34 (72%)</td>
</tr>
</tbody>
</table>

A cross tabulation of categorical variables revealed no significant relationship between type of service and provision of advance directives. A Pearson $\chi^2$ calculation revealed no significant correlation between type of service and the provision of advanced directives ($p= 0.332$) therefore the null hypothesis was supported for the second hypothesis.

Discussion

_Ulysses: “You must bind me very tight, standing me up against the step of the mast and lashed to the mast itself so that I cannot stir from the spot. And if I beg and command you to release me, you must tighten and add to my bonds.”_ (Homer, 2003).

Ulysses’ instructions to his crew as he anticipated an encounter with Sirens trying to lure him to disaster may be thought of as an early advance directive although he was not concerned with what would be done to him, rather he entreated his crewmates to ignore what he himself may say when he was incapacitated by the lure of the Sirens. Some 3,000 years later, the problematic nature of acting on someone’s earlier wishes remains, as evidenced by the very low AD implementation recorded in this Trust. Two-thirds of the case notes audited for this study did not have a recorded advance directive and the priority must be to increase the take-up significantly. The difficulty in increasing the provision of ADs may lie in the balance which the National Health Service must strike between patient autonomy and clinical judgement or any perceived hierarchy in clinician-patient relationships. This perceived hierarchy led
some American patients to avoid revealing their advance directive to hospital staff for fear of being ignored or punished while others said some clinicians intimidated them into not mentioning the directive, Kim et al (2007).

This study revealed no racial disparities in the availability of advanced directives; contrary to Degenholtz et al (2002) which found that African Americans were 30 per cent less likely to have advance directives compared with Caucasians in long-term care settings. It may be, however, that ethnicity is confounded by other factors. McAdam et al (2005) found family members with more education had more positive attitudes toward advance directives. Notwithstanding a small sample size (n=44), it raises questions about the global impact of any disparities in the commitment of education resources among ethnic minorities. Srebnik et al (2003) also warned that ethnicity could be confounded with socio-economic status or education level after collecting data from 303 adults with serious and persistent mental illnesses.

Bilder et al (2006) found that each psychotic exacerbation among patients with schizophrenia led to subtle brain damage, re-iterating the urgency which NICE attaches to rapid identification and early referral as patients diagnosed with schizophrenia may face increasingly pronounced cognitive impairment from which a written advance directive, where recorded, may provide some respite. Bilder et al (2000), studying patients with schizophrenia or schizoaffective disorder, found they showed a generalised cognitive deficit of approximately 1.5 standard deviations relative to the comparison group, a large effect in both statistical and clinical terms. In the context of this generalised deficit, however, language function was relatively spared; memory, executive and motor dysfunction was most impaired. The authors explored whether neuropsychological deficit in schizophrenia may be attributable to medication effects. Significant correlations between antipsychotic dose and impairment on every neuropsychological scale were found but higher dose also correlated with severity of hallucinations, leading the authors to argue that they are no more inclined to suggest that antipsychotic drugs cause neuropsychological deficit than to suggest that antipsychotic drugs cause hallucinations.
Age may also have an impact on the uptake of advance directives as they may be associated with deteriorating health (Salm, Will & Hommel 2005). Schizophrenia onset occurs typically in late adolescence and early adulthood, so advance directives must be discussed at an earlier age than people in the general population typically begin to think about plans for what to do when they are incapacitated. It is therefore possible that age, educational background, socio-economic status and time since onset could all confound the impact of ethnicity on provision of advance directives.

Amering, Stastny & Hopper (2005) concluded that advance directives are complex planning tools rather than focal interventions and systemic factors are linked to the provision of advance directives. Historically, the efficacy of advance directives is unproven. In the first randomised trial of advance directives for psychiatric care, Papageorgiou et al (2002) found users’ advance instruction directives had little observable impact on the outcome of care at 12 months. Data had been collected from in-patients receiving compulsory Mental Health Act treatment who were due for discharge in the 12 months up to October 1998 but the overall framework changed when NICE guidelines were introduced in 2002 (although they can be ignored by health care professionals if the patients are sectioned under the Mental Health Act) so further exploration of their efficacy is needed. Another practical difficulty with advance directives is that they may be only available in paper form although, as records are migrated to a national database, it may be easier for health care professionals to access advance directives electronically. To enhance availability and access, Rethink, the operating name of Britain’s National Schizophrenia Fellowship (2007), champions the use of “crisis cards” which can be carried at all times and contain details of allergies, chronic illnesses or advance directives. If the patient were incapacitated, for instance by a psychotic episode, the card would alert health care professionals to the advance directive.

Limitations of audit

Initially the NICE Project Board hoped to use the diagnosis recorded on enhanced care plan approach records to generate a sample but this became unfeasible as it was found that 96% of new referrals and 88% of re-referrals did not have a summary sheet with recorded diagnosis. The implication was that auditors had to spend
considerable time reading detailed and lengthy case notes or talk to the care co-ordinator which reduced the number of cases that could be audited in the allocated time. The data tool was also designed to facilitate data collection over six different diagnoses, inevitably compromising its specificity. For instance, the response grid (Met, evidenced in case notes; Met following conversation with the care co-ordinator; Not met; Not applicable) was unsuitable for interpretation of advance directive provision and the tool refers to both ‘advance directives’ and ‘advance decisions’ although after conversation with fellow auditors it was agreed that both terms referred to advance directives. These anomalies may foster variations in interpretation and inconsistencies between auditors. Other research has suggested a wide variation in attitudes to advance directives between professionals (Srebnik et al 2003) but as this study did not record the particular professionals involved in each team it could not address that issue and could only explore differences between services, a hypothesis eventually unsupported.

The audit tool recorded ethnicity in nine categories and the data was treated as race in three categories. BPS guidelines recommend race, ethnic or national origin should be referred to only when it is relevant, which it is here, but the issue is so complex and potentially controversial it is beyond the scope of this report to address diversity issues in the NHS in any depth.

Extrapolating from this audit is also problematic because, as the guidelines are barely five years old, there are very few studies to support a longitudinal comparison. Amering, Stastny & Hopper (2005) described an advance directive as a ‘sustained act of self-examination and situation appraisal’ implying that a long-term perspective would be useful. Also, the stigma associated with a diagnosis of schizophrenia is widely reported, Mann and Himelein (2004), and this study may reveal one of the ramifications. As NICE guidelines only require an advance directive be made available to those with a diagnosis, the health care professionals’ reluctance to make a diagnosis of schizophrenia makes that requirement redundant and introduces a variable which may contaminate any results. The usefulness of this study would also be enhanced if socio-economic status and education were recorded in order to further explore any correlation with the provision of advanced directives.
Clinical implications

A broad training need is revealed by the low implementation of ADs but that may be refined according to the make-up of the multi-disciplinary team. Srebnik et al (2003) found clinicians’ attitudes toward advance directives influenced service recipients’ interest while Atkinson, Garner and Gilmour (2004) found a wide range of views among stakeholders as to whether advance directives were necessary, ranging from 89% support among voluntary organisations to 28% among psychiatrists. This suggests institutional interventions could focus on training, education and exploration of attitudes among health care professionals. However, Atkinson, Garner and Gilmour’s (2004) sample comprised mental health voluntary organisations, psychiatrists, nurses, social workers, NHS Trust directors and Directors of Social Work in England and Scotland but did not include clinical psychologists or occupational therapists.

Ease of applicability was addressed by Papageorgiou et al (2004) which found that patients with severe and enduring mental health problems were capable of drawing up realistic, logical, rational and consistent advance directives and did not use them as an opportunity to refuse all subsequent treatment. The legal status of advance directives could also be clarified in training as Toller & Budge (2006) found specialist registrars in the United Kingdom were confused about the legal status of advance directives. Srebnik & Kim (2006) argued that capacity to create a psychiatric advance directive can be reasonably presumed so formal assessment of capacity should be reserved for cases in which doubts have arisen about decisional capacity based on available clinical information. Clinicians could also be encouraged to focus on sustained face-to-face discussion of advance directives as Ramsaroop, Reid & Adelman (2007) found the most successful interventions incorporated direct patient–healthcare professional interactions over multiple visits while passive education of patients using written materials was a relatively ineffective method.

Recommendations

Based on the evidence discussed in this audit, it is recommended that
training programmes for clinicians are instigated to increase the understanding, availability and effectiveness of advance directives;

the migration to electronic databases for case notes be coupled with promotion of ‘crisis cards’ to improve the implementation of advance directives.

future audits record which professions are involved in multi-disciplinary teams

educational level and socio-economic status are recorded in future audits

Conclusion
This study was modelled on Crombie et al’s (1993) audit process of reviewing the delivery of healthcare to identify deficiencies so that they may be remedied. The fundamental remedial need highlighted by this study is that, by only effecting advance directives for 33% of patients, the Trust is not meeting NICE guidelines. There is no evidence, however, that this is related to ethnicity or service organisation. Also, having the Trust's own audit department draw up the audit tool may ameliorate resentment among the teams being audited, but it also means the trust is effectively auditing itself which may lead to a conflict of interest.

To answer the trust’s initial question “How NICE are we?” the answer is “not very NICE – but not in a systemic or racial way”.
REFERENCES


To whom it may concern;

Please accept this letter as verification that Martyn Bignold, Fay Coster, Gemma Ellis and Anna Preston, Trainee Clinical Psychologists, each presented their Service Related Research Projects on September 14th 2007. The CMHTs enjoyed the feedback and it sparked an interesting discussion around NICE guidelines and other related projects in the Trust. Their contribution both through the projects and their presentations, was very much appreciated.

Yours Sincerely

Jane Street
Consultant clinical psychologist
The prevalence of post-traumatic stress disorder among journalists and the impact of attachment style and coping strategies.

by

Martyn Bignold

Submitted for the degree of Doctor of Psychology
(Clinical Psychology)
Department of Psychology
School of Human Sciences
University of Surrey

September 2009

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19,803 words
ABSTRACT

Background: Among those exposed to traumatic events, only a small minority will go on to develop post traumatic stress disorder (PTSD). Research among clinical populations and professions with high work-related exposure to trauma suggests that attachment style and coping style may explain some of the recorded variation in response to traumatic events. Journalists may also experience work-related exposure to trauma but there is little data on rates of PTSD in the profession or the impact of attachment style or coping style. Method: Participant journalists ($N = 195$) were assessed for adult attachment style and coping strategy via a self-report online questionnaire comprising demographic data, the Post-Traumatic Stress Disorder Checklist – Civilian; the Experiences in Close Relationship Scale Short Form measure of attachment and the BRIEF Cope measure of coping strategies. Links to the questionnaire were posted on websites relevant to journalists including the National Union of Journalists (NUJ). Data were analysed using analysis of variance, correlation co-efficients and logistic regression. Results: journalists are almost four times more likely to develop PTSD than the general population. An anxious attachment style was significantly associated with PTSD symptomology. An avoidant coping style, the use of religion, self-blame and substance abuse was also positively associated. The impact of work culture on vulnerability to and recovery from PTSD is discussed. Conclusions: the prevalence of PTSD among journalists is higher than in the general population and the development of PTSD may be influenced by attachment style and coping strategies.
ACKNOWLEDGEMENT

Grateful thanks go to my research supervisor Dr Fiona Warren; clinical tutor Dr Susan Howard; Dr Marie Thompson; Dr Amanda Pennell; the Traumatic Stress Service team at South West London and St George's Mental Health Trust; the Dart Centre research group; David Ayrton of the National Union of Journalists; Rodney Pinder of the International News Safety Institute and many former colleagues in journalism.

Special thanks also go to my partner Kristiina and son George for their support and patience.
INTRODUCTION

It has been theorised that a child’s initial experience with its parents will inform its behaviour in adult life (Bowlby, 1988) because the availability, or absence, of parental care influences a child’s psychological development. Ainsworth et al. (1978) explored the nature of the attachment bond by examining a child’s responses when tired or ill and found children seek and maintain proximity to just one caregiver, suggesting that attachment style is especially influential on behaviour in stressful circumstances. While attachment style has a strategic impact on an adult’s capacity to develop relationships, a coping strategy may be seen as a tactical response to stress. Folkman and Lazarus (1980) developed one of the earliest models of response categorisation by distinguishing between problem-focussed coping, such as seeking information or actively modifying the situation, and emotion-focussed coping which acts on the internal world through behaviours such as venting, avoidance or self-control. If coping strategies are overwhelmed by traumatic experience - such as being the victim of violence, accident or injury - then post-traumatic stress disorder may develop.

However, while trauma is a necessary precursor to the development of post traumatic stress disorder (PTSD) it is not the only precursor (Mezey & Robbins, 2001). While the dose-response model is predominant, that is greater exposure to potentially traumatic events (PTEs) is associated with higher rates of PTSD, the vast majority of people exposed to a traumatic stressor will not develop the disorder (Boals & Schuettler, 2009) which suggests that individual differences and some quality or aspect of the traumatic event may play a role in determining the development of PTSD. A holistic model of stress response might then include the impact of attachment style and coping strategies.

Some professions such as the armed forces, emergency services and relief workers will experience greater exposure to work-related PTEs and subsequent potential for higher rates of PTSD, so these vocational cohorts have proved fertile ground for research into factors influencing vulnerability, onset and treatment of the disorder.
Studies of Vietnam Veterans\(^1\) in particular have been used to develop treatment protocols including exposure therapy, systematic desensitisation, stress inoculation training, biofeedback and EMDR (Fo\(a et al., 2000\)). However, not every profession with a higher exposure to traumatic stressors has been studied in depth. Journalists - by virtue of their role as witness to and communicator of dramatic events - could be expected to encounter a higher number of work-related PTEs than the general population but there is little data on rates of PTSD within the profession.

Treatment interventions for PTSD in the UK are largely based on a classical conditioning model (Orr \(et al., 2006\)) and do not specifically accommodate the impact of disrupted attachment so, although these treatments are largely effective, it may be that exploration of the interplay between attachment style, coping strategy and PTSD will contribute to a greater understanding of the aetiology and maintenance of the disorder and improved assessment and treatment protocols in future.

While recognising the limitations of analogies, one that encompasses attachment, coping style and PTSD may be to use a sea voyage as a metaphor for life. The prevailing winds at the outset represent secure or insecure attachment, a ‘secure’ wind is a tailwind that moves the boat along; an ‘insecure’ wind is a headwind that makes progress more difficult. As time goes by the sailor learns to use sails, a rudder or a sextant to steer the boat. These represent adult coping strategies, deployed to meet specific challenges. If the boat encounters a storm, a metaphorical stressor, a combination of the sailors’ skill with the boat and the impact of the prevailing wind may largely determine if they are successful in navigating the maelstrom. If they are successful, they will continue their voyage, if they are overwhelmed and their boat capsizes, they have developed PTSD.

\(^1\) For the purposes of this study, Vietnam Veterans refers to American soldiers who fought during the Vietnam War.
The Psychology of Trauma

"to a generation of men who,
even though they may have escaped its shells,
were destroyed by the war."

dedication in
All Quiet on the Western Front
by Erich Maria Remarque

Many of the landmarks of development in psychology involve understanding the response to trauma. The physical trauma experienced by Phineas Gage in an industrial accident led to an early understanding of brain function regionalisation (Macmillan, 2008); the psychological trauma Freud’s patients had experienced as children led him to develop theories about repressed memories (Freud, 1960) and Milgram (1963) focussed on the impact on behaviour of witnessing someone else’s trauma. The concept that simply witnessing a traumatic event can provoke a shift in behavioural, cognitive and emotional functioning is now accommodated in the major Western models of psychology but the terminology used to describe response to trauma reflects a gradual shift from attributing it to a physical cause to the contemporary position that simply witnessing trauma can provoke a profound response (Jones & Wessely, 2005).

The Evolution of Post-traumatic Stress Disorder

It may be useful to briefly trace the provenance of the term ‘post-traumatic stress disorder’ as the definitive diagnostic criteria - particularly as specified by the Diagnostic and Statistical Manual of Mental Disorders (DSM) - are landmarks by which many clinicians must navigate. The two most widely used compendia of mental disorders are the DSM and the International Classification of Diseases (ICD) but the DSM is used in this study as empirical studies use DSM criteria “almost exclusively” (O’Connor, et al., 2007, p.320).
PTSD is classified as an anxiety disorder but one aspect that separates it from other anxiety disorders, such as phobic responses or obsessive-compulsive disorders, is that PTSD follows a specific environmental event (Vasterling & Brewin 2005). Psychological consequences of traumatic exposure were called ‘gross stress reaction’ in the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1952) but this label was dropped in favour of ‘transient situational disturbances’ in the first revision, DSM-II (American Psychiatric Association, 1968). Post-traumatic stress disorder formally entered the diagnostic nomenclature in 1980 when it was included in DSM-III (American Psychiatric Association, 1980). The re-evaluation of diagnostic criteria in successive editions reflects changing interest and attitudes around the disorder, indeed Spitzer *et al.* (2007, p.233) report that “no other diagnosis (with the exception of the related Dissociative Identity Disorder) has caused so much controversy - in terms of the boundaries of the disorder, diagnostic criteria, central assumptions, clinical utility and prevalence” – but a detailed account of the political battle for recognition of PTSD is outside the scope of this study.

In the latest revision, DSM-IV-TR, a traumatic stressor involves “actual or threatened death or serious injury, or a threat to the physical integrity of self or others” with the subjective response of “intense fear, helplessness or horror” (APA, 2000, 309.81). The characteristic constellation of symptoms includes re-experiencing of the traumatic event, avoidance of stimuli associated with the event and increased arousal. (See Appendix 1 for full criteria).

It may be wrong, however, to assume a full and final definition of the condition has been reached. Subjective aspects entered the DSM in the revised fourth edition (APA, 2000,309.81) as criteria A2: “the response includes intense fear, helplessness or horror” which accommodated reports such as that by Flannery (1999), in which it was argued that risk factors such as genetics, intelligence, education and social support only account for some of the variation in causality of PTSD and that the caustic nature of some events lies in their potential to challenge subjective perceptions such as mastery of one’s environment; caring attachments and meaningful purpose in life. The
subjective nature of PTSD may be illuminated by examining the risk of developing PTSD in relation to different stressors. For men, the risk of developing PTSD after being physical assaulted or threatened with a weapon is less than 2% but if the man is raped the risk for PTSD rises to 65% (Sue et al., 2003), suggesting that the stigma and taboo around male sexual assault may make the experience more damaging than a non-sexual assault.

However, the inclusion of subjective criteria has been contentious. Accommodating subjective criteria places the experience of someone who is horrified at what has happened to others in the same rubric as someone “huddled in a trench under artillery bombardment for days on end”, according to McNally (2003, p.231). Metaphorically, the ‘traumatic stressor’ which lead to the development of the term PTSD was the Vietnam War and recognition of the disorder had profound implications for Vietnam Veterans’ entitlement to benefits suggesting that the emergence of the term had as much to do with politics as science, Brewin (2001). As the diagnostic criteria for PTSD have been influenced by socio-political factors and developments in clinical understanding, it may be assumed that those criteria will continue to evolve.

**Prevalence of PTSD**

As trauma exposure is a factor in the development of PTSD (Collimore, 2008), the rate of PTSD must be understood within the context of the rate of exposure to PTEs. In a meta-analysis of epidemiological studies, Hidalgo and Davidson (2000) found lifetime exposure rates to PTEs ranged from 36.7% (Breslau et al., 1991) to 92.2% (Breslau et al., 1997). The lower exposure rates were from populations of young adults (aged 21-30 years) while the higher reported rates were found in studies using older populations (aged 18-45 years) and a broader range of definitions of trauma, including traumatic bereavement. The range between age groups may be partly explained by the increasing likelihood that, as a person ages, they are more likely to experience trauma such as bereavement although it must be remembered that within groups there is not a linear relationship between exposure and traumatic response (Flannery, 1999). Kessler et al. (1995), in what may be the largest epidemiological study \(N = 8,098\), found that 60.7% of men and 52.1% of women had been exposed
to PTEs at some point in their life. The differing rates between genders however, illustrates the difficulty of comparing experiences as some of the PTEs had been experienced by both sexes in roughly equal numbers (e.g. natural disasters or fires) while others were not, (e.g. females had a higher experience of rape and males of combat). Notwithstanding the range of estimated exposure to traumatic stressors, it is evident that such exposure is common in the general population. Although traumatic exposure may result in high levels of traumatic distress - Norris et al. (2003) found 95% of those exposed to trauma showed some psychological distress – that distress rarely develops into a disorder with up to two-thirds of those exposed to a traumatic incident emerging mentally unscathed (Friedman, 2005).

Epidemiological studies have found some variation in the prevalence of PTSD, which may reflect higher incidence or issues around defining and diagnosing the condition. Darves-Bornoz et al. (2008) examined 12-month prevalence rates in several European nations and found a range from 0.56% in Spain to 2.63% in the Netherlands. The Zurich Cohort Study found lifetime exposure to PTEs to be 28% in Switzerland but none of the 367 participants met DSM-IV criteria for PTSD (Hepp et al., 2006). This was attributed to several factors including the low murder rate of 2.6 per 100,000 (compared with a European average of 7.2), little terrorism; social stability and few migrants from conflict regions. Using the National Comorbidity Survey Replication (NCS-R), Kessler, Berglund et al. (2005) found adult Americans had a lifetime prevalence of PTSD of 6.8% (3.6% among men, 9.7% among women) and the past-year prevalence at 3.5% (Kessler, Chiu et al., 2005) (1.8% among men, 5.2% among women). These findings are largely consistent with the first National Comorbidity Survey conducted in the 1990s which found a lifetime prevalence of 7.8% with women (10.4%) more than twice as likely as men (5%) to have PTSD at some time in their lives (Kessler et al., 1995). The prevalence of PTSD has been measured among migraine sufferers (Peterlin et al., 2009); UK soldiers with combat experience (Iversen et al., 2008) and soldiers treated for burns (McGhee et al., 2008). Because of the varied exposure to PTEs which may be expected among journalists, it may be appropriate to compare rates of PTSD with the general population, rather than a specific trauma group. Feinstein et al. (2002) established the rate of PTSD among war
reporters at 29 per cent but the rate among all those involved in news-gathering and production does not appear to have been established.

With no consistent use of sampling methods, diagnostic criteria or timeframes though, the different rates of PTSD reported make cohort comparison with the general population problematic and epidemiological studies using the Post Traumatic Stress Disorder Checklist for Civilians (PCL-C), which measures PTSD symptomology experienced in the last month, are rare but Stein et al. (1997), using a random sample of 1,002 Canadians, estimated the one-month prevalence in the general population to be 3.4% (5% for women; 1.7% for men). Wilberforce et al. (2010) in a survey of Canadian GPs (n = 159) found a one-month prevalence of PTSD of 4.4% using a cut-off of 50 on the PCL-C.

In summary, it appears that while many will be exposed to a traumatic stressor at some point in their lives, only a minority will go on to develop PTSD, suggesting that the onset is a complex process influenced by individual differences with biological, psychological and social aspects.

Risk and resilience

Individual differences such as a genetic vulnerability, age and gender could be categorised as those that increase vulnerability to developing PTSD (predictive), those that reduce vulnerability to PTSD (protective) and those that may maintain the disorder or delay recovery after its onset (perpetuating).

Predictive factors

Mental health, genetic factors, gender and age have all been explored in terms of predicting vulnerability to PTSD. In a meta-analysis of epidemiological studies, Brewin et al. (2000) found three risk factors for the development of PTSD consistently reported: a history of psychiatric disorder; childhood trauma and family history of psychiatric disorder but Hidalgo and Davidson (2000) report personal and familial psychiatric history increases the likelihood of exposure to trauma so it may be that higher rates of PTSD reflect higher exposure to PTEs rather than an inherent vulnerability. In one of the few prospective studies of the impact of individual
differences on vulnerability to PTSD, Baschnagel et al. (2010) found that among American undergraduates coincidentally assessed just prior to the World Trade Center attacks, being female and having previous trauma experiences were significant predictors of PTSD symptomology.

Yehuda et al. (1998) found adult children of those who survived the Holocaust (but did not develop PTSD) had lower risk of PTSD subsequent to trauma when compared with adult children of those who developed PTSD after the Holocaust. The authors concede it is unclear whether this apparent vulnerability is transmitted biologically or environmentally but Gurvits et al. (2006) found that the sympathetic nervous system of individuals with PTSD was at a higher state of arousal during conditioning so, given the biological foundations of neural interactions, this may explain one heritable mechanism for vulnerability to PTSD.

Breslau et al. (1997) found that, although men and women had similar levels of lifetime exposure to traumatic events, women were more vulnerable to developing PTSD although pre-morbid anxiety and depressive disorders partially explained the differences. In a study using participants from six European nations, being female was found to be a risk factor for PTSD without being a risk factor for exposure to traumatic events (Darves-Bornoz et al., 2008) but Lilly et al. (2009) may offer some explanation of the apparent gender anomaly. In a study comparing female police officers with female civilians, it was found that it was the intensity of the emotions related to PTSD vulnerability that explained the apparent gender differences. That is, women were not more emotional, but experienced the peri-traumatic emotions more strongly than men. Intrapersonal factors may influence apparent gender differences too. Vogt et al. (2008) found female soldiers deployed in the Gulf War had higher rates of PTSD than their male counterparts and surmised that the cohesion which men experienced in active duty units (where men outnumber women by at least 10 to one) was not experienced by women, who were in a minority. Galea et al. (2008) found higher rates of PTSD among women living in Mississippi before Hurricane Katrina when compared with men but could only offer, by way of explanation, that this finding was consistent with most post-disaster studies. These studies report on situations outside the scope of ordinary life. War, law enforcement and catastrophe are
unfamiliar scenarios for most people and the gender differences may be better explained by broader psychological, social and political differences between men and women.

Given the apparent gender disparity in experience of childhood sexual abuse - reported by 11.4% of women but only 2% of men according to Sachs-Ericsson et al. (2005) - and the likelihood that that would be experienced as a traumatic event it may be that a comparison of the prevalence of PTSD between young men and women will be more illuminating if the stressor is a natural disaster and so more likely to be experienced equally by both sexes. In studies of children affected by earthquakes, Groome and Soureti (2004) and Bal (2008) found girls reported more PTSD symptoms than boys, although there was no reported gender difference in severity of exposure, but cultural differences (such as gender-associated willingness to report symptoms) may explain the disparity and no conclusion can be drawn as childhood sexual abuse was not controlled for. Herman (1992, p.28) offers a more strategic explanation for the gender difference in vulnerability to PTSD with the assertion that “the most common post-traumatic disorders are not those of men in war but of women in civilian life” which suggests the higher rates in particular sub-groups (young girls, female soldiers or police officers) reflect higher rates in women in general.

External factors found to be associated with higher reported rates of PTSD include the degree of exposure to a perceived danger, a lack of social support and poverty. Eberly and Engdahl (1991) used weight loss as a measure of the harshness of treatment among former POWs and found it positively correlated with PTSD but, as their data was self-report, it is also possible that in a retrospective design, memory of the trauma was influenced by the contemporary clinical state. Dohrenwend et al. (2008) found greater exposure (also measured by self-report, in terms of direct combat action) predictive while Groome and Soureti (2004) found an exposure effect among those living nearest to the epicentre of an earthquake in that rates of reported PTSD were directly proportionate to the distance from the participant’s home to the epicentre.
Protective factors

In a study of those involved in the response to the World Trade Centre attacks, Perrin et al. (2007) found PTSD rates among unaffiliated volunteers (21.2%) were higher than for police officers (6.2%) and concluded that training had a protective effect. However, the higher rates may be confounded by the impact of group cohesion as Rona et al. (2009) found strong group cohesion associated with lower reported rates and Laffaye et al. (2008) found symptom severity negatively correlated with perceived social support. It may be that intelligence underlies the protection afforded by training or preparation as Davison et al. (2004) found high intelligence to be protective.

Perpetuating factors

A pre-existing severe and enduring mental illness may perpetuate PTSD by masking its symptoms and so delay diagnosis and intervention. Mueser et al. (1998) found that almost half of the participants diagnosed with schizophrenia also met criteria for PTSD but only 2 per cent had been diagnosed as such, leading the authors to suggest that after diagnosing a psychosis, clinicians were less inclined to investigate for further pathologies. It may be that the PTSD was a consequence of the participants’ schizophrenia in that their capacity for risk assessment was impaired by their psychosis with consequently higher potential for traumatic encounters. However, a comparison between patients experiencing their first psychotic episode and those with chronic schizophrenia (Neria et al., 2002) found the two groups reported similar levels of trauma exposure which suggests exposure was not correlated to the length of time schizophrenia had been endured.

As work-related PTSD may result in litigation, Sayer et al. (2008) explored whether ongoing claims for compensation may perpetuate PTSD symptoms but, in a study of Veterans reactions after disability claims were settled, found no link between drop-out rates, psychiatric status or compensation claims. As a caveat, however, Guriel and Fremouw (2003) could not find a method or instrument universally recognised as the best to detect malingering in PTSD.
Flannery (1999) suggests some of those exposed to traumatic stressors may go on to put themselves in harm’s way again in some attempt to gain mastery over the original critical incident while Pat-Horenczyk et al. (2007) found a strong link between post-traumatic distress and risk-taking behaviour although the authors warn that behaviour may be a manifestation of functional impairment. Although the latter participants were aged 15-19, it may be possible to extrapolate their behaviour to some war reporters where their PTSD prompts risk-taking behaviour (such as elevated exposure in war zones) which may in turn increase vulnerability to the disorder.

**Secondary Trauma**

Larsen and Stamm (2008) argue that even those who encounter a powerful stressor second-hand may experience what they termed secondary traumatisation to contrast with direct involvement in or witnessing of a traumatic event which would be primary traumatisation. Other terms used almost interchangeably to describe this apparent phenomenon are burnout, compassion fatigue, counter-transference, secondary traumatic stress and vicarious traumatisation, (Sabin-Farrell & Turpin, 2003). Burnout, referring to the finite capacity of a person’s coping resources (Larsen & Stamm 2008) may be too broad a definition to be useful diagnostically as it could be provoked by excessive workload, the impact of shift work or physical fatigue rather than exposure to someone else’s trauma. Similarly, counter transference, which results from a patient’s projection of their experience, may include traumatic experience but is not limited to it. Regan et al. (2006, p39) discriminated between compassion fatigue - a state of exhaustion with “re-experiencing of the traumatic event, avoidance/numbing, and continued arousal” paralleling PTSD – and vicarious traumatisation which has few overt symptoms but reflects a fundamental shift in a therapist’s beliefs about “trust, safety, control, attachment and esteem for others” (Regan et al., 2006, p.39).

Adopting the language of Larsen and Stamm (2008), secondary traumatisation via visual stimuli was widely investigated in the wake of the World Trade Center attacks in 2001 and it appears that both the quantity and quality of images viewed can alter the development of PTSD. Schuster et al. (2001) found a significant correlation
between the hours of television watched and self-reported stress responses while Bernstein et al. (2007) found that more distressing images, such as those of bodies falling from the World Trade Center towers, were associated with higher rates of PTSD symptoms. The impact of distressing images may be influenced by their frequency (Weidmann & Papsdorf, 2010) so it may be that journalists who were present at a traumatic event may be more distressed by repeated subsequent viewings than those who have no ‘connection’ with the incident. Auditory stimuli may also provoke secondary traumatisation. Feinstein (2006) relates the experience of a videotape editor who deliberately avoided watching gruesome images but inadvertently heard an audio recording of the beheading of a man. “He could not forget the screams of that man being beheaded, that ghastly piercing cry, a distillation of fear so pure and intense it relayed the horror just as powerfully as any image could,” (Feinstein 2006 p.179). Auditory stimuli may also provoke the development of distressing visual images. Krans et al. (2010) found that participants who listened to a journalist describing the scene of a road accident developed intrusive visual images related to the accident and the authors suggest therapists working with PTSD patients might deploy an interference task to minimise the risk of developing visual intrusions.

It has also been theorised that narrative accounts of traumatic experiences may also provoke secondary traumatisation. According to Vrklevski and Franklin (2008), criminal lawyers – whose clients often recounted traumatic experiences within their legal consultation – had higher levels of vicarious or secondary trauma than lawyers working in non-criminal settings such as conveyancing or academia. However, it was not clear if the symptoms reported were related to the participant’s own trauma (primary trauma) or the impact of working with traumatised clients (secondary trauma) and this may reflect some unintentional confabulation in the participants’ minds about the source of their distress. Although self-reported or subjective units of distress are used in many clinical settings, identifying the source of that distress may require a level of psychological insight not universally enjoyed. There may also be aspects of the legal work culture which militate against recognition of secondary traumatisation. Brewin (2003) reports how some viewers who had watched the Hillsborough disaster on television later launched legal action citing media coverage as the source of a subsequent psychiatric disorder but had their cases rejected on the
grounds they were not in proximity to the traumatic events and knowledge of this legal precedent may have affected responses from participants in Vrklevski and Franklin (2008).

So those who regularly listen to distressing accounts of suffering may risk becoming secondary victims themselves although the mechanism is not entirely clear. The mechanism by which strong emotions such as fear are communicated visually, fear acquisition, has been studied in depth elsewhere and is beyond the scope of this study. However it is acquired, the powerful affect that results from exposure to traumatic stories, images or sounds may exacerbate pre-existing post-traumatic distress or lead some, unable to distinguish the source of their distress, to attribute their symptoms to contemporary events because of the recency effect. Or it may be that those who are highly distressed by an event may try to understand it better by watching more television or reading more newspapers, in which case their greater exposure reflects increased use of a coping strategy.

However, it is communicated, it is clear that secondary traumatisation could be experienced by far more people than primary trauma. If exposure to traumatic images, sounds and even narratives can influence PTSD symptomology then it may be surmised that vocational cohorts with greater exposure to such media would report higher rates of PTSD symptomology than those without such exposure. For example, lawyers may take detailed testimony and study evidence around violent crimes; admin staff working alongside healthcare professionals may edit and collate reports from traumatised patients and journalists may be repeatedly exposed to distressing images as part of their job. However, given the variety of definitions and paucity of data, it is difficult to operationalise the concept of secondary traumatisation for clinical or research purposes.

**Models of PTSD**

Several models have been developed to describe and explain PTSD via primary exposure, both psychological and biological, and some of these have been further developed into clinical interventions. In order to understand the complex interplay between environment and individual differences apparent from the variation in
vulnerability to PTSD, it may be useful to triangulate between the physiological underpinnings of the disorder and the clinical approaches that have been developed for its treatment. There are several competing psychological models which attempt to describe PTSD within a cognitive behavioural framework (Taylor, 2006).

Conditioning model

In the conditioning model, the disorder is seen as an example of avoidance learning (Orr et al., 2006). This model originated with Mowrer (1960) and the following scenario may illustrate how classical and operant conditioning interact. A woman is working alone in a house as a cleaner; there's a knock at the door and a man forces his way in, he is carrying a petrol can and pours the contents over the woman before brandishing a cigarette lighter and demanding to know the combination for the safe. The woman is petrified but does not know the combination. The man leaves. The woman calls for help and is taken to hospital. The unconditioned stimulus of the man’s aggression and verbal abuse produced an unconditioned response in the woman of fear and dread. The previously innocuous smell of petrol becomes a conditioned stimulus, producing fear as a conditioned response. Among the many symptoms the woman exhibits, she can no longer fill her car up at the petrol station and constantly checks her doors are bolted when in her own home. The woman’s avoidance and hyperarousal are seen as the result of a surge in conditioned stimuli activating her memory of the attack and producing the fear and dread as a conditioned response. So within this model, the association between trauma experiences and trauma-related anxiety is extinguished through repeated exposure (Carr, 2006). By modelling the traumatic memory as phobic, it is apparent that avoidance may negatively reinforce the symptoms and actually sustain them via instrumental conditioning so a behavioural intervention may be used to sever the link between trauma-related cues and responses. Evidence for this model is largely based on an interaction of biology and behaviour. Fear conditioning is associated with prolonged adrenergic activation (Orr et al., 2006) and preliminary studies have found that beta-adrenergic blockers reduce arousal in patients recounting their traumatic experiences. However, translating this biochemical model into an intervention may be problematic. Although the conditioning model explains the avoidance and hyperarousal often seen in those with
PTSD it does not appear to accommodate individual differences recorded between people exposed to the same traumatic stressor.

*Emotional processing*

Foa and Kozak's (1986) emotional processing model incorporates an information processing mechanism alongside conditioning, that is it includes the *meaning* attached to the stimulus and response. In this paradigm, the fear response – which includes stimuli, response *and meanings* - initiates avoidance or escape when activated. A strength of the emotional processing model is that it encompasses beliefs and attributions in those meanings. Responses to fear stimuli are either adaptive or non-adaptive, with the latter being pathological. In the scenario used earlier, the emotional processing model suggests the pathology arises because of the woman's view that she was utterly safe in her house. Subsequent to the violation of that attribution, the woman's response included even questioning her safety in her own home. Emotional processing may therefore explain why rigid positive or negative beliefs are more vulnerable to PTSD (Taylor, 2006). In those instances, the meaning of the traumatic experience, that the world is a dangerous place, either foments a complete collapse in a rigid positive view or strengthens a rigid negative view. However, while the model's accommodation of individual differences is an advance on the more simplistic two-factor conditioning model, the suggestion that rigidity of belief is more influential than whether that belief is positive or negative, seems at odds with the thrust of the dominant therapeutic intervention (CBT) which attributes most pathology to negative attribution, not positive or rigidly held attributions.

*Dual representation model*

Also, as the emotional processing model emphasises the 'meaning' attributed to events it is more closely related to verbal memories rather than visual memories. This apparent imbalance is addressed within the dual representation model (Brewin *et al.*, 1996) which holds that memories comprised of images and sensory perceptions are stored in the amygdala, verbal memories in the hippocampus. Therapy involves elaborating on those 'situationally accessible memories' (SAMs) so they become 'verbally accessible memories' (VAMs) which facilitates the relocation of the memory from the amygdala to the hippocampus. In this model, the smells and sounds
of the assault (SAMS) are stored in the amygdala so not verbally accessible to the woman victim but provoke a sense of current threat when activated – by the smell of petrol for instance. Treatment would comprise cognitive restructuring of the event by re-living, the aim being to assimilate the memory into the woman’s autobiographical memory and world view (Carr, 2006). The limbic system, which includes the hippocampi and amygdalae, is a brain structure involved in emotion so the dual representation model is also strengthened by encompassing both neural and cognitive mechanisms (Yule, 2003).

**Cognitive model**

Ehlers and Clark (2000) add a cognitive aspect to the behavioural-focussed models with three factors:

- “excessive negative appraisals of the trauma and its aftermath”
- “a disturbance of the autobiographical memory characterised by poor elaboration and conceptualisation of the trauma, strong associative memory and perceptual priming which evokes rapid recollection of vivid emotional memories in response to trauma cues”
- “the use of avoidant coping strategies” (Ehlers & Clark, 2000 p.342).

Consequently, trauma-focussed CBT, such as described by Ehlers *et al.* (2005), combines repeated exposure to the trauma with cognitive restructuring of the meaning of the event, including the impact of the event on the victim’s assumptions.

**Psychological interventions**

There is sufficient evidence to support the cognitive model and its associated intervention in the form of trauma-focussed CBT, for it to be the treatment of choice in the National Health Service (NICE, 2005). Eye Movement Desensitisation and Reprocessing (EMDR), also combines cognitive and behavioural elements. In practice, the bilateral stimulation, mostly in the form of eye movements, apparently facilitates the processing of traumatic memories (Coetzee & Regel, 2005) but McNally (1999) explored historical similarities between EMDR and Mesmerism, in which the patient tracked the movement of the therapist’s finger.
**Biological models**

Given the individual differences in vulnerability to PTSD and diagnostic criteria that require physiological markers such as arousal, a full understanding of the disorder requires exploration of the biological mechanisms. According to Gill *et al.* (2008) both the hypothalamic-pituitary-adrenal (HPA) axis - involved in stress response - and the hippocampus – implicated in the formation of new memories - are central to understanding the development of PTSD. Fonagy (2004) also cites biological factors in support of the impact of stress on mentalisation as the pre-frontal cortex – seat of executive function, strategic thinking and impulse inhibition - is effectively taken offline by extreme stressors allowing the limbic system, home to the fight or flight response, to dominate.

If a biological substrate is valid, then a genetic heritability of vulnerability to PTSD is supported. Indeed, Koenen *et al.* (2008), in a study of identical and fraternal twins involved in the Vietnam War, showed a modest hereditary vulnerability to PTSD and major depression but it is not clear if this can be extrapolated beyond male Vietnam Veterans.

**Pharmacological interventions**

A biological substrate to PTSD vulnerability suggests that a pharmacological intervention might be appropriate and Bisson (2007) found that the selective serotonin re-uptake inhibitor paroxetine had a significant positive effect, compared with placebo, but concerns have been reported about links between the use of paroxetine in adolescents and suicide (Duff, 2003). While NICE recognises meta-analysis of randomised controlled trials (RCTs) as the gold standard of evidence, Bisson (2007) found that some trials which found no positive affect were not published and called for the pre-registration of trials and an undertaking to publish all results.

Conceptualising PTSD as a failure of information processing systems or biochemical functioning may marginalise the individual differences behind the range of responses to traumatic stress. While a biological model may explain individual differences at a genetic level, it appears reductionist as an attempt to explain what is a complex process with social, cultural and emotional overtones. Conversely, if the psychological
models are judged on the basis of the interventions they spawned then according to Shavlev (as cited in Foa et al., 2000) even trauma-focussed CBT – the most studied intervention for PTSD – does not benefit all patients and it is not clear what factors predict success.

Attachment

It may be then that a classical conditioning view of anxiety disorders such as phobias, and by extension PTSD, is an inadequate paradigm. Even an elaborate model that accommodates meaning as well as conditioned response still leaves unanswered questions about any pre-morbid aspect which makes some more vulnerable to the development of PTSD but cannot be accounted for by individual differences such as gender, social support or education. For instance, although Pyevich (2003) found support for a cognitive model linking traumatic exposure to the development of PTSD, the underlying factor behind those negative cognitive beliefs was not uncovered. Attachment theory initially described the importance of the development of early relationships and their impact on capacity for emotional connection but has been extended to explain individual differences in capacity for emotional regulation and coping (Renaud, 2008) and is “one of the most successful psychological theories of the past half century” (Shaver & Mikulincer, 2008, p.17).

Attachment theory may then be fertile ground for an explanation of those individual differences in vulnerability to developing PTSD. In the first incarnation of the theory, Bowlby took an evolutionary perspective on children’s behaviour. In this paradigm, the infant’s desire to remain close to its primary caregiver - or attachment figure - conferred an evolutionary advantage, especially under threatening situations, (Bowlby 1988). Bowlby’s work was further developed by Ainsworth’s ‘strange situation’ methodology in which the importance of the child/caregiver relationship is tested by examining what happens when it is disrupted (Ainsworth, 1991). As children develop, the attachment figure becomes a ‘secure base’ from which the world is explored or returned to in times of stress. The availability of this secure base may then foster both confident exploration and an approach to new situations that is not purely defensive. The obverse of secure attachment is insecure, which Ainsworth et al. (1978) further categorised as anxious-ambivalent, in which the child experiences a care-giver as
inconsistent between neglectful and appropriate responses, and avoidant in which the care-giver hardly responds to the child’s distress. A fourth category, disorganised, was added by Main and Solomon (1990) which describes a pattern of behaviour oscillating between avoidance and anxiety but the fundamental secure/insecure model still informs contemporary understanding (Mikulincer et al., 2003) and as most of the studies reviewed do not include this fourth type, discussion here is limited to the first three.

The mechanism by which a care-giver’s behaviour influences a child’s may involve mentalisation. Fonagy et al. (2002) describe a mentalisation model that draws on an evolutionary perspective to explain individual differences in the ability to understand others. Mentalisation is the ability to interpret behaviour in terms of mental states, that is to think of ourselves from the outside or others from the inside. The ability to mentalise may be facilitated by the first experience of being understood by our primary care-giver, that is it is dependent on the same good enough, not overbearing/not neglectful care that fosters secure attachment. Fonagy et al. (2002) distinguish between two groups who have not developed the capacity for mentalisation. Psychopaths, who struggle to read tone of voice or facial expression so cannot recognise mental states in others and consequently don’t develop the ability to inhibit their latent violence. And those who fail to develop attachment relationships because their primary caregiver is either absent, neglectful, abusive or overly anxious so provides little or no consistent opportunity to develop an understanding of mental states. For a securely attached child, latent violence is replaced by more pro-social behaviour as mentalisation skills evolve. For the insecurely attached, poor mentalisation skills may mean they lead more violent lives (as perpetrators or victims) and have difficulty forming lasting relationships, which may result in higher exposure to PTEs and delayed recovery of PTSD does develop.

*Attachment in adult life*

The predominant model of attachment theory is the ‘ABCD’ model which comprises secure, insecure anxious, insecure avoidant and disorganised styles and assumes they are largely consistent throughout the lifespan (Stacks, 2010) but an alternative is the dynamic-maturational model (DMM) which emphasises the fluid interaction of human
change across the life-span with the focus on functions of self-protection, reproduction and protection of progeny (Crittenden & Claussen, 2000). In a comprehensive five-study report, however, Hazan and Shaver (1987) found attachment style was largely consistent across the lifespan and that classifying attachment styles as secure, insecure avoidant and insecure anxious produced roughly the same proportions in adults as infant cohorts (some 60%; 25% and 15% respectively). But while attachment styles may be stable they do not appear to be fossilised. Muller and Rosencrantz (2009) found that patients receiving inpatient group therapy for PTSD developed more secure attachment styles after an 8-week group programme. Interestingly, although self-reported anxious and avoidant attachment scores diminished during the programme, avoidant attachment scores returned to their pre-treatment level within six months suggesting anxious attachment patterns are more responsive to change than avoidant styles. This is consistent with Crittenden (1997) in which it was argued that the therapist may act as the secure base from which patients develop a more secure attachment style. If attachment style can then be thought of as trait-like (Hazan & Shaver 1994), it follows that for the securely attached child, repeated interactions with attachment figures who are sensitive and responsive may enhance mentalisation and the development of a constellation of skills which aid emotional regulation, including:

- confidence in their ability to tap into internal and external resources following positive experiences of support-seeking
- problem-solving skills developed after revising erroneous beliefs or strategies without incurring excessive self-doubt or self criticism
- tolerance for ambiguity and uncertainty while creatively exploring a challenging situation (Mikulincer & Shaver, 2007).

Poor skills at mentalisation however, may lead to a vulnerability to hindsight bias in which it is assumed, post-traumatically, that the event could have been anticipated and that the failure to do so is a source of some of the guilt and shame reported by those with PTSD, Brewin (2003). Well-honed mentalisation fostered by secure attachment may then mean lower exposure to violence and more stable relationships available to ameliorate the impact. However, there are weaknesses in attachment theory which make it difficult to use it alone to map a trajectory of behaviour from childhood to adulthood. Attachment theory may not accommodate environmental influences such
as siblings or socio-economic status or religious background. Ainsworth’s early work was almost exclusively concerned with mother-infant attachment (Ainsworth *et al.*, 1978) to the exclusion of father-infant attachment, a factor further complicated in later life by the development of other attachments to partners and offspring.

**Insecure avoidant attachment**

For those with an avoidant attachment style, their emotional goal is to keep the attachment system deactivated (Mikulincer & Shaver, 2007). Consequently, a defensive inhibition is maintained, especially toward fear because that could trigger unwanted activation of the attachment system. Even emotions such as anger may be avoided as they undermine the pretext of self-reliance and detachment which the unavailability of their caregivers had engendered (Mikulincer & Shaver, 2007). Consequently, the child who develops an avoidant attachment style may, as an adult, struggle to use emotions flexibly in behaviour regulation. Repeated experiences of punishment or rejection as the sequel of any expression of distress or vulnerability taught the child that emotions are best suppressed (Cassidy, 1994).

**Insecure anxious/ambivalent attachment**

For some children, the experience of inconsistent parenting may foster an anxious attachment style in which the goal is to ensure more consistent interactions by emphasising emotions that call for attention and care (Bowlby, 1988). This anxious hyperactivation may also be manifested internally by intensifying emotions that activate the attachment system such as fear of abandonment and doubts about self-efficacy. As an adult, that insecure anxious attachment may diminish the capacity for self-soothing as the relaxation - the goal of self-soothing - may provoke disengagement from the inconsistently available caregiver. Similarly, problem-solving and overt competence may not be nurtured as early experience has taught the child that to be problem-free is to be ignored. In order to sustain anxious hyperactivation, the anxiously attached may engage in catastrophic appraisals, amplify perceived threat, maintain pessimistic beliefs about their ability to manage distress and attribute threatening events to uncontrollable causes and personal inadequacies (Mikulincer & Shaver, 2009).
To sum up, insecure attachment, whether avoidant or anxious, may prompt deactivating or hyperactivating strategies which, although opposites, both result in dysfunctional emotions while optimal functioning of the attachment system facilitates better problem-solving, cognitive reappraisal, self-soothing and support-seeking.

Attachment and PTSD

If attachment style explains the mechanism by which individuals respond to stress in general, can it be extrapolated to explain traumatic stress in particular? Mikulincer and Shaver (2007) suggest attachment style is manifested by navigating three “if-then” scenarios: if threatened, then find an attachment figure; if the attachment figure is available, then return to other activities; if the attachment figure is unavailable or unresponsive either work harder to get closer (hyperactivation of the attachment system) or deactivate it and rely on oneself. If then, a securely attached adult encounters a traumatic stressor, they have well-developed skills in problem-solving and cognitive reappraisal and the capacity to mobilise support from others. And if the event does not end in unqualified success, they are also more likely to be able to self-soothe without rumination or catastrophising (Mikulincer & Shaver, 2007, p190). Securely attached adults could be expected, therefore, to be better at handling stress and more confident in their abilities to self-soothe. In the way that the child accepts the mother’s return without guilt in Ainsworth’s strange situation, a securely attached adult may also be less susceptible to the overwhelming shame and guilt reported by many who develop PTSD. Attachment theory may also explain why the impact of interpersonal violence, as opposed to natural disaster, is so much more profound as it may be perceived by the victim as a violation of the fundamental human connection which initiated and sustained the child/care-giver bond. However, categorisation of PTEs as acts of human agency or natural disaster may be too simplistic as some human-engendered trauma, such a robbery or assault, may be more likely in the chaos ensuing a natural disaster.

Research into the links between attachment style and vulnerability to PTSD has largely focused on populations with exposure to specific stressors. Mikulincer et al. (1999) found secure attachment negatively correlated with PTSD symptomology among Jewish settlers living in occupied territory; Fraley et al. (2000) found that
among witnesses to the WTC attacks, securely attached participants exhibited fewer PTSD symptoms than insecurely attached participants (although this was based on self-report measures and the evaluation of friends and relatives rather than a clinician-administered interview so may be prone to subjective errors of reporting) and (Jeavons et al., 2000) found avoidant attachment style associated with higher reported PTSD symptomatology in road accident victims.

Dieperink et al. (2001) found attachment style a better predictor of vulnerability to developing PTSD than exposure to extreme trauma. In a study of American POWs, it was found that prisoners with secure attachment styles scored significantly lower on PTSD measures than those with insecure attachment styles. Dieperink et al. (2001) used data gathered by Engdahl et al. (1997), including self-reported weight loss during captivity as a measure of trauma exposure, but of the 262 former POWs who took part in the initial study, only 156 were still living for the second study and, of those, only 107 responded. So while Dieperink et al. (2001) gives a well-explored account of a possible link between attachment style and vulnerability to PTSD, it should be noted that the participants were self-selecting, as they are in this study, so those with avoidant attachment styles or who use denial or avoidance as a coping style may not have responded. Also, although attachment is viewed as a lifelong mechanism, the impact of the young age at which the participants were captured (average 22 years), the length of time in captivity (average 17 months) and the passage of five decades since their experience on attachment is not known. This, together with the unusual nature of long-term captivity as a prisoner-of-war, means that generalising to other professional groups or the general population may not be legitimate.

In a study involving 544 people working for either a security company or the Belgian Red Cross, Declercq and Willemsen (2006) found those with an insecure attachment style were more vulnerable to PTSD than those with a secure style. Renaud (2008) hypothesised that avoidant attachment might be adaptive in the short-term because it reduces the activation of uncomfortable emotional states but the long-term cost of this strategy is that it diminished the possibility of receiving positive social support. The interplay between attachment style and social support was further investigated by Ein-Dor et al. (2010) in a study of Israeli soldiers who fought in the Yom Kippur war,
when it was found that insecure attachment was associated with the development of PTSD in the veterans and the development of secondary traumatic stress in their wives. The veterans were further divided into those who had been held captive and those who had not. It was found that the type of stress had an impact on whether it was associated with higher vulnerability in those with anxious or avoidant attachment styles. It was hypothesised that avoidant attachment would only be associated with the development of PTSD in cases of extreme trauma because the otherwise effective avoidant strategies - such as suppressing attachment needs or distress - while effective in the short-term, collapsed under the prolonged human-engendered trauma of being held prisoner. The authors concede however that the avoidant attachment-PTSD link to specific human-engendered stressors, such as being held captive, may be felt as such a challenge to notions of the fundamental goodness of people that it prompts an increase in avoidant behaviour. It is also possible that imprisonment and solitary confinement would challenge the sense of cohesion experienced by those fighting alongside fellow soldiers so future studies might also differentiate between those who were held captive in isolation and those who were held in groups. The post-hoc nature of this report means that causality cannot be inferred, which the authors concede, but Solomon et al. (2008) found that complex trauma was capable of modifying attachment orientation although the mechanism was not clear.

Attachment appears to be then an innate psychobiological system which links a child’s earliest experience of others to its adult cognitive style and emotional framework. It can accommodate genetic and socially inherited traits; individual differences in cognitive style and – most importantly – go some way to explaining individual differences in distress regulation. Bowlby (1988) however, suggests attachment theory can inform the stance taken by the therapist with five goals: to provide the patient with a secure base from which to explore aspects of their life; to assist the patient in exploring ways in which they engage in relationships; to assist the patient in exploring the patient-therapist relationship; to consider how current thoughts, feelings and behaviours are informed by the patient’s childhood experience and to enable the patient to recognise that their models of themselves and others may not be appropriate or justified. However, there appears little agreement on what ‘attachment therapy’ is
or could be and some argue it can only inform rather than define interventions (Slade, 1999).

**Coping Style**

While attachment style may describe a qualitative aspect of a significant relationship and the subsequent impact of that style on an individual’s emotional regulation, the tactical strategies used in response to singular stressors are called coping styles. Folkman and Lazarus (1980) developed one of the earliest models of coping styles by distinguishing between *problem-focussed coping*, such as seeking information or actively modifying the situation, and *emotion-focussed coping* which acts on the internal world through behaviours such as venting, avoidance or self-control. Carver (1997) identifies three major coping styles: positive coping (equating to problem-focussed coping); support-seeking (or emotion-focussed) and avoidant (denial). The four ‘minor’ coping styles identified (religion; self-blame; humour and substance abuse) were distinct factors which did not load onto other coping styles factors. The inclusion of the latter factors illuminates the difference between attachment styles and coping styles as attachment is seen as a trait-like, lifelong quality whereas coping is modelled as a more transient state. The minor coping styles in particular may be used tactically in response to stress (for example, an individual may join a religious group or use alcohol to deal with stress) whereas it is assumed in the ABCD model of attachment that attachment styles remain largely consistent throughout the lifespan and within different relationships. There is however, some overlap in terminology between descriptions of attachment styles and coping styles but, for the purposes of this study, attachment is treated as a quality of a relationship while coping style is a consciously deployed response to particular stressors.

Coping refers then to a process by which individuals avoid thinking about their experience (avoidant coping) or modify some aspects of their internal world (support-seeking) or external world (positive coping) in order to minimise threats (Gil, 2005). But, while these strategies may be broadly effective in dealing with a range of challenges, it is not clear which strategy is most effective at dealing with the particular stressors surrounding a traumatic experience or whether different traumatic experiences require different responses.
Coping strategies are assumed to be consciously and deliberately used (Zeidner & Endler, 1996) so sit within a cognitive-behavioural model in contrast to a psychodynamic approach where defence mechanisms for regulating negative emotions are assumed to operate unconsciously. So while attachment style appears trait-like and refers to the quality of a relationship, coping strategy is state-like and describes the largely conscious deployment of certain behaviours in response to specific situations. It is clear, however, that attachment style and coping style are both implicated in stress response and associations between the two have been explored.

A securely attached individual may have robust self-confidence which allows them to adopt a positive coping strategy as they are well equipped to absorb new information and respond flexibly. There are also links between attachment style, coping and response to traumatic events although they have elicited little research attention (Gil, 2005). Cognitive models of PTSD emphasise the importance of the processing of memories so an insecure avoidant attachment could foster an avoidant coping style which interferes with the integration of the traumatic memories with previous knowledge. In a study of Israelis’ reactions to the threat of missile attack during the Gulf War, Mikulincer et al. (1993) found that secure adults relied more heavily on positive coping strategies for the effective regulation of negative emotions. The central tenet appears that resistance to PTSD may be enhanced by the deployment of effective coping skills which is consistent with the promotion of coping skills in many treatments for PTSD (Foa & Jaycox, 1999).

As coping strategies are often deployed in response to stressors, much investigation in this area is retrospective however, Gil (2005), used data coincidentally collected a fortnight before a terrorist attack near a university campus. Students were initially assessed for coping style as part of a study of the relationship between coping style and academic achievement but, after a terror attack near the university left 17 dead, the focus of the study was modified and those students who had directly witnessed the explosion were assessed for post-traumatic coping styles. It was found that high use of support-seeking or avoidant coping style and low use of positive coping style predicted the development of PTSD six months after the attack. Avoidant coping
strategies such as thought suppression were also found to predict higher rates of PTSD among those caught up in the Madrid bombings (Vazquez et al., 2008) while Cameron et al. (2010) found thought suppression, consistent with an avoidant coping style, associated with PTSD symptomology among 248 undergraduate psychology students but the study was retrospective so it is not clear if thought suppression was deployed in response to a PTE. Baschnagel et al. (2009) also used a prospective design among a group of American undergraduates in New York who were coincidentally assessed for coping style prior to their indirect exposure to the WTC attacks. They found that support-seeking coping was predictive of increased symptomology, consistent with Gil (2005), but positive and avoidant strategies were not significantly related to development of PTSD. As the Baschnagel et al. (2009) participants had indirect exposure, it may be that avoidant coping – that is not thinking about the event – is a sufficiently robust coping style if the event is experienced indirectly but may not offer protection against direct exposure or that avoidant coping is only deployed after the event which suggests that avoidant coping is not related to the onset of PTSD but may interfere with recovery after the symptoms have developed.

So there seems to be evidence that a positive coping style may offer some protection against developing PTSD after exposure to a PTE but a support-seeking style increases vulnerability. An avoidant coping style appears to have an ambivalent impact on vulnerability to PTSD in that it may offer some protection if the trauma is experienced indirectly but, if avoidance cannot be sustained then PTSD may still develop.

**PTSD and Journalists**

"If your photographs aren't good enough, you're not close enough."

Robert Capa, founder member of Magnum Photos

(Bird, 2002)

As the development of PTSD requires a specific event or stressor, research has often focussed on individuals with high rates of exposure to traumatic stressors such as
those who work in the armed forces or emergency services, where researchers can
epect to find more participants with PTSD and so enhance the power of their
findings. ‘Innocent bystanders’ who are caught up in war or disaster may also have
higher exposure to PTEs but their study presents certain challenges as, by definition,
they may live in hostile environments with damaged infrastructure or may have fled
the area and so be difficult to trace. Vocational groups with higher rates of exposure
may then make an easier target for PTSD researchers and there have been numerous
studies of groups such as police officers (Meffert et al., 2008); medical staff (Ben-
Ezra, 2008) and Gulf War veterans (Vogt et al., 2008). De Zulueta (2006) argues that
the symptoms of PTSD are not precipitated solely by the event but also by the
response of others to the victim’s experience. Those ‘others’ could be colleagues and
coworkers so research within these groups may also illuminate vocational differences
which affect an individual’s risk or resilience - such as work culture, pre-deployment
training and group cohesion. However, by concentrating on trauma-specific or clinical
populations, the capacity to generalise from the findings is diminished. It could be
argued then that a useful cohort, for the purposes of generalisation, would be a non-
clinical group where higher exposure to a range of PTEs could be anticipated. DSM-
III criteria for PTSD initially specified that the traumatic stressor must be an event
“outside normal human experience” (APA, 1980, p.247) and this could also serve as a
definition of ‘newsworthy’. In a study of stress response among people living in
Israel, Keinan et al. (2003, p.150), recognised that the media focus on events that are
“unexpected, dramatic, exceptionally violent and extremely distressing”. Indeed,
conflict in one form or another may be seen as the staple diet of news media, summed
up anecdotally in the editor’s adage by which priority is attributed to competing news
items: ‘if it bleeds, it leads’. Some journalists may risk violence, as part of their
making known what some may prefer to remain unknown, or risk secondary exposure
by interviewing victims or deciding which of the many graphic images available best
illustrates a story. So it is that journalists – with their higher rate of primary and
secondary exposure to traumatic stressors – may make a valid target for PTSD
research.

Although there does not appear to have been a comprehensive survey of rates of
trauma exposure or PTSD among journalists as a whole, there has been some
investigation within particular subsets. Feinstein et al. (2002) estimated the lifetime prevalence of PTSD among war journalists to be 28.6 per cent; compared to 7-13 per cent in traumatised police officers and 5 per cent in the general population. McMahon and McLellan (2007) found that 24% of journalists who had witnessed a traumatic stressor met criteria for a diagnosis of PTSD but participants were selected on the basis that they had covered incidents they considered traumatic so generalisation to include journalists who do not specifically cover traumatic incidents is problematic.

Drilling a little deeper into the relationship between trauma and journalism, Keinan et al. (2003) argue that the ultimate target of terrorism is the viewer not the victim. Schmid and de Graaf (1982, p.14) liken the victim of terrorism to “the skin on a drum beaten to achieve a calculated impact on a wider audience”. To extend that analogy, the sound of the drum is broadcast by the news media so journalists face an elevated risk of exposure to the traumatic ‘noise’ of terrorism. Ben-Ezra (2008), comparing doctors’ and nurses’ responses to PTEs, suggested nurses were more vulnerable to PTSD because they developed greater identification with the patients. The authors concede, however, that an equally plausible reason is that nurses have less control over the situation than do doctors but both explanations – more identification with victims and less control over outcomes – are also relevant to journalists’ professional roles. So, similar to soldiers on ‘peace-keeping’ missions, journalists trying to get the human angle but remain detached could be expected to experience some dissonance in their working lives.

A repetition compulsion may also contribute to journalists’ greater exposure to PTEs. Van der Kolk et al. (2005) suggests there may be some self-sustaining aspect to work-related PTSD for war correspondents as they expose themselves to ever greater risks in an attempt to gain mastery over their distress. And for freelance reporters or photographers who work independently, the absence of professional peer support may increase their vulnerability to PTSD as Vogt et al. (2008) found cohesion to be protective when comparing active duty military personnel with national guards.

Feinstein (2006) combines a narrative account of the experiences of war reporters with some of his own quantitative studies of PTSD but in one instance the methodology
itself is revealing. A study on risks facing reporters was initiated by posting questionnaires to participants only to find one journalist had been murdered before the questionnaire reached him. The quantitative data may be methodologically flawed, however, as selection of participants for the core study is described as random without any transparency as to the method except that the participants were “names given to me by respected news organisations” (Feinstein, 2006, p.19), but the qualitative insight may be more pertinent. Feinstein highlights the neglect, approaching disdain, which many in the profession exhibit for psychological health and which prevents many journalists from seeking treatment for PTSD or depression. He suggests that a “macho culture of silence” (Feinstein, 2006, p.182) may explain why news organisations have failed to provide treatment for the journalists. The 140 journalists sampled in the largest study (Feinstein, 2006), were all specialist foreign correspondents drawn from a global total of perhaps a few dozen professionals who specialise in covering war and disaster. As the role of foreign correspondent is a high-status and high-reward position only available in the largest international media organisations, this cohort may not be representative of the many thousands of men and women who call themselves journalists, let alone the general population.

No comparable study of PTSD prevalence in UK journalists appears to have been made but there are some 38,000 members of the NUJ in the United Kingdom (National Union of Journalists, n.d.) who work as photographers, reporters and sub-editors covering local news, write features or work in production and, although they may rarely cover the famine, war and pestilence which is the staple diet of the foreign correspondent, they may still face a higher risk of witnessing trauma when compared with the general population. Local reporters and photographers will report on incidents ranging from house fires to floods – and even the WTC attacks or the Lockerbie bombing if it happens on their ‘patch’. There are also journalists and photographers who occasionally cover war or civil disorder, especially when a long-running story cannot be covered by specialist foreign correspondents. Few of these journalists could be described as foreign correspondents but many would have higher exposure to traumatic stressors so, while they fall outside the scope of studies such as Feinstein (2006), they are a useful target for research as they are a large group which can be expected to have a higher rate of exposure to traumatic stressors than the
general population. Journalists may also be exposed to greater risk of secondary exposure too as they often witness the impact of trauma when, for instance, interviewing victims; reporting on court cases or viewing images which will not get into the public domain because they are deemed too shocking. Research on secondary traumatisation has focussed on therapists and lawyers but journalists have no psychological training and respond more immediately than lawyers so may be especially vulnerable to the impact of secondary traumatisation.

It is also evident that the nature and frequency of journalists’ exposure is changing. Demand for news has grown in step with the increasing number of internet sites and television channels so journalists vulnerability to PTSD may be increasing. Perrin et al. (2007) found the probability of developing the disorder greater for World Trade Center relief workers who started on September 11th compared to those who started after September 18th – even though neither witnessed the traumatic events first-hand. War zones are easier to reach as well. A four-hour flight from London and a reporter can file from Baghdad or Kabul whereas to get into the theatre of combat in World War Two may have taken days. The time taken to return from an assignment may also be relevant. Gavagan and Brodyaga (1998) report that the assimilation of painful aspects of an experience is deferred by the immediate relief of arrival and safety and it may be that the shortened return journey is implicated in more stress-related difficulties for journalists. Anecdotally, many reporters refer to the time between leaving a war zone and returning home as ‘decompression’, reflecting its importance as an adjustment period from the high-stress environment of a war zone to the different stresses of life at home. Also, since the military intervention in Iraq or Afghanistan by Western forces, journalists representing the Western media may, by association, be seen as valid targets for violence or kidnapping.

Even those journalists who do not operate in war zones may have an elevated exposure to traumatic images. In most Western countries, rules about what is appropriate for broadcast prohibit the transmission of disturbing images such as those showing close-ups of bodies or body parts. It may be though that some images, which are ultimately deemed too disturbing for broadcast, are seen by newsroom personnel. Also, Hilton (1997) suggested that the re-counting of traumatic events in the media –
at times such as anniversaries – may trigger the development of PTSD among those who had encountered similar events.

If, journalists do develop work-related PTSD, it appears they are unlikely to seek professional help, Greenberg et al. (2009). After surveying 124 media professionals, authors concluded that the majority of journalists were not confident in their manager’s capacity to deal with the consequences of work-related PTSD. Cobbe (2008) also found that the majority of frontline journalists would prefer to get help from a colleague, friend, family member or partner, rather than seek professional help or contact their employers for assistance.

It can be seen that investigating the development of PTSD within a cohort with increased exposure to PTEs is a resource-efficient route to increasing understanding of a debilitating condition and may support mental health professionals in their quest to avoid pathologising transient post-traumatic distress while targeting resources at those who will not recover spontaneously. Journalists are valid subjects for research because, compared to the general population, their work involves greater direct and indirect exposure to traumatic events; they have limited psychological training and low cohesion and an expectation to be involved but not intervene.

AIMS AND HYPOTHESES

Research Questions

What is the prevalence of PTSD among journalists and is the disorder influenced by attachment style or coping strategy?

Aims

- to determine whether the prevalence among journalists is greater than in the general population
- to determine whether attachment style has an impact on vulnerability to PTSD
- to determine whether coping strategies have an impact on vulnerability to PTSD
• to determine the best predictor of vulnerability to PTSD

_Hypotheses_

H₁: the prevalence of PTSD among journalists will be greater than among the general population.

H₂: Insecure attachment styles will be positively associated with the number of PTSD symptoms reported.

H₃: The development of PTSD will be negatively related to the use of positive coping and positively related to the use of a support-seeking coping style, the use of religion, substance abuse, humour and self-blame.

H₄: An anxious attachment style will be the best predictor of development of PTSD when compared with avoidant attachment, major or minor coping styles, age, gender or vocational variables.

_METHODS_

_Design_

A quantitative online survey was used to gather data about journalists' attachment styles, coping strategies and self-reported symptoms of PTSD. The data were then analysed to determine any relationship between attachment style, coping style and development of the disorder. Continuous independent variables were age, attachment style and coping style data; categorical independent variables were gender and work sector. The dependent variable was continuous (summed scores on the PTSD symptomology scale) but for the purposes of hypothesis-testing, PCL-C scores ≥ 50/≤ 49 were treated as PTSD/no PTSD as the focus of this study was the diagnosis of PTSD.

_Participants_

As there is no central register of journalists and the term has no statutory regulation, for the purposes of this study I have used a broad definition of journalists as _those who work in news gathering or news production_. Participants were volunteer, self-identifying journalists recruited via relevant web pages, such as those of the National Union of Journalists or the International News Safety Institute. It was assumed that the
majority of UK-based journalists would have access to computers and the internet through their work. As the questionnaire was anonymous it was not possible to organise a financial incentive such as a prize draw.

Of the 363 journalists who logged on to the questionnaire website, two did not consent to take part and a further 166 abandoned the questionnaire before completing all scales. Those participants who did complete the questionnaire ($N = 195$) represent < 0.5% of the 38,000 members of the NUJ. This cohort comprised 108 female (55%), 87 male (45%); 127 journalists on staff contracts (65%) and 68 working freelance (35%). Participants' ages ranged from 20-71 ($M = 42, SD = 11$); career length ranged from 1 – 50 years ($M = 18; SD = 11$ years). Participants worked in all sectors of the media (see Table 1) including book publishing, magazines and public relations; for broadcast media such as TV and radio; newspapers; new media such as web sites and agencies which are news ‘wholesalers’ supplying raw video footage or text to broadcasters, newspapers or new media. Almost half of the participants had worked on international stories and more than half worked mainly in the field as reporters, producers or camera operators rather than in the newsroom as editors or sub-editors. Only 156 of the participants recorded whether they worked on domestic or international news or both.

Table 1: Sectors covered by participants

<table>
<thead>
<tr>
<th>Sector</th>
<th>n (%)</th>
<th>Sector</th>
<th>n (%)</th>
</tr>
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<tbody>
<tr>
<td>Book</td>
<td>15 (8)</td>
<td>Domestic</td>
<td>119 (61)</td>
</tr>
<tr>
<td>Public relations</td>
<td>25 (13)</td>
<td>International</td>
<td>93 (48)</td>
</tr>
<tr>
<td>Magazines</td>
<td>56 (28)</td>
<td>In the field</td>
<td>115 (59)</td>
</tr>
<tr>
<td>Broadcast</td>
<td>75 (38)</td>
<td>In the newsroom</td>
<td>89 (46)</td>
</tr>
<tr>
<td>Newspapers</td>
<td>94 (47)</td>
<td>Freelance</td>
<td>68 (35)</td>
</tr>
<tr>
<td>New media</td>
<td>39 (20)</td>
<td>Staff</td>
<td>127 (65)</td>
</tr>
</tbody>
</table>

Measures

All measures were self-report. A bespoke measure was used to collect demographic and vocational details and published, standardised questionnaires used to collect data.

$^2$ Will not sum to 100 % as some participants work in more than one sector
on PTSD, attachment styles and coping strategies (see Appendix 2). Existing measures were chosen as their reliability, validity, discrimination and standardisation was known. After collecting demographic details, the online questionnaire comprised three measures: the Post-Traumatic Stress Disorder Checklist (PCL-C); the ECR-S measure of attachment style and the BRIEF Cope measure of coping strategies.

**PTSD CheckList - Civilian version (PCL-C)**

As discussed earlier, there may be a tendency to use ICD criteria in clinical practices but DSM criteria in research (O'Connor et al., 2007). Notwithstanding that this study aspires to provide clinically relevant data, DSM criteria have been adopted as that allowed a wider choice of self-rating scales. The PCL-C is among the most widely used self-report instruments for assessing PTSD (Terhakopian et al., 2008) and was chosen from among three self-administered instruments which match the DSM-IV criteria for PTSD, Ruggiero et al. (2003): the PSSI, the Davidson Trauma Scale and the PCL-C. As only the PCL-C is in the public domain, and so available for use free of charge, it was chosen for this study. The PCL-C is a 17-item questionnaire with five available responses (not at all; a little bit; moderately; quite a bit; extremely) to identify how much the participant has been bothered by behaviour such as suddenly acting or feeling as if a stressful experience were happening again. The PTSD Checklist (PCL-C) is a self-report instrument for the assessment of PTSD symptoms in a civilian population (Weathers et al., 1993) but is a screening tool rather than a diagnostic tool as it does not assess DSM-IV criterion A1 (an event involving actual or threatened death or serious injury or a threat to the physical integrity of self or others) or A2 (the response included fear, helplessness or horror) (APA, 2000). It is not clear whether events need to meet Criterion A to provoke PTSD (Rosen & Lilienfeld, 2007) but for the purposes of this study the PCL-C is an adequate screening tool for PTSD symptomology. Ruggiero et al. (2003) found support for psychometric properties of the PCL-C, including internal consistency, test–retest reliability, convergent validity and discriminant validity. In a review of PTSD screening instruments, Brewin (2005), found the PCL-C obtained best results in homogenous trauma samples while Wilson and Keane (2004) found the PCL-C demonstrated adequate reliability and validity. Adkins et al. (2008), in an assessment of several measures of PTSD symptoms, found strong support for test-retest reliability.
and internal consistency of the PCL-C including a correlation of .65 between scores on the PCL-C and the clinician-administered PTSD scale (CAPS). While the CAPS is considered the “gold standard” of PTSD assessments (Weathers et al., 1993, p134) it can take an hour to complete (Elhai et al., 2005) so is unsuitable for online questionnaires.

There are two methods of scoring the PCL-C: a cut-off point or diagnostic mapping. The cut-off point method has the attraction of simplicity but there is no consensus on a cut-off point that would be valid for all populations (Ruggiero et al., 2003). The checklist authors recommend a cut-off score of 50 for male war veterans (Weathers et al., 1993) while Grubaugh et al. (2007) recommend a cut-off point of 54 with adults suffering severe and enduring mental illness; Blanchard et al. (1996) found if they lowered the cut-off score to 44, it improved diagnostic efficiency and identified 17 of the 18 cases from their sample of assault and road accident survivors which were diagnosed using the CAPS; Wilson et al. (2001) used a score of 50 or more among British military personnel; Forbes et al. (2001) compared the PCL-C with the clinician-administered PTSD scale (CAPS) among 97 American veterans of the Vietnam war and found the PCL-C demonstrated high diagnostic accuracy at a cut-off score of 50 and an item score of 3 for symptom criterion. In a review of PTSD screening instruments, Brewin (2005) found that reducing the cut-off score from 50 to 44 produced the best performance but the cohort involved (n = 40) had all been involved in a severe road accident or experienced a sexual assault, leaving 45% with PTSD. As the cohort for this study (N = 195) are not selected by traumatic exposure the prevalence might be expected to be similar to that of the general population and, among cohorts with lower prevalence, a cut off of 50 was the most efficient (Terhakopian et al., 2008).

Experiences in Close Relationship Scale - Short Form (ECR-S)

Many self-report measures of attachment style have been developed but for an online study with limited financial resources brevity and availability must be considered alongside customary psychometric properties when choosing a tool. Brennan et al. (1998) metaphorically threw 14 widely used attachment measures into the pot, with 323 items, and boiled them down using factor analysis to isolate core components.
The resulting Experiences in Close Relationships (ECR) scale comprised the two major higher-order factors of insecure anxious and insecure avoidant common to most of the other measures (Mikulincer & Shaver, 2007). While there is debate about the stability, or otherwise, of attachment styles (Crittenden & Claussen, 2000), as this is a cross-sectional design, the provenance of attachment style is less important than its impact on stress response so it will be treated as trait-like.

The ECR-Short Form (ECR-S) is a 12-item version of the ECR and includes questions about how the participant generally feels in romantic relationships such as “It helps to turn to my romantic partner in times of need” and “I want to get close to my partner, but I keep pulling back”. It can be answered on a 7-point Likert scale (strongly disagree; disagree; slightly disagree; neutral; slightly agree; agree; strongly agree). The tool is scored by totalling responses to questions 2, 4, 6, 8 (reversed), 10 and 12 for an insecure anxious subscale and questions 1 (reversed), 3, 5 (reversed), 7, 9 (reversed) and 11 for an insecure avoidant subscale. Wei et al. (2007) developed the ECR-S from the original ECR and found that, after dropping 24 of the 36 original questions, the short form produced coefficient alphas from .77 to .86 for the anxiety subscale and from .78 to .88 for the avoidance subscale across all six studies used in the tool’s development. Test-retest reliability for the subscales was adequate and relatively stable when the short form was administered (r = .82 for anxiety and .89 for avoidance) over a 3-week period indicating that scores on the two subscales were relatively stable. A lower overall score on the ECR-S indicates a more secure attachment; a higher score on the avoidant subscale indicates a more insecure avoidant style; a higher score on the anxious subscale indicates a more insecure anxious style (Koleva & Rip, 2009). Wei et al. (2007) conclude that for participant cohorts with either a wider age range than found among undergraduates or those accessed by internet survey, such as those in this study, the brevity of the ECR-S is preferable as it enhances participant’s motivation and compliance. A literature search of the PsychInfo database revealed no published assessments of the psychometric properties of the ECR-S, possibly due to it relatively recent inception.
**BRIEF Cope**

The Brief COPE, comprising 28 items rated on a 4-point Likert scale, is an adaptation of the longer COPE inventory developed by Carver (1997). The Brief COPE was derived from the 60-item full COPE because the authors found participants became impatient with the length and repetition of the instrument. Behaviours - such as using humour or alcohol to deal with stressful events can be answered as happening: not at all; a little bit; a medium amount or a lot. Carver (1997) reports adequate internal reliability. Burns *et al.* (2002) found that although each strategy is measured by just two items, internal consistency was acceptable, with Cronbach’s alpha ranging from 0.50 to 0.90. Miyazaki *et al.* (2008) found the Brief COPE consistent with COPE. Cooper *et al.* (2008) found the Brief COPE to be internally consistent; have test/re-test reliability; convergent and concurrent validity. Burns *et al.* (2002) found three composite styles of coping: active; emotion-focused and disengaged while Gil (2005) classified these as problem-focused, emotion-focused and avoidant, respectively but this study adopts the language of Carver (1997) and uses the terms positive coping; support-seeking coping and avoidant coping. The Brief COPE also measures the use of four ‘minor’ coping styles: religion, substance abuse, humour and self-blame.

The survey went online on June 26 2009. Responses were monitored at regular intervals by the researcher via a password-protected portal at [http://www.fahs.surrey.ac.uk/survey/journalists/jouradm.htm](http://www.fahs.surrey.ac.uk/survey/journalists/jouradm.htm) then downloaded by Psychology Department staff as SPSS files and sent to the researcher via secure e-mail. The survey remained open from June – December 2009.

**Procedure**

An online questionnaire was chosen as, when attempting to recruit as many potential participants as possible, it has financial and pragmatic advantages over paper-based questionnaires. Collecting data is also free online whereas printing and postage would make a large-scale survey unfeasible within the resource constraints of this study. In a meta-analysis of almost 200 online surveys, Hamilton *et al.* (2004) report that 95% of all responses were received within a fortnight but there is little literature to establish anticipated response rates to online questionnaires over a longer period. Lonsdale *et
al. (2006) found online response rates greater than response rates to postal questionnaires with the added benefit that online data was returned more quickly and with fewer missing data. However, that questionnaire was addressed specifically to each respondent via e-mail whereas in this study a non-specific recruitment article was placed on web sites prominent within the news industry. Preckel and Thiemann (2003) posted a questionnaire online which could be accessed by the 20,000 worldwide members of Mensa (a society for people with a high IQ) but while more than 3,000 respondents engaged with the questionnaire, only 358 returned valid responses, possibly because the featured study took more than two hours to complete. McLay et al. (2008) investigated the impact of anonymity in determining the rates of PTSD among soldiers returning from Iraq or Afghanistan. Comparing anonymous with on-the-record reporting, it was found that more symptoms were reported anonymously than when the information was to be recorded in a personal file so results from this study must accommodate the possibility that anonymous reporting elicits an over-reporting of symptoms. Bethlehem (2008) warns of the pitfalls facing online anonymous surveys in which the participants are self-selecting and any conclusions will have this caveat attached.

Within the UK, the largest forum for journalists is the National Union of Journalists with 38,000 members covering a range of editorial work including staff and freelance reporters, editors, sub-editors and photographers working in broadcast, newspapers, magazines and books. In order to reach as many members as possible, it was arranged through the NUJ Research Officer for the following article to appear on the NUJ website home page:
How do journalists cope under pressure?
It's widely recognised that journalists work under stressful conditions but the psychological impact of that pressure is rarely researched. A former journalist is investigating how journalists respond to stress and the importance of coping strategies and relationship styles. Click here (web link to questionnaire) to take part in a short online survey. This will take approximately six minutes to complete, all information gathered will be anonymous and confidential. This study will form part of a doctorate in clinical psychology, a summary of the findings will be available in October.

The web link directed the participant to an online questionnaire at http://www.fahs.surrey.ac.uk/survey/journalists/ hosted by the University of Surrey. The recruitment article also appeared on the home page of the International News Safety Institute (a coalition of news organisations, journalist support groups and individuals dedicated to the safety of journalists in hazardous environments) and journalism.co.uk (a news industry website with almost 17,000 subscribers).

The first page of the questionnaire outlined the nature of the study including how stress can prompt a range of responses; the link between traumatic events, conflict and news coverage and how journalists may be exposed to trauma as part of their working lives and the significance of different coping strategies and the importance of childhood experience, or attachment style, in dealing with stress. The first page also included a short glossary of terms and the proviso that all responses would be anonymous and confidential and no identifying details taken. Contact details for the researcher and research supervisor were followed by a statement of consent. If the participant answered ‘No’ they were directed to a courtesy page thanking them for their interest. If they answered ‘yes’ they were directed to the first page of the questionnaire which collected demographic data (gender, age, career length, which sector of journalism the participant worked in, the type of news they covered and whether they were freelance or staff).
**Ethical Considerations**

In order to sustain the anonymity of the participants, no identifying information was included in the responses and the data were stored initially on a secure university server and ultimately on a password-protected encrypted memory stick. Because taking part in a PTSD-focused study may involve a small risk of re-igniting any trauma, for example by overwhelming a participant's previously successful avoidant coping strategies, support services were signposted at the end of the questionnaire. The study was approved by the University of Surrey's Faculty of Arts and Human Sciences Ethics Committee (see Appendix 3).

**Statistical Analysis**

Statistical Package for Social Sciences (SPSS, version 17.0) was used for data analysis. Participants' scores on the ECR-S measuring attachment style were computed to produce two subscales (comprising the responses to six questions each): insecure anxious and insecure avoidant. Scores on the Brief COPE measuring coping style were computed to produce three major coping styles (comprising six responses each): positive; support-seeking and avoidant. Four minor scales were computed (comprising two responses each): religion; substance abuse; humour and self-blame. The three major coping styles (positive, support-seeking and avoidant) may predict stress response and are deployed strategically, that is they are deployed consistently over a period of time and rarely changed. In contrast, the minor coping styles (religion, self-blame, substance abuse and humour) may be deployed tactically in response to stress and do not load onto any other factors. Consequently, the major and minor coping styles were analysed separately.

**Missing Data**

The data were initially assessed for errors in entry and missing data. Of the 363 journalists who logged on to the questionnaire website, two did not consent to take part and a further 166 abandoned the questionnaire before completing all scales so those cases were deleted as they provided insufficient usable data for analysis.
**Testing for Normality**

A Kolmogorov–Smirnov test established that the data were not normally distributed: PCL-C scores $D(195) = 0.12, p < .05$; ECR-S scores $D(195) = 0.07, p < .05$ and Brief COPE scores $D(195) = 0.07, p < .05$ were all significantly non-normal but only the skewness of the PCL-C (see Table 2) fell outside known values for normal distribution ($\geq 1.96$ at $p < .05$) so, consistent with Field (2009, p.139), the data were treated as normally distributed and parametric tests used.

**Table 2: z-scores of skew and kurtosis**

<table>
<thead>
<tr>
<th>Measure</th>
<th>z-score of skewness</th>
<th>z-score of kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCL-C</td>
<td>-4.747</td>
<td>0.789</td>
</tr>
<tr>
<td>ECR-S</td>
<td>0.983</td>
<td>1.844</td>
</tr>
<tr>
<td>COPE</td>
<td>-0.534</td>
<td>0.450</td>
</tr>
</tbody>
</table>

**Relationships Between Demographic and Vocational Characteristics and PTSD symptoms**

The relationship between demographic and vocational variables and PTSD symptomology was explored using independent t-tests, correlation, Pearson’s $\chi^2$ and ANOVA to identify confounding variables and compare this data with previous work. Various demographic and vocational characteristics, identified by previous studies (as discussed in the Introduction) as possibly related to PTSD, were explored and subsequently analysed using a one-tailed calculation. These include associations between PTSD vulnerability and gender (Galea *et al.*, 2008) and age (Dohrenwend *et al.*, 2008). Diminished group cohesion (Rona *et al.*, 2009) has also been identified as a factor related to the development of PTSD and is explored in this study by identifying whether participants are on staff contracts (working in a team) or freelance (working independently). As the literature has suggested that direct exposure to traumatic events has been related to the development of PTSD (Wahlstrom *et al.*, 2008), data were collected on career length and the participants’ sector, whether they worked in newsrooms or in the field and whether their work involved domestic or international
duties based on the argument that these aspects of journalistic work may influence exposure to PTEs.

For $H_1$, a $\chi^2$ test was used to determine whether the prevalence of PTSD is significantly greater among journalists than in the general population. As the PCL-C refers to symptoms experienced in the last month, prevalence was compared with Stein et al. (1997) in which the Modified PTSD Symptom Scale was administered and a monthly prevalence reported for the general population. For $H_2$ and $H_3$, continuous data from measures of attachment style or coping style measures were used with categorical data (PTSD/no PTSD) and analysed using Pearson's $r$, multiple regression and analysis of variance to test whether attachment styles or coping styles were significantly associated with the development of PTSD. For $H_4$, the PCL-C was treated as a categorical independent variable and attachment styles, coping styles and demographic data were entered as dependent variables into a backwards stepwise logistic regression analysis to identify the best predictor of this outcome (PTSD/no PTSD). Where possible, an effect size ($r$) was calculated as a product of the between group effect size and the total amount of variance in the data for comparisons of means (Field, 2009, p.192) and odds ratios were calculated to specify the effect sizes for $\chi^2$ and logistic regression analyses (Field, 2009, p.270).

RESULTS

Description of Sample

The sample comprised 195 journalists from whom data were collected on measures of PTSD symptomology (PCL-C); attachment style (ECR-S) and coping style (Brief COPE). See Participants (p.49) for summary of vocational and demographic data.

Post Traumatic Stress Disorder Symptoms

Participants’ PCL-C scores ranged from 17-80 ($M = 35, SD = 13$).
Attachment Styles

Participants’ scores on the ECR-S were summed to produce two subscales: insecure anxious scores ranged from 10-37 \((M = 22, SD = 5)\) while insecure avoidant scores from 12–32 \((M = 20, SD = 5)\).

Coping Styles

Participants’ scores on Brief COPE were summed to produce three major coping style subscales: positive coping style scores ranged from 6-24 \((M = 14, SD = 4)\); support-seeking coping style scores ranged from 6-24 \((M = 14, SD = 4)\) and avoidant coping style scores ranged from 6-17 \((M = 10, SD = 3)\). Of the four minor coping styles, 60% of the participants \((n = 115)\) reported trying to use religious or spiritual beliefs, scores ranged from 2-8 \((M = 3.5, SD = 1.7)\). Humour was used by 76% \((n = 148)\) of the participants, scores ranged from 2-8 \((M = 4.0, SD = 1.7)\). Using alcohol or drugs was reported by 56% \((n = 109)\), scores ranged from 2-8 \((M = 3.7, SD = 1.8)\). Using self-blame was reported by 87% of the participants \((n = 171)\), scores ranged from 2-8 \((M = 4.8, SD = 1.8)\).

Data from all three measures was treated as continuous in the first instance to describe the sample and explore relationships with demographic and vocational variables and Table 3 gives the mean scores on measures of PTSD, attachment and coping style broken down by gender and contract type.

Demographic and Occupational Characteristics of the Sample and their Relationship to PTSD Symptomology

A relationship between PCL-C score and age or career length was explored using Pearson’s product-moment correlation coefficient. As the evidence suggests age and career length increase exposure to PTEs (Breslau et al. 1997) and so the likelihood of developing PTSD, a one-tailed calculation was used. No significant relationship was found between age and PCL-C score, \(r = .06\) \(p\) (one-tailed) = 0.41 or between career length and PCL-C score, \(r = -.08\) \(p\) (one-tailed) = 0.28.
Independent t-tests were used to explore the relationship between PCL-C scores and gender or contract type (see Table 3). There was no significant difference in PCL-C scores for women and men or for freelance and contract staff.

A one-way Anova was used to determine whether a relationship existed between the particular sector in which the journalist worked and PCL-C scores (see Table 4). Data collected from those participants who worked in more than one sector ($n = 77$) was excluded in order to use a between groups design. Also, there were no participants working solely in the book sector and just one in new media so those categories were excluded. There was no significant effect of the sector of work on PCL-C scores, $F(4, 112) = 1.97, p>.05$. 
Table 3: PTSD symptoms, attachment and coping style in all participants and as a function of gender and contract

<table>
<thead>
<tr>
<th>Tool</th>
<th>M (SD)</th>
<th>M (SD)</th>
<th>M (SD)</th>
<th>M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All participants</td>
<td>Gender</td>
<td>Contract</td>
<td></td>
</tr>
<tr>
<td></td>
<td>M (SD)</td>
<td>Male</td>
<td>Female</td>
<td>Staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M (SD)</td>
<td>M (SD)</td>
<td>M (SD)</td>
</tr>
<tr>
<td></td>
<td>N = 195</td>
<td>n = 87</td>
<td>n = 108</td>
<td>n = 127</td>
</tr>
<tr>
<td>PCL-C</td>
<td>PTSD symptoms</td>
<td>35.11 (13.20)</td>
<td>33.34 (13.40)</td>
<td>36.54 (12.92)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ECR-S</td>
<td>(Attachment style)</td>
<td>Insecure anxious</td>
<td>21.59 (5.37)</td>
<td>21.06 (5.00)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Insecure avoidant</td>
<td>19.70 (5.19)</td>
<td>19.51 (4.84)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Avoidant</td>
<td>9.61 (2.76)</td>
<td>8.82 (2.39)</td>
</tr>
<tr>
<td></td>
<td>(Minor styles)</td>
<td>Religion</td>
<td>3.53 (1.67)</td>
<td>3.33 (1.57)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Humour</td>
<td>4.08 (1.76)</td>
<td>4.17 (1.87)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-blame</td>
<td>4.83 (1.83)</td>
<td>4.47 (1.79)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Substance abuse</td>
<td>3.66 (1.85)</td>
<td>3.93 (2.00)</td>
</tr>
</tbody>
</table>

*M = Sample mean, SD = Standard deviation*
Table 4: PTSD symptoms, attachment and coping style as a function of job sector

<table>
<thead>
<tr>
<th>Tool</th>
<th>PTSD symptoms</th>
<th>Attachment style</th>
<th>Coping style</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(Insecure anxious)</td>
<td>(Insecure avoidant)</td>
</tr>
<tr>
<td>n = 15</td>
<td>38.93 (10.63)</td>
<td>20.87 (4.58)</td>
<td>14.40 (4.47)</td>
</tr>
<tr>
<td>n = 75</td>
<td>32.26 (10.27)</td>
<td>21.95 (5.83)</td>
<td>13.91 (4.82)</td>
</tr>
<tr>
<td>n = 56</td>
<td>38.50 (13.78)</td>
<td>21.48 (5.18)</td>
<td>14.39 (4.45)</td>
</tr>
<tr>
<td>n = 94</td>
<td>35.52 (13.34)</td>
<td>20.80 (5.07)</td>
<td>14.02 (4.49)</td>
</tr>
<tr>
<td>n = 34</td>
<td>35.00 (15.83)</td>
<td>20.44 (4.87)</td>
<td>14.56 (4.97)</td>
</tr>
<tr>
<td>n = 25</td>
<td>40.44 (14.17)</td>
<td>21.76 (5.32)</td>
<td>15.24 (4.74)</td>
</tr>
<tr>
<td>n = 39</td>
<td>38.15 (15.29)</td>
<td>21.10 (5.72)</td>
<td>14.69 (4.48)</td>
</tr>
</tbody>
</table>

*Sample mean, SD = Standard deviation*
A one-way Anova was used to determine whether a relationship existed between the geographical area the participants covered (domestic or international) and PCL-C scores (see Table 5). There was no significant effect of the area covered and PCL-C scores $F(2, 156) = .86, p>.05$.

Table 5: PTSD symptoms, attachment and coping style as a function of geographic coverage

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Domestic</th>
<th>International</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tool</td>
<td>$n = 119$</td>
<td>$n = 93$</td>
</tr>
<tr>
<td>PCL-C PTSD</td>
<td>33.70 (12.20)</td>
<td>34.53 (13.43)</td>
</tr>
<tr>
<td>(Attachment style)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ECR-S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insecure anxious</td>
<td>21.50 (5.22)</td>
<td>22.22 (5.26)</td>
</tr>
<tr>
<td>Insecure avoidant</td>
<td>19.39 (5.11)</td>
<td>19.75 (4.94)</td>
</tr>
<tr>
<td>(Major coping style)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>13.98 (4.67)</td>
<td>14.19 (4.57)</td>
</tr>
<tr>
<td>Support-seeking</td>
<td>13.97 (4.07)</td>
<td>14.41 (3.95)</td>
</tr>
<tr>
<td>Avoidant</td>
<td>9.51 (2.80)</td>
<td>9.63 (2.71)</td>
</tr>
<tr>
<td>(Minor coping style)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td>3.50 (1.67)</td>
<td>3.30 (1.49)</td>
</tr>
<tr>
<td>Humour</td>
<td>4.08 (1.76)</td>
<td>4.24 (1.77)</td>
</tr>
<tr>
<td>Self-blame</td>
<td>4.73 (1.81)</td>
<td>4.77 (1.85)</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>3.59 (1.89)</td>
<td>3.95 (2.00)</td>
</tr>
</tbody>
</table>

$M =$ Sample mean, $SD =$ Standard deviation

**Summary**

There was no relationship between any of the vocational or demographic variables (age, career length, gender, contract type, sector or geographic area covered) and the development of PTSD among journalists in this sample.
Hypotheses

H₁: the prevalence of PTSD among journalists will be greater than among the general population.

As the development of PTSD appears dependent on exposure to traumatic events, which are a staple of media coverage, it was hypothesised that journalists would be more vulnerable to developing PTSD than the general population. As PCL-C data refer to a one-month period, comparison was made with Stein et al. (1997), see Table 6.

Table 6: One month prevalence of PTSD

<table>
<thead>
<tr>
<th></th>
<th>PTSD (%)</th>
<th>no PTSD (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General population</td>
<td>39 (3.9)</td>
<td>963 (96.1)</td>
</tr>
<tr>
<td>(Stein et al., 1997)</td>
<td>(N = 1002)</td>
<td></td>
</tr>
<tr>
<td>Participants in this</td>
<td>24 (12.3)</td>
<td>171 (87.7)</td>
</tr>
<tr>
<td>study (N = 195)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As all expected cell frequencies were greater than 5, and it was assumed that none of the participants in this study were involved in Stein et al. (1997), Pearson’s Chi-square was used to test this hypothesis. There was a significantly higher prevalence of PTSD among the journalists in this sample than in the general population, $\chi^2(1, N = 1197) = 23.18$, $p < .001$.

Summary

The prevalence of PTSD among journalists was greater than in the general population. The odds ratio shows that journalists were 3.5 times more likely to develop PTSD than those in the general population.

H₂: Insecure attachment styles will be positively associated with the number of PTSD symptoms reported.

As insecure anxious or insecure avoidant attachment styles may increase vulnerability to the development of PTSD, it was hypothesised that participants with insecure attachment styles, anxious or avoidant, would report higher rates of PTSD than those with secure attachment styles. The sample was divided into two groups (PTSD/no PTSD, see Methods section p.52). Mean ECR-S anxiety and avoidant subscale scores of those with PTSD were higher than those without PTSD (see Table 7).
Table 7: ECR-S subscale scores for participants with / without PTSD

<table>
<thead>
<tr>
<th>Attachment style:</th>
<th>PTSD M (SD)</th>
<th>no M (SD)</th>
<th>PTSD M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insecure anxious</td>
<td>24.1* (3.9)</td>
<td>21.2 (5.4)</td>
<td></td>
</tr>
<tr>
<td>Insecure avoidant</td>
<td>21.3 (4.0)</td>
<td>19.5 (5.3)</td>
<td></td>
</tr>
</tbody>
</table>

\( M = \) Sample mean, \( SD = \) Standard deviation \(* p < .05\)

1 Levene’s test indicated unequal variances \((F = 4.96, p = .027)\), so degrees of freedom were adjusted from 193 to 36.

2 Levene’s test indicated unequal variances \((F = 4.61, p = .033)\), so degrees of freedom were adjusted from 193 to 35.

Independent t-tests were used to explore the relationship between ECR-S scores on anxiety and avoidant subscales and the development of PTSD. Scores on the anxiety subscale were significantly higher for those with PTSD than for those without. \( t(36) = -3.11, p = .004, 95\% \text{ CI } [-4.70, -.99] \). There was a medium effect size, \( r = .37 \). There was no significant difference in scores on the avoidant subscale for those with PTSD than for those without \( t(35) = -1.96, p = .058, 95\% \text{ CI } [-3.70, .06] \). There was a medium effect size, \( r = .31 \).

Summary
This hypothesis was partially supported: there was, as expected, a relationship between journalists with an insecure anxious attachment style and PTSD but there was no relationship between an insecure avoidant attachment style and journalists meeting the threshold for PTSD on the PCL-C.

H3: The development of PTSD will be negatively related to the use of positive coping and positively related to the use of a support-seeking coping style, the use of religion, substance abuse, humour and self-blame.
As a reminder, the Brief COPE (Carver, 1997), gives scores on ‘major’ and ‘minor’ styles of coping (see Methods section p.38). Inspection of the means suggests that all three major coping styles were used to a greater extent by those with PTSD than those without (see Table 8).
Table 8: the use of major coping styles and PTSD

<table>
<thead>
<tr>
<th>Major coping style</th>
<th>PTSD $M(SD)$</th>
<th>no $M(SD)$</th>
<th>PTSD $M(SD)$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>15.88 (4.19)</td>
<td>13.96 (4.56)</td>
<td></td>
</tr>
<tr>
<td>Support-seeking</td>
<td>14.21 (4.15)</td>
<td>14.18 (2.71)</td>
<td></td>
</tr>
<tr>
<td>Avoidant</td>
<td>11.21* (2.62)</td>
<td>9.38 (1.81)</td>
<td></td>
</tr>
</tbody>
</table>

$M =$ Sample mean, $SD =$ Standard deviation * $p < .05$

These relationships were analysed using ANOVA. Major coping styles were analysed using analysis of variance with PTSD/no PTSD as the grouping variable and Brief COPE major subscale scores as the dependent variables. Neither the use of a positive coping style, $F(1, 193) = 3.757, p = .054$, nor the use of a support-seeking coping style was significantly associated with PTSD, $F(1, 193) = .001, p = .969$. However, the use of an avoidant coping style was significantly associated with PTSD, $F(1, 193) = 9.641, p = .002, r = .21$. See Table 8 for means.

Minor coping styles

Inspection of the means suggests that all four minor coping styles were used to a greater extent by those with PTSD than those without (see Table 9).

Table 9: the use of minor coping styles and PTSD

<table>
<thead>
<tr>
<th>Minor coping style</th>
<th>PTSD $M(SD)$</th>
<th>no $M(SD)$</th>
<th>PTSD $M(SD)$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religion</td>
<td>4.79* (1.91)</td>
<td>3.35 (1.56)</td>
<td></td>
</tr>
<tr>
<td>Self-blame</td>
<td>5.62* (1.76)</td>
<td>4.71 (1.81)</td>
<td></td>
</tr>
<tr>
<td>Substance abuse</td>
<td>4.42* (1.98)</td>
<td>3.55 (1.81)</td>
<td></td>
</tr>
<tr>
<td>Humour</td>
<td>4.17 (1.79)</td>
<td>4.06 (1.76)</td>
<td></td>
</tr>
</tbody>
</table>

$M =$ Sample mean, $SD =$ Standard deviation * $p < .05$

Again, ANOVA was used to explore whether the use of these coping styles differed between those with PTSD and those without. Minor coping styles were analysed using analysis of variance with PTSD/no PTSD as the grouping variable and Brief COPE minor subscale scores as the dependent variables. The use of religion was significantly associated with PTSD, $F(1, 193) = 16.969, p = .000, r = .28$. The use of self-blame was significantly associated with PTSD, $F(1, 193) = 5.352, p = .022, r = .16$. 

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Substance abuse was significantly associated with PTSD, $F(1, 193) = 4.710, p = .031$, $r = .15$. The use of humour was not significantly associated with PTSD, $F(1, 193) = 0.071, p = .790$. See Table 9 for means.

There was a significant relationship between developing PTSD and the use of religion, self-blame or substance abuse although the effect size was small in all cases. Humour was used to a greater extent by those with PTSD but the association was not significant.

**Summary**

This hypothesis was partially supported: the use of avoidant coping was significantly associated with the development of PTSD, as was the use of religion, self-blame and substance abuse but there was no relationship between the use of a positive or support-seeking coping style or the use of humour and journalists meeting the threshold for PTSD on the PCL-C.

$H_4$: An anxious attachment style will be the best predictor of development of PTSD when compared with avoidant attachment, major or minor coping styles, age, gender or vocational variables.

The results from hypotheses 1-3 were used to identify variables which were significantly related to PTSD for entry into a regression analysis to explore the relative contribution of these predictors to the development or not of PTSD. As the impact of an avoidant attachment style was only narrowly non-significant it was included as a predictor variable alongside anxious attachment, support-seeking coping and avoidant coping, which were all significantly related to PTSD, the categorical outcome variable in previous analyses. As age, gender and vocational variables such as career length, contract type, sector and geographical area covered were not significantly associated with the development of PTSD in earlier analyses they were excluded from this analysis. As a positive coping style was not significantly related to the development of PTSD and the minor coping styles all had a very small effect, they too were excluded in order to avoid unnecessary compromise to the power of the analysis. The relationship of subscale scores of anxious attachment, avoidant
attachment, support-seeking coping and avoidant coping to PTSD was then analysed using logistic regression. The backwards stepwise method was chosen as the forward method has a greater risk of making a Type II error (Field, 2009).

Table 10: Initial model summary

<table>
<thead>
<tr>
<th>Variables not in the equation</th>
<th>Score*</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxious attachment</td>
<td>5.94</td>
<td>.015</td>
</tr>
<tr>
<td>Avoidant attachment</td>
<td>2.60</td>
<td>.107</td>
</tr>
<tr>
<td>Support-seeking coping style</td>
<td>0.01</td>
<td>.969</td>
</tr>
<tr>
<td>Avoidant coping style</td>
<td>9.28</td>
<td>.002</td>
</tr>
</tbody>
</table>

* Roa's efficient score statistic

The initial model summary (Table 10) revealed that avoidant coping style made the greatest contribution to the model, with the highest Roa's efficient score statistic of those variables where \( p < .05 \). The model has an initial -2LL of 145.47 and a final -2LL of 133.40 which confirms the predictor variables provide a better fitting model than a constant-only model.

The odds of a journalist developing PTSD were negatively related to the use of a support-seeking coping style and positively related to an avoidant or anxious attachment style (Table 11), but neither was significant (\( p < .05 \)). After removing those variables from the model, an avoidant coping style was positively related to PTSD (\( p < .05 \)).
Table 11: Backwards stepwise logistic regression analysis of PTSD

<table>
<thead>
<tr>
<th>Included</th>
<th>B (SE)</th>
<th>Odds ratio</th>
<th>CI1 (LL/UL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxious attachment</td>
<td>0.08 (0.05)</td>
<td>1.08</td>
<td>(0.99/1.19)</td>
</tr>
<tr>
<td>Avoidant attachment</td>
<td>0.01 (0.05)</td>
<td>1.00</td>
<td>(0.91/1.10)</td>
</tr>
<tr>
<td>Support-seeking coping</td>
<td>-0.03 (0.06)</td>
<td>0.97</td>
<td>(0.86/1.09)</td>
</tr>
<tr>
<td>Avoidant coping</td>
<td>0.20* (0.09)</td>
<td>1.22</td>
<td>(1.04/1.44)</td>
</tr>
<tr>
<td>Constant</td>
<td>-5.46 (1.54)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Step 2

<table>
<thead>
<tr>
<th>Included</th>
<th>B (SE)</th>
<th>Odds ratio</th>
<th>CI1 (LL/UL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxious attachment</td>
<td>0.08 (0.04)</td>
<td>1.08</td>
<td>(1.00/1.18)</td>
</tr>
<tr>
<td>Support-seeking coping</td>
<td>-0.03 (0.06)</td>
<td>0.97</td>
<td>(0.86/1.09)</td>
</tr>
<tr>
<td>Avoidant coping</td>
<td>0.20* (0.08)</td>
<td>1.23</td>
<td>(1.05/1.43)</td>
</tr>
<tr>
<td>Constant</td>
<td>-5.42 (1.44)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Step 3

<table>
<thead>
<tr>
<th>Included</th>
<th>B (SE)</th>
<th>Odds ratio</th>
<th>CI1 (LL/UL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxious attachment</td>
<td>0.08 (0.04)</td>
<td>1.08</td>
<td>(1.00/1.18)</td>
</tr>
<tr>
<td>Avoidant coping</td>
<td>0.20* (0.08)</td>
<td>1.22</td>
<td>(1.04/1.43)</td>
</tr>
<tr>
<td>Constant</td>
<td>-5.81 (1.28)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 95% Confidence Intervals for odds ratio (Lower Limit / Upper Limit)

R² = .05 (Hosmer & Lemeshow), .06 (Cox & Snell), .12 (Nagelkerke). Model χ²(2) 12.07, p < .01.

Interpreting residual and influence statistics according to Field (2009, p.292) suggests the model is a good fit and no cases exert undue influence. Cook’s distances are all less than 1; expected leverage lies between 0 (no influence) and 1 (complete influence) in all cases where average leverage is (k + 1)/n, (4+1)/195 = .025641. All but two cases fall within (3(k + 1)/n) where k is the number of predictors and, in terms of standarized residuals, 91% of cases lie within ±1.96 and 96% within ±2.58 and DFBetas for the Constant are all less than 1.

Anxious attachment styles and avoidant or support-seeking coping styles all have significant interactions. An avoidant attachment style does not quite meet the assumption of linearity of the logit (Table 12).
Table 12: Variables in the equation

<table>
<thead>
<tr>
<th>Variables</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxious attachment by Ln Anxious attachment</td>
<td>.07</td>
</tr>
<tr>
<td>Avoidant attachment by Ln Avoidant attachment</td>
<td>.04</td>
</tr>
<tr>
<td>Support-seeking by Ln Support-seeking</td>
<td>.31</td>
</tr>
<tr>
<td>Avoidant coping style by Ln Avoidant coping style</td>
<td>.37</td>
</tr>
</tbody>
</table>

This model was far more accurate at predicting those who had developed PTSD than those who had not (see Table 13). The model failed to predict any of the 24 cases of PTSD and this may be due to the small sample size of participants with PTSD. However, the overall prediction of 87.2% is an improvement over the chance level.

Table 13: Observed and predicted frequencies for development of PTSD

<table>
<thead>
<tr>
<th>Observed</th>
<th>Predicted</th>
<th>PTSD</th>
<th>% correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>No PTSD</td>
<td>170</td>
<td>1</td>
<td>99.4</td>
</tr>
<tr>
<td>PTSD</td>
<td>24</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Overall % correct</td>
<td></td>
<td></td>
<td>87.2</td>
</tr>
</tbody>
</table>

Note: Sensitivity = 170/(170+1)% = 99.4%. Specificity = 0/(24+0)% = 0%. False positive = 24/(24+170)% = 12.3%. False negative = 1/(1+0)% = 100%.

Summary

Hypothesis 4 predicted that an anxious attachment style would be the most significant predictor of development of PTSD and it was partially supported. Step 1 of the regression revealed that an avoidant attachment style had no effect on PTSD and Step 2 revealed that a support-seeking coping style was slightly protective but the effect was small. For every extra point scored on the anxious attachment sub-scale, participants were 8% more likely to have developed PTSD whereas for every point scored on the avoidant coping sub-scale, participants were 22% more likely to have developed PTSD.

In summary, this hypothesis was not supported as an avoidant coping style was the best predictor of PTSD when compared with insecure attachment styles or a support-seeking coping style.
DISCUSSION

Summary of Results

Participants’ PCL-C scores suggest that journalists in the UK are almost four times more likely to develop PTSD than the general population. Almost one in eight \((n = 24)\) of the journalists who participated in this study scored more than 50 on the PCL-C, an established cut-off score appropriate for this cohort. This compares with a one-month rate of 3.4% recorded by Stein et al. (1997) in a survey of Canadian citizens; a 12-month rate of 7.8 per cent in the general population (Kessler et al., 2005), 21 per cent among adults working for a security company or the Belgian Red Cross (Declercq & Willemsen, 2006) and 29 per cent among war reporters (Feinstein et al., 2002). Reported symptomology among journalists appears consistent with relative exposure to trauma among those groups but with such a small sample size (195 participants from an NUJ membership of 38,000), this figure must be treated with caution.

With no central register of journalists deployment for comparison, no conclusions can be drawn about whether the participants in this study are representative of the industry as a whole but it is evident they are drawn from every sector of journalism, include freelance and staff and those who work on domestic and international news. Those in book publishing and public relations could be expected to have lower exposure to PTEs than those working for news agencies where the staple diet is anecdotally referred to as ‘hard news’ and could be expected to include natural disasters, civil unrest and war. Those working for broadcast outlets, magazines, new media and newspapers may also be exposed to distressing images and audio recordings.

While causality is difficult to determine, it is possible that the news diet of famine, war and pestilence which journalists are immersed in supports and reinforces the negative schemas which Alden et al. (2008) found could compound negative appraisals of symptoms and so supports the development of PTSD. Anecdotally, many journalists develop a jaundiced view of the world, often couched in black humour, which appears consistent with negative cognitive schemas and may lead them to interpret re-experiencing and hyperarousal symptoms in a more negative fashion.
Anxious attachment style was significantly correlated to PTSD and, while no conclusions can be drawn about causality, applying Ockham's razor - that is the simplest explanation is the best - it appears that if attachment styles are traits as suggested by Bowlby (1988) then they are pre-morbid factors and not products of traumatic exposure. This is consistent with previous work on attachment and PTSD (Declercq & Willemsen, 2006; de Zulueta, 2006; Dieperink et al., 2001).

The relationship between avoidant attachment style and PTSD fell just outside the nominal significance value so it appears that an avoidant attachment style may be more robust than an anxious style. Solomon et al. (2008) found that the complexity of the trauma may determine its potency with differing attachment styles. A less intense traumatic experience – such as a natural disaster – may not overwhelm a victim with an insecurely avoidant attachment style as they may maintain their defensive inhibition however a complex trauma involving human agency (such as sustained physical assault or imprisonment) cannot be ignored or avoided so the defences crumble. While journalists may be exposed to trauma as witnesses, it may be extremely rare for them to face sustained assault or imprisonment – situations more associated with domestic violence or direct combat experience – so an avoidant style may offer some protection against developing PTSD where trauma is witnessed rather than experienced.

Applying this understanding to clinical practice, is however problematic as attachment is a way of understanding relationships, not a model of therapy. Muller and Rosencranz (2009) found that patients receiving inpatient group therapy for PTSD developed more secure attachment styles but avoidant attachment scores returned to their pre-treatment level within six months. However, the rationale of the group programmes studied does not appear to be well operationalised: aims such as “the establishment of a sense of safety” and “orientation to group healing” (Muller & Rosencranz, 2009, p.82) may be too vague to be a useful guide to clinical intervention. Are there any groups which foster a sense of insecurity or aspire to group relapse?
An avoidant coping style and the use of religion, self-blame or substance abuse was significantly associated with PTSD but the effect of the minor coping styles was small. The use of problem-solving strategies has been shown to be effective at regulating negative emotions and correlated to secure attachment style, both of which are implicated in a lowered vulnerability to PTSD, but no causality can be inferred. It is possible that the use of religion, self-blame or substance abuse led to the development of PTSD but, intuitively, it appears more likely they are coping styles deployed in response to a traumatic event. Minor factor coping styles such as religion and substance abuse appear state-like and may sit at the periphery of any overlap with attachment style as they can be consciously moderated, as some people are able to give up smoking or change religion.

**Impact of Work Culture**

> "an admission of emotional distress in a macho world
was feared as a sign of weakness and a career liability"

Feinstein (2006, p.157)

While results reported here are largely consistent with similar studies into the impact of attachment style and coping skills on vulnerability to PTSD the impact of work culture on that vulnerability is not clear. As journalists appear to be exposed to a range of primary and secondary stressors that are work-related, the culture within journalism may play a role in vulnerability to developing PTSD. Journalists are often present at potentially traumatic events - a war-zone, a road accident, a court hearing – but objectivity is prized within journalism and they may aspire to suppress a subjective response. When Middle East correspondent Barbara Plett said in a report for BBC Radio 4 that she started to cry as a dying Yasser Arafat left the West Bank in 2004, there were hundreds of complaints from listeners and the BBC ruled that she had breached the requirements of impartiality (Gibson, 2005).

If journalists are expected to navigate apparently contradictory requirements to report objectively but include the human angle, it may require some investment in their psychological skills alongside their conventional journalistic skills. Hays (2008) recommends that those entering journalism should be made aware of current research
on the impact of witnessing trauma and, perhaps more ambitiously, helped to be more mindful of the victims' humanity. However, there appears little evidence that journalists are amenable to that attention. Feinstein (2006, p.154) refers to the "naivety of a profession that believes it can go off to war and emerge emotionally unscathed" and Underwood (2008, p.4) suggests that several features including the "macho professional culture of news workers, the pose of 'objectivity' and detachment in standard news writing, the assumption that risk-taking in the name of newsgathering should be undertaken without complaint, the pressures of a deadline-oriented work environment that leaves little room for introspection" dissuade journalists from delving into their psyche.

Limitations of Study

Using self-report data is problematic as only motivated individuals were recruited so a response bias cannot be ruled out. Bethlehem (2008) warns of the pitfalls facing online anonymous surveys in which the participants are self-selecting and journalists with experience of potentially traumatic events may be more likely to engage in a study entitled "How do journalists deal with stress" as they seek to understand their own condition so it is difficult to establish responder / non-responder differences. And with no control over circumstances in which the questionnaire was completed, participants accessing this study while at work may have been influenced to under report or been distracted by the work environment or completed the survey in collaboration with a colleague, all of which may confound the results.

The impact of anonymity is not clear. McLay et al. (2008), investigating PTSD among soldiers returning from Iraq or Afghanistan, found that more symptoms were reported anonymously than when the information was to be recorded in a personal file so results from this study must accommodate the possibility that anonymous data collection elicits an over-reporting of symptoms. Conversely, rates in this study could be under-reported as it may be that potential participants with PTSD and/or avoidant styles would not participate because to do so would remind them of their original trauma but anonymity leaves no opportunity to clarify misunderstandings or missing data.
Females comprise 42% of the 38,000 members of the NUJ, which may reflect an industry-wide trend, but women comprised 55% of the participants of this study. Given the links between gender and PTSD, such as a lifetime prevalence for PTSD of 9.5% for men and 17.7% for women (Breslau et al., 1997), it is possible this study has over-reported PTSD rates due to an over-representation of women.

Also, debate around coping style and attachment style reflects their status as a ‘work in progress’. The Brief COPE asks “what you generally do” which could be interpreted as relating to a state or trait and since the original three-factor model of attachment was initially developed a fourth style (disorganised) has been postulated (Shaver & Mikulincer, 2010). The choice of measures is always a compromise between availability and application, for this study it was decided that as the three-factor model had received most attention it would be deployed here as it gave access to the widest body of literature for comparison although this may be seen as colluding in a resistance to new ideas.

More fundamentally, if PTSD results from the shattering of core beliefs around subjective qualities such as benevolence, meaningfulness and self-worth, contemporary Western beliefs appear to attribute those qualities to humans rather than inanimate objects or forces of nature. This places attachment, cognitive schemas and PTSD vulnerability firmly in the bailiwick of contemporary Western beliefs so makes generalisation of findings to other cultures problematic.

**Recommendations**

*For journalists*

This study shows that journalist are at greater risk of developing PTSD than the general population but translating that knowledge into preventative protocols may be problematic. If journalists were screened for attachment style and coping strategy it might introduce some powerful motivation to distort data. For instance, news organisations’ insurance premiums might reflect a ‘PTSD vulnerability profile’ making media organisations reluctant to send some journalists with certain attachment
or coping styles. A more promising route may be to follow the advice of Hays (2008) and add psycho-education to the established training programmes for journalists entering the profession.

For therapists

As an insecure anxious attachment style is significantly associated with PTSD in journalists, and notwithstanding the problems already discussed around using attachment theory therapeutically, it may be that the working alliance between a patient with PTSD and a mental health professional must be more carefully fostered if the patient is insecurely attached. If this is not achieved, there may be a risk that any difficulties in developing this relationship are attributed to the traumatic event and so amplify the patient’s perception of the injuries suffered. And although the data around secondary traumatisation does not support a conclusion, mental health professionals should be aware of the potential for traumatisation among those indirectly exposed to PTEs such as administrators, lawyers and interpreters.

For researchers

While there is a vast body of evidence to support attachment theory there is much less on coping style and very little on the interplay between the two. Unanswered questions include whether attachment style is fixed or malleable, whether adults operate with more than one model of attachment and the relationship between attachment and coping style. Within PTSD, future studies might examine variables prior to exposure to further illuminate causality.

Conclusion

Journalists are at greater risk of developing PTSD than the general population and insecure anxious attachment or avoidant coping strategies may contribute. However, the dose-response model may be too simplistic and work-related factors such as a macho culture and an apparent quest for objectivity may also contribute to greater vulnerability and slower recovery from PTSD.
References


Developmental Psychopathology: Developmental Perspectives on Trauma (pp.33–84). Rochester: University of Rochester Press.


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Appendix 1: diagnostic criteria

Diagnostic criteria for Posttraumatic Stress Disorder (APA, 2000)

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 an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   2. the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior

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 (or more) 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 an 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 a 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, and 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.
Appendix 2: online questionnaire

How do journalists cope under pressure?

Journalists may face a range of stressors in their working lives, from the pressure of working to deadlines to reporting on, or witnessing, traumatic events on assignment. Some common responses to stressful situations include becoming more alert, avoiding the cause of the stress or becoming numb to the powerful emotions produced. In situations where the stressful event is traumatic, such as a life-threatening situation, those responses can become overwhelming; this is termed a post-traumatic stress disorder (PTSD).

Historically, PTSD has been associated with the armed forces and emergency services because of their involvement in conflict and life-threatening situations. As most TV, radio and newspaper coverage focuses on conflict, journalists may also be exposed to a range of life-threatening situations both directly, as witnesses, and indirectly such as when covering inquests, coroners' courts and crime reporting. Psychological research has identified different coping strategies and the importance of childhood experience, or attachment style, in dealing with stress.

Glossary:

*Post-traumatic stress disorder* (PTSD) is a severe and ongoing psychological reaction to an event that involved the threat of death or serious injury. The range of possible stressors includes witnessing extreme violence, involvement in a serious road accident or the diagnosis of a potentially terminal illness.

*Attachment* is a theory used to explain some of the fundamental elements of human relationships. It suggests that our earliest experiences as a child will inform our adult responses, including those to stressful situations.

*Coping Style* describes the process of responding to stress and can be categorised as problem-focused coping (addressing the situation which causes the stress) or emotion-focused coping (regulating emotions produced by the stress).
This project also aims to extrapolate studies on other professional groups which have investigated whether attachment style or coping strategy is a useful predictor of vulnerability to PTSD. It will take about six minutes to complete this survey. The data gathered will form part of a doctoral thesis in clinical psychology. It is hoped this thesis will improve understanding of what is a significant welfare issue for many journalists.

All journalists are invited to complete this questionnaire, whether they feel they have been exposed to a traumatic event or not. All responses will be anonymous and confidential and no identifying details will be taken.

If you have any questions about the nature or purpose of this study, please contact
Researcher: Martyn Bignold
Trainee Clinical Psychologist
Department of Psychology
University of Surrey
Guildford, GU2 7XH
e-mail: mb00014@surrey.ac.uk
phone: 01483 689441

If you have a complaint you would like addressing, please contact:
Research Supervisor: Dr Fiona Warren
Senior Research Tutor
Department of Psychology
University of Surrey
Guildford, GU2 7XH
e-mail: f.warren@surrey.ac.uk
phone: 01483 686944

Consent:
I understand the nature, purpose and likely duration of this study. I have been given the opportunity to ask questions on all aspects of the study. I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

I confirm that I have read and understood the above and freely consent to participating in this study.

Yes  No
Thank you for agreeing to take part.

Please indicate:

Male: Female:
Age:
Career in journalism (years):

Which sector do you work in: (please tick all that apply)

- Book publishing
- Broadcasting
- Magazines
- Newspapers
- News agency
- Public/press relations
- New media

Do you cover: (please tick all that apply)

- Domestic news
- International news
- In the field (as writer / reporter/correspondent)
- In the field (as a camera operator, still or video)
- In the newsroom (e.g. sub-editor / producer / presenter)
- Other

Are you:

- Freelance
- Staff
Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully and put an “X” in the box to indicate how much you have been bothered by that problem in the last month.

<table>
<thead>
<tr>
<th>Response</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repeated, disturbing dreams of a stressful experience from the past?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling very upset when something reminded you of a stressful experience from the past?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoid activities or situations because they remind you of a stressful experience from the past?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trouble remembering important parts of a stressful experience from the past?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the ‘stressful experience’ encountered as part of your work?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Loss of interest in things that you used to enjoy?</td>
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<tr>
<td>Feeling distant or cut off from other people?</td>
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<tr>
<td>Feeling emotionally numb or being unable to have loving feelings for those close to you?</td>
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<td>Feeling as if your future will somehow be cut short?</td>
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<tr>
<td>Trouble falling or staying asleep?</td>
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<td>Feeling irritable or having angry outbursts?</td>
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<tr>
<td>Having difficulty concentrating?</td>
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<td>Being “super alert” or watchful on guard?</td>
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<td>Feeling jumpy or easily startled?</td>
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</table>
The following statements concern how you feel in romantic relationships. We are interested in how you generally experience relationships, not just in what is happening in a current relationship. Respond to each statement by indicating how much you agree or disagree with it by putting an “X” in the appropriate box.

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Slightly Disagree</th>
<th>Neutral</th>
<th>Slightly Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>It helps to turn to my romantic partner in times of need.</td>
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<td>I need a lot of reassurance that I am loved by my partner.</td>
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<td>I want to get close to my partner, but I keep pulling back.</td>
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<td>I find that my partner(s) don't want to get as close as I would like.</td>
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<tr>
<td>I turn to my partner for many things, including comfort and reassurance.</td>
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<td>My desire to be very close sometimes scares people away.</td>
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<td>I try to avoid getting too close to my partner.</td>
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<td>I do not often worry about being abandoned.</td>
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<td>I usually discuss my problems and concerns with my partner.</td>
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<td>I get frustrated if</td>
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<td>romantic partners are not available when I need them.</td>
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<td>I am nervous when partners get too close to me.</td>
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<td>I worry that romantic partners won't care about me as much as I care about them.</td>
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</tbody>
</table>
Please read each of the following items carefully and put an “X” in the box that feels most appropriate. Please choose the most accurate answer for you – not what you think most people would say or do. Indicate what you generally do when trying to cope with things.

<table>
<thead>
<tr>
<th></th>
<th>I haven't been doing this at all</th>
<th>I've been doing this a little bit</th>
<th>I've been doing this a medium amount</th>
<th>I've been doing this a lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>I've been turning to work or other activities to take my mind off things.</td>
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<tr>
<td>I've been concentrating my efforts on doing something about the situation I'm in.</td>
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<td>I've been saying to myself &quot;this isn't real.&quot;.</td>
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<td>I've been using alcohol or other drugs to make myself feel better.</td>
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<td>I've been getting emotional support from others.</td>
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<td>I've been giving up trying to deal with it.</td>
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<tr>
<td>I've been taking action to try to make the situation better.</td>
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<tr>
<td>I've been refusing to believe that it has happened.</td>
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<tr>
<td>I've been saying things to let my unpleasant feelings escape.</td>
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<tr>
<td>I've been getting help and advice from other people.</td>
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<tr>
<td>I've been using alcohol or other drugs to help me get through it.</td>
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</tbody>
</table>
I've been trying to see it in a different light, to make it seem more positive.
I’ve been criticizing myself.
I've been trying to come up with a strategy about what to do.
I've been getting comfort and understanding from someone.
I've been giving up the attempt to cope.
I've been looking for something good in what is happening.
I've been making jokes about it.
I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.
I've been accepting the reality of the fact that it has happened.
I've been expressing my negative feelings.
I've been trying to find comfort in my religion or spiritual beliefs.
I’ve been trying to get advice or help from other people about what to do.
I've been learning to live with it.
I've been thinking hard about what steps to take.
I’ve been blaming myself for
things that happened.

I've been praying or meditating.

I've been making fun of the situation.
Thank you for your contribution.

This survey is part of a doctoral thesis for the award of a PsychD in Clinical Psychology from the University of Surrey. A summary of the results will be available in October. It is hoped that this study will establish the prevalence of PTSD among journalists; improve understanding of journalists’ vulnerability to PTSD and explore the impact of secondary or vicarious trauma.

If you have any questions about the nature or purpose of this study, please contact:

Researcher: Martyn Bignold
Trainee Clinical Psychologist
Department of Psychology
University of Surrey
Guildford, GU2 7XH

e-mail: mb00014@surrey.ac.uk
phone: 07768 406 220

If you have a complaint you would like addressing, please contact:

Research Supervisor: Dr Fiona Warren
Senior Research Tutor
Department of Psychology
University of Surrey
Guildford, GU2 7XH

e-mail: f.warren@surrey.ac.uk
phone: 01483 686944

Stress in the workplace is a significant welfare issue for journalists. If you are concerned about any of the issues raised, you may want to speak to your GP or contact the following:

- The DART centre for journalism and trauma is a global network of journalists, journalism educators and health professionals dedicated to improving media coverage of trauma, conflict and tragedy. The Centre also addresses the
consequences of such coverage for those working in journalism.  
http://www.dartcenter.org/

- The International News Safety Institute is a non-governmental coalition of news organisations, journalist support groups and individuals exclusively dedicated to the safety of news media staff working in dangerous environments. (http://www.newssafety.com)

There are also a range of self-help books available, such as:

- *The PTSD Workbook. Simple, Effective Techniques for Overcoming Traumatic Stress Symptoms* by Mary Beth Williams and Soili Poijula
- *Post-traumatic Stress Disorder for Dummies* by Mark Goulston
Appendix 3: Ethical approval

Dr Adrian Coyle
Chair: Faculty of Arts and Human Sciences Ethics Committee
University of Surrey

Martyrs Bignold
Clinical Psychology Trainee
Department of Psychology
University of Surrey

15th June 2009

Dear Martyn

Reference: 344-PSY-09 RS
Title of Project: A quantitative investigation into journalists’ vulnerability to post-traumatic stress disorder (PTSD) through the lens of attachment style and coping strategies

Thank you for your re-submission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has given favourable ethical opinion.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the Faculty Ethics Committee.

Yours sincerely

[Signature]

Dr Adrian Coyle
<table>
<thead>
<tr>
<th></th>
<th>Research Log Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Formulating and testing hypotheses and research questions</td>
</tr>
<tr>
<td>2</td>
<td>Carrying out a structured literature search using information technology and literature search tools</td>
</tr>
<tr>
<td>3</td>
<td>Critically reviewing relevant literature and evaluating research methods</td>
</tr>
<tr>
<td>4</td>
<td>Formulating specific research questions</td>
</tr>
<tr>
<td>5</td>
<td>Writing brief research proposals</td>
</tr>
<tr>
<td>6</td>
<td>Writing detailed research proposals/protocols</td>
</tr>
<tr>
<td>7</td>
<td>Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly</td>
</tr>
<tr>
<td>8</td>
<td>Obtaining approval from a research ethics committee</td>
</tr>
<tr>
<td>9</td>
<td>Obtaining appropriate supervision for research</td>
</tr>
<tr>
<td>10</td>
<td>Obtaining appropriate collaboration for research</td>
</tr>
<tr>
<td>11</td>
<td>Collecting data from research participants</td>
</tr>
<tr>
<td>12</td>
<td>Choosing appropriate design for research questions</td>
</tr>
<tr>
<td>13</td>
<td>Writing patient information and consent forms</td>
</tr>
<tr>
<td>14</td>
<td>Devising and administering questionnaires</td>
</tr>
<tr>
<td>15</td>
<td>Negotiating access to study participants in applied NHS settings</td>
</tr>
<tr>
<td>16</td>
<td>Setting up a data file</td>
</tr>
<tr>
<td>17</td>
<td>Conducting statistical data analysis using SPSS</td>
</tr>
<tr>
<td>18</td>
<td>Choosing appropriate statistical analyses</td>
</tr>
<tr>
<td>19</td>
<td>Preparing quantitative data for analysis</td>
</tr>
<tr>
<td>20</td>
<td>Choosing appropriate quantitative data analysis</td>
</tr>
<tr>
<td>21</td>
<td>Summarising results in figures and tables</td>
</tr>
<tr>
<td>22</td>
<td>Conducting semi-structured interviews</td>
</tr>
<tr>
<td>23</td>
<td>Transcribing and analysing interview data using qualitative methods</td>
</tr>
<tr>
<td>24</td>
<td>Choosing appropriate qualitative analyses</td>
</tr>
<tr>
<td>25</td>
<td>Interpreting results from quantitative and qualitative data analysis</td>
</tr>
<tr>
<td>26</td>
<td>Presenting research findings in a variety of contexts</td>
</tr>
<tr>
<td>27</td>
<td>Producing a written report on a research project</td>
</tr>
<tr>
<td>28</td>
<td>Defending own research decisions and analyses</td>
</tr>
<tr>
<td>29</td>
<td>Submitting research reports for publication in peer-reviewed journals or edited book</td>
</tr>
<tr>
<td>30</td>
<td>Applying research findings to clinical practice</td>
</tr>
</tbody>
</table>
Media constructions of schizophrenia:

how do Britain’s national newspapers
construct an understanding of schizophrenia
in their reporting of John Barrett’s
conviction for manslaughter?

ABSTRACT

Four trainee clinical psychologists collaborated on a qualitative study into the construction of schizophrenia by Britain’s national newspapers. A critical discursive approach was used to analyse discourse in the Telegraph, Mirror, Guardian and Sun newspapers from February 26, 2005 following the conviction of John Barrett for the manslaughter of Denis Finnegan in September 2004. Prominent themes which emerged were a construction of dangerousness focussing on ‘mad’ or ‘bad’; responsibility expressed via a failure and blame dialogue; and the positioning of the readership within an us and them paradigm as either ‘respectable’ or ‘criminal/animal’. The implications of public perception on understanding schizophrenia, destigmatising mental illness and supporting sufferers and carers are discussed.