Vicarious Traumatisation and Secondary Traumatic Stress Among Interpreters and Translators

By

Timothy David Carrington Green

Submitted for the degree of Doctor of Psychology
(Clinical Psychology)

Volume One

Department of Psychology
School of Human Sciences
University of Surrey

July 2003

© Timothy David Carrington Green
Copyright Statement

No part of this portfolio may be reproduced except with permission of the author. Only the librarian of the University library may make additional copies without expressed permission.
Acknowledgements

Firstly, I would like to thank the PsychD (Clinical Psychology) course team, who have all been helpful and kind over the past three years. Special thanks goes to Dr. Nan Holmes, supervisor of my Service Related Research project and Clinical Tutor and Dr. James Murray, supervisor of my Major Research Project. Special thanks are also due to Professor Ian Robbins for his help, support and field supervision of my Major Research Project. Additionally I would like to thank the Interpretation and Translation Agencies who helped me recruit participants for my Major research project.

Thanks are also due to my placement supervisors, from whom I benefited a great deal: Mr. Brain Turton, Dr. Gill Koheeeallee, Dr. Sarah Allcock, Dr. Liz Croft, Dr. Farzad Shamsavari and Professor Ian Robbins.

Finally, I have enjoyed and valued the support and encouragement from my fellow trainees, my parents and step-parents and Penny.
Volume 1 – Contents

Academic Dossier

Adult Mental Health Essay .......................................................... Page 7
Compare and contrast cognitive behavioural and psychoanalytic concepts of depression in adults, and the evidence underlying each of these models.

People with Learning Disabilities Essay ............................................. Page 27
Sexually abused and/or sexually abusing: what is the role of the clinical psychologist in working with people with learning disabilities who have been abused or abuse others?

Child, Adolescent and Family Essay .................................................. Page 49
Anxiety disorders in childhood are fundamentally different to anxiety disorders in adulthood. Discuss with reference to the theory and treatment of two anxiety disorders.

Older People Essay ........................................................................ Page 73
"Dementia cannot be cured. It takes its course." Critically evaluate with a discussion of known theories of causes and treatment approaches.

Clinical Dossier

Summary of Adult Mental Health Placement ........................................ Page 95
Adult Mental Health Case Report ....................................................... Page 96
Summary of People with Learning Disabilities Placement .................. Page 99
People with Learning Disabilities Case Report ................................. Page 101
Summary of Child, Adolescent and Family Placement ....................... Page 105
Child, Adolescent and Family Case Report ....................................... Page 107
Summary of Older People Placement ................................................ Page 111
Older People Case Report ............................................................... Page 113
Summary of Specialist placement ...................................................... Page 116
Specialist Case Report ..................................................................... Page 118
Research Dossier

Log of Research Experience ................................................................. Page 124
Service Related Research Project .......................................................... Page 130
A study of attendance and ethnicity in a primary care psychotherapy service
Qualitative Research Project ................................................................. Page 149
What influence do religious or spiritual trainee clinical or counselling psychologists perceive their religious or spiritual beliefs have on their training, with particular reference to choice of model.
Major Research Project ................................................................. Page 171
Vicarious Traumatisation Among Interpreters and Translators
Academic Dossier

This section contains four essays written over the three-year course. They cover topics pertaining to the four core placements of Adult Mental Health, People with learning Disabilities, Children, Adolescents and Families and Older Adults.
COMPARE AND CONTRAST COGNITIVE BEHAVIOURAL AND PSYCHOANALYTIC CONCEPTS OF DEPRESSION IN ADULTS, AND THE EVIDENCE UNDERLYING EACH OF THESE MODELS.

December 2000

Year 1
Introduction

"Concepts" and "models"
This question addresses an important issue for the development of psychological therapy within the modern NHS. Current health service trends in the UK focus on the demonstration of the effectiveness of treatments. This is an assessment of external validity and is different from examining efficacy, the internal validity that a theory is shown to hold. This split could be seen as a distinction between epistemological and practical/therapeutic outcomes of psychological treatment. The words "concept" and "model" in the question reflect this: A “concept” is something unseen, an abstract notion from which theories and procedures flow. A “model”, by comparison, describes a representation of a theory that can be seen, an outline for a procedure that might be followed. Models are frequently used in psychology to represent and operationalise a theory. Therapy is an example of this. Rycroft (1995) suggests that reliance on models can lead to reification, if they are taken into treatment settings without proper scrutiny of their conceptual basis. It is important, therefore, in treatment settings that we further our understanding of complex conditions, examining both if and why a therapy may prove beneficial. I hope to give an account of both concept and model in this essay.

Structure
I will follow Roth and Fonagy (1996) and examine unipolar depression as it is distinct from bipolar disorder in DSM-IV and noted to be the more relevant in the analysis of research studies. As the title suggests I will also restrict analysis to research and theory involving only adults. I propose to begin with descriptive facts about depression in the UK and beyond. Following this I will discuss the similarities, areas of ambiguity and differences that might be observed between cognitive-behavioural therapy (CBT) and psychoanalytic theories on depression and its treatment. For the purposes of brevity in this review, CBT will roughly correspond with the school of thought begun in mainstream psychology by Aaron Beck, psychoanalytic therapy will roughly correspond to the work begun by Sigmund Freud. A number of thinkers have subsequently contributed to both theories and many, though not all will be drawn on here. I am keen to portray a discussion emphasising the contribution each therapy has made to the understanding depression and to improving the quality of life for sufferers, rather than partisan fault
finding. Finally I will look at the outcome evidence that underlies each model of therapy, with an emphasis on the utility of these findings and implications for the psychological treatment of depression in the NHS.

Depression

Nature

Many people ruminate on negative themes without developing a clinical level of depression. What distinguishes a clinical depression is the severity, chronicity and co-occurrence of symptoms influencing different aspects of functioning as shown in Table 1.

Table 1: Symptoms experienced in different areas of function in depression.

<table>
<thead>
<tr>
<th>Area of functioning</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional</td>
<td>Extreme sadness; hopelessness</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Low self-esteem; guilt; memory and concentration difficulties</td>
</tr>
<tr>
<td>Behaviour</td>
<td>Feeling agitated; irritable; ‘slowed down’</td>
</tr>
<tr>
<td>Physical</td>
<td>Loss of energy; changes in sleep pattern; changes in appetite; sexual problems</td>
</tr>
</tbody>
</table>

Five of these symptoms must have been present continuously for at least two weeks in order to justify a diagnosis of Major Depressive Disorder (DSM-IV; American Psychiatric Association, 1994).

Prevalence, incidence and course

Roth and Fonagy (1996) report the results of a study commissioned by The National Institute of Mental Health (NIMH) in the USA, which drew on a sample of 15,000 adults. The results indicate that at least 6% of the population will suffer depression at any one time. These results were somewhat affected by a greater number younger respondents prepared to admit to mental health problems, bringing into question the possibility of comorbid substance abuse. The artefact gave some weight to an assertion that rates of depression are rising, although this has not yet been established. Williams (1987, in Clark and Fairburn, 1987) reports studies postulating a lifetime risk of suffering depression of 12% in males and 20% in females.
The course of depressive disorder seems to depend on type and chronicity. Observation in a 'natural' setting is difficult, however, as people with depression are normally observed in a treatment setting. Williams (1987) reported findings of 22% of patients still depressed two years after diagnosis, Roth and Fonagy reported evidence of 42% of outpatients experiencing remission in the first year, and 60% by the second year if none had occurred in the first year. Overall depression is characterised by high levels of relapse with 75% of patients becoming ill again over a 10 year follow up (Piccinelli and Wilkinson, 1994 in Roth and Fonagy, 1996). The implication of this finding is that treatments cannot be judged simply by their management of an index episode. Maintaining change is a more useful way to evaluate treatment success (Roth and Fonagy, 1996) and has greater implications both for cost-effectiveness and quality of life.

**Comparisons and Contrasts Between CBT and Psychoanalytic Concepts of Depression**

I would like to address issues in this section by looking first at my view of the similarities, differences and points of cross-over between the two theories in general. Then I will examine the contrasts between them with regard to the conception and treatment of depression. Finally I will look at the similarities and convergence between them. In this section I will also evaluate the evidence base underlying the internal validity of each of the concepts.

**Theoretical comparisons**

I hope to examine some fundamental similarities and differences between 'purist' forms of these two approaches by comparing Beck's cognitive triad (1983) with Malan's triangle of the person (1979) as shown in figure 1. This is very much a personal view developed from my reading of the theory and exposure in the work setting.
Figure 1: Comparison of Beck's cognitive triad with Malan's triangle of the person:


Malan (1979) Triangle of the Person

My exposure to the two concepts has led me to believe that the area inside the circle can be thought to represent areas of fundamental similarity between CBT and psychoanalytical approaches, whilst the two points of the triangles represent fundamental differences.

Differences
Firstly, the orientation of the triangles is important. In "Individual Psychotherapy and the Science of Psychodynamics" (1979) Malan stated that the triangle of the person should be point down, as the past could be thought of as "lying underneath" the outward behavioural manifestations of other and transference. Beck did not stipulate an
orientation of the cognitive triad, but my perception of CBT is that one's opinion about the self and the world form an 'underlying basis' from which one regards the future. This, I believe, marks a fundamental difference in conceptual orientation of the two theories which profoundly influences the style of treatment that they offer. CBT sessions are goal orientated. CBT practitioners use direct, focussed questioning with objective, rational scrutiny that aims to produce observable results in the future. Techniques such as thought inventories, standardised assessment measures and behavioural experiments are all orientated towards an observable outcome. These are traits that are reflected in the research conducted by CBT practitioners that aim to 'prove' the effectiveness of CBT techniques.

By contrast, psychoanalytic approaches have much less directive questioning from the therapist. The aim is a resolution of unconscious conflicts that have arisen from events in an individual's past which manifest in a state of distress. The notion that this arises as a result of issues of unworked through phases of instinctual drive or from problems with internalised objects further reflects how elements from the past are somehow 'underneath', being hidden or shielded from consciousness. The unconscious is tapped by techniques such as questioning aspects of the transference that occurs between therapist and patient, dream analysis or even a "mutitive interpretation" (Bateman, Brown and Pedder, 2000). The idiosyncratic and hidden nature of the material being worked on in therapy is reflected in the way evidence is often collected to demonstrate the efficacy of this theory through case report with individually tailored outcome variables (e.g.: Malan, 1979).

This is not to say that past events are not thought important in CBT. Both theories draw on a diathesis-stress model of psychological distress which emphasises the importance of what has gone before (Clark and Steer, 1996). Similarly I am not saying that psychoanalysis is not interested in someone's view of the future, but I believe that each has its own leaning that is congruent with its philosophy.

**Similarities**

Within the circle in figure 1 I believe there is a degree of cross-over. In Beck's cognitive triad the concept of the self refers to the person's own view of their "self". This concept
was operationalised by Beck to describe how a patient suffering depression has an
inaccurately negative view of themselves. In Malan’s triangle of the person “transference”
interpretation is used by the therapist to understand the person and their internal world.
It could be argued that these are similar ideas: the desire on the part of the clinician to
understand what is going on inside the person that is motivating the manifestation of the
depression.

In the same vein, Beck’s view that the individual's experience of the “world” as “making
exorbitant demands on him” (Beck et al, 1979) could be seen as corresponding to
Malan’s “other”, which corresponds to feelings (both positive and negative) the patient
has to others in his immediate world. Beck’s term is slightly broader, encompassing how
the individual feels about “his animate and inanimate environment” whereas Malan talks
only about other people interaction with the subject, but both refer to the influence others
in one’s environment have on levels of distress and psychological functioning.

Revisions have recently been made to both approaches highlighting common interests
in what happens in the future for patients, and a belief that past events have a profound
effect on organising an individual’s mind and contributing to psychological functioning

Even though I feel that philosophically there are several similarities between what the
concepts are trying understand and describe about human experience and a search for
meaning, differences in actual practice may be quite profound.

Conceptions of meaning and models of therapy in depression
For a discussion of conception of depression and the therapeutic style the adopt to for
treatment I would like to begin with a table (see table 2) detailing some of the main areas
where disagreement occurs and follow this with a brief discussion of the main themes.
Table 2: CBT and Psychoanalytic concepts of depression and therapeutic factors:

<table>
<thead>
<tr>
<th></th>
<th>CBT</th>
<th>Psychoanalysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cause</strong></td>
<td>negative schema/beliefs, irrational thoughts</td>
<td>- loss, distorted mourning (Freud)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- ambivalent about internal objects (Klein)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- dysfunctional attachment style (Bowlby)</td>
</tr>
<tr>
<td><strong>Maintenance</strong></td>
<td>negative automatic thoughts</td>
<td>Lack of resolution/insight regarding the above</td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
<td>Questionnaires, structured interview</td>
<td>Conversation, transference issues,</td>
</tr>
<tr>
<td><strong>Focus of therapy</strong></td>
<td>Future goals, cognitive change, behavioural change, time limited</td>
<td>Resolution of painful emotions from past/ development of insight/understanding, emotional processing, longer term/open ended, fundamental personality change</td>
</tr>
<tr>
<td><strong>Therapeutic Tools</strong></td>
<td>Thought diaries, thinking skills</td>
<td>Transference interpretation, dream analysis</td>
</tr>
<tr>
<td><strong>Level of work in</strong></td>
<td>Conscious active therapist</td>
<td>Unconscious Passive therapist</td>
</tr>
<tr>
<td><strong>therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Evaluation</strong></td>
<td>Pre and post questionnaire scores, symptom reduction</td>
<td>Idiosyncratic</td>
</tr>
</tbody>
</table>

**Cause and Maintainence:** For Freud, depression resulted from anger being turned upon the self. In the same way that sadness follows the loss of a loved person on the outside, sadness follows the loss of an ego ideal (an internalised object). The disappointments felt towards this loss becomes anger, which is inflicted on the ego, resulting in a lowering of self-esteem and causing depression. In extreme cases the anger is so severe it leads to suicide (Freud, 1917). Similarly, Klein’s Depressive Position saw a conflict good and bad internalised objects resulting from the ambivalent feelings that go to the mother following a realisation that she is the same person who feeds or does not feed lead the
infant to feel frustration, anger and then depression about the anger (Hinshelwood, 1994). Bowlby similarly saw the conflict resulting from the pattern of absence of the mother during critical periods of the young child's development as prompting distress and sadness (Gomez, 1997). These states are all thought to lead to a failure in adaptive functioning, a disparity between the person's perception of their actual self and their ego ideal. The profound sense of anger this induces leads to conflicts in the unconscious and a repetition of this pattern. This results in the maintenance of a depressed state.

Traditionally CBT looks less to the very early life of patients, but examines their thought patterns in the present to determine what is causing and maintaining low mood. A pattern of thoughts that are predominantly negative about the self, other people and the demands the world is making dominate thinking, eventually becoming overlearned into firmly held beliefs (Beck, 1983). These beliefs can become further entrenched in the personality to form schema, methods of understanding and processing information about the world. A pattern of schema is the guiding cognitive process from which beliefs and thoughts flow. The beliefs and schema that develop throughout the life are maintained by the negative automatic thought that a person has about themselves. These thoughts are thought to characterize the maintenance of depression (Beck, 1983). Thus, if a person has a belief that they are unlovable, they may have thoughts such as "I am horrible, no-one will ever want to go out with me". Such a negative cognition indicates that the person is thinking negatively about themselves, their feelings about others in the world, and their perception of the future.

The difference here is between process and content. Psychoanalytic theorists emphasize the development of pervasive maladaptive patterns of interpersonal relating and low self-esteem being continually replayed in the absence of insight by the person as a part of their personality and way of being. CBT theories argue more for a the content of everyday thought to be maladaptive, suggesting that broadening the repertoire of cognitions and behaviors will give the person a richer variety ways to feel about themselves and manage their moods. Psychoanalytic theories suggest that it is the fundamental character of the person that must alter. That through developing insight, they can grow and develop into a new life.
Models of therapy - Assessment, Focus of therapy, Therapeutic Tools, Levels of Work in Therapy:
CBT is distinguished from psychoanalysis by its emphasis on developing and understanding of the cognitive constructs that motivate behaviour Clark and Steer (1996). This is in contrast to psychoanalysis in which behaviour is understood through analysis of a person's internal world and its impact on their inter-personal realtionships as experienced in the transference with the therapist 'in the room'. In one sense psychoanalysis might be thought of as less abstract than CBT, as it deals with what is happening 'here and now' rather than what happens to the client when they are not with the therapist. This is emphasised by the examination of 'process' in the therapeutic time, rather than the agenda setting of CBT. The CBT practitioner is much more active, helping the patient in a collaborative way to identify concrete goals of treatment and measurable ways of assessing change. The psychoanalytic practitioner is more passive, reflecting on their own experience of being with the patient as a way of understanding the problem and reflecting back these insights.

Evaluation: With its use of questionnaire assessment measures and observations of behavioural change, CBT has been the psychotherapy more predisposed to outcome research and as such has had proponents suggesting that it holds the scientific high ground (Gelder, 1997). With its emphasis on the individual and the personality, psychoanalysis has been more usefully researched in an idiosyncratic way that claim to be filled with rich clinical data. The implications if these differences will be discussed more fully later.

Similarities and "rapprochement" (Bateman et al, 2000)
The differences detailed above I would perceive as existing more in the 'classic' schools of thought. Clark and Steer (1996) note that CBT does not differ from other therapies in terms of the therapeutic techniques, many of which are borrowed from other disciplines. Some easily observed similarities in traditional methods of both therapy include: structured sessions (the psychoanalytic 50 minute hour and the agenda setting of CBT); establishment of a therapeutic relationship and; the emphasis of inner mechanisms of
change. More recently, writers in the field have made reference to a “convergence”, with the cross-fertilisation of many aspects of each approaches work to the other (Fonagy, 1989, Ouimette and Klein, 1993). This is perhaps best illustrated by the development of “newer” therapies (Bateman et al, 2000) such as Cognitive Analytic Therapy (CAT) and Interpersonal Therapy (IPT). These will be discussed later, first I will examine how the convergence of the two approaches came about.

There is lots of evidence proving that cognitive therapy works (Dobson, 1989) but less consensus on the validity of cognitive theory (Haaga et al, 1991). Beck has found it necessary to provide several revisions of his theory (Beck, 1983, 1987). Several authors (Clark and Steer, 1996) point to the need for prospective rather than cross-sectional designs to properly assess the empirical status of a theory, but obviously this is more difficult to achieve. Studies that do examine the empirical status of the CBT concept point to several shortcomings.

The central question is whether cognition’s cause depression or are the product of depression. Teasdale (1997) reports that negative cognition’s often seem to disappear when a persons mood is lifted by medication. Haaga et al, (1991) make a distinction between descriptive and causal aspects of CBT’s theory of depression. They make several reservations about the descriptive claims that CBT make, chiefly that depressed people do have positive thoughts as well as negative ones, a feature not accounted for by the theory. They conclude that the causal hypothesis of CBT is not supported and cite research involving remitted depressives casting doubts on the stability of dysfunctional beliefs and further describe longitudinal research that generally does not support CBT’s onset hypothesis. There are fewer studies that test this hypothesis. They did, however, find empirical support for an increase in negative cognition’s about the self, increased sense of hopelessness, specific themes of loss and mood-congruent recall, but describe as “weak” evidence illustrating depressive thinking as illogical.

Blatt (1998) offers a comprehensive and modern interpretation of a psychodynamic understanding of depression. Beginning with Freud, he traces a theme through psychodynamic writings on depression that distinguishes two distinct processes that influence the manifestations of depression. Freud saw development of personality as an
interaction between urges towards personal happiness, which he called “egoism”, and the urge for contact with other, “altruism”. This split was echoed by other psychoanalytic thinkers, including Bowlby, who made a distinction between strivings for attachment and separateness, and Ballint who took an object-relations perspective and saw a split of relatedness and self-definition. Blatt states that this notion is borne out by research findings, adding weight to psychoanalysis’ claims of internal validity. The nature of these findings is not clearly stipulated, but would appear to be the results of case study analysis. Blatt sees this distinction as having important consequences for thinking about psychopathology in depression, through an exaggeration of one part and avoidance of the other. He defines his dichotomy as: anaclitic and introjective psychopathologies.

“Anaclitic Psychopathologies” define depressed people who have a primary preoccupation with interpersonal issues, such as trust, caring and sexuality. These pathologies are concerned with relatedness throughout their being, from a lack of differentiation between self and other to infantile, dependent attachments to more ‘normal’ issues of interpersonal relationships. They share a primary preoccupation with libidinal issues of interpersonal relatedness and use primarily avoidant defences to cope with psychological trauma such as repression, denial, withdrawal. In depression, this personality type is characterised by loneliness, helplessness, weakness, intense chronic fears of being abandoned, longing to be loved and protected. Little internalisation of the positive aspects of other people has occurred, resulting in constant need for others to provide satisfaction. Lack of people can lead to object loss and leads to denial or desperate attempts to get people into their life.

“Introjective Psychopathologies” describe people who are more concerned with establishing, protecting and maintaining a viable sense of self (or self-concept) at different stages of development. These include basic sense of separateness to concerns about autonomy and control to internalise issues of self worth. Such a person is not so interested in feelings of trust and affection in relationships. Anger and aggression feature prominently, either directed towards themselves or at others. They display projective defence mechanisms such as rationalisation, intellectualisation, projection. In depression, this sub-type is demonstrated in patients by feelings of unworthiness, inferiority, failure, guilt, chronic fear of criticism from significant others. They may strive
to maintain approval and recognition. Often introjective depressives are very critical of others, as they are of themselves, and can be intensely competitive.

Similarly, Blatt quotes from Beck (1983) who, in a revision, or augmentation, of his previous work, develops the notion of "sociotropic" (socially dependent) and "autonomous" personality types that lead to different presentations of depression. "Sociotropic" depression "refers to the person's investment in positive interchange with other people.....including passive-receptive wishes (acceptance, intimate, understanding, support, guidance)". Sociotropic individuals are "concerned about the possibility of being disapproved of by others". Depression is most likely to occur in these individuals when they perceive a loss of social role or experience a rejection.

Autonomy (individuality) refers to the person's "investment in preserving and increasing his independence, mobility, and personal rights; freedom of choice, action and expression; protection of his domain, attaining meaningful goals". Autonomously depressed individual is "permeated with the theme of defeat and failure" and being self-critical. Autonomous people often try to control all of their environment in order to minimise the chance of failure or criticisms. Depression occurs in response to perceived failure or lack of control over environment.

All of these perspectives have the view that there is an interaction of personal characteristics and environment used to understand depression, rather than deduction from symptoms based inventory (e.g.: DSM-IV; American Psychiatric Association, 1994). This differentiation into two groups aids the understanding of treatment, functioning in remission, and vulnerabilities of each group. Perhaps it is most interesting to note that the two approaches show this level of convergence when they come from very different research traditions: From the outset Beck's model has been one of outcome studies based on standardised assessment so that many people might be compared and results generalise. The research tradition in psychoanalytic approaches has tended towards idiosyncratic definition of outcome variables and rigorous analysis of process data from therapeutic session that was extensively used by Malan in the 1970's. It is worth of comment that both have arrived at a similar conclusion. Both seem to be looking towards
personality traits directly influencing vulnerability to depression (Ouimette and Klein, 1993), what might be termed a diathesis-stress model (Clark and Steer, 1996).

Ouimette and Klein (1993) comment on this convergence, saying that both argue for traits and these should be stable over time and appear to be so, although it is unclear whether they are affected by 'state' depression. They report that convergent validity between these scales appears adequate, discriminant validity was poorer, and it is possible that the sociotropic/dependent and the autonomy/self-criticism concepts may be part of a broader concept as they correlate so highly. Further research is needed to elucidate the specific mechanisms of this, as current conceptions appear to bear more relevance to Axis II personality disorders (DSM -IV; American Psychiatric Association, 1994) with no clear understanding of how personality is associated with specific constellations of symptoms.

Evidence Underlying Models

The evidence supporting the conceptual basis of the approaches has been discussed in the previous section. This section is dedicated to the evidence underlying the models of therapy that each concept uses in therapy. The reason for dedicating a discussion specifically to this element of evidence base is the current importance given by western healthcare systems to what in the UK has become known as "clinical effectiveness" (Department of Health, 1998). Simply put, this can be thought of as the evaluation of how theories perform in clinical practice. Under this evaluation, the generalisability of findings is thought all-important, and as such research protocols that allow for comparisons of patients across a number of different sites are considered superior. CBT's use of standardised assessment methods and a standardised treatment package have meant that it has been able to lend itself to this type of scrutiny more easily and incorporate new research findings as it goes (Gelder, 1997). Psychoanalysis, however, is catching up (Bateman et al, 2000). Results for both therapies are reported here.

Meta-analyses have often been used to distinguish the relative effectiveness of different treatment approaches. A consistent problem with this, however, is the lack of well structured psychoanalytical studies that would form a good basis for comparison (Roth
and Fonagy, 1996). For this reason, I will examine three important pieces of research that "meet stringent criteria of methodological rigour" (Roth and Fonagy, 1996) in examining comparative outcome of CBT and psychoanalysis. They are the National Institute of Mental Health's (NIMH) Treatment of Depression Collaborative Research Programme (TDCRP) and the Sheffield Psychotherapy Projects (SPP-1 and SPP-2).

The TDCRP study had two main aims (Bateman et al, 2000): the first was to assess the feasibility of conducting large-scale psychotherapy research trials, the second was to compare the efficacy of CBT and Interpersonal Therapy (IPT), a psychoanalytical derived treatment approach, against medication. This was a multi-site venture, with therapists who were trained in their discipline and regularly supervised with tapes of their session to ensure therapeutic quality. There was very little difference observed between groups, although drug treatments were shown to reduce more symptoms and IPT was shown to be slightly superior than CBT in treatment more depressed patients. There was also evidence of lower relapse rates in those given both psychological treatments suggesting a "sleeper effect".

The two Sheffield Psychotherapy Projects (SPP 1 and 2) and the collaborative Psychotherapy Project (CPP). SPP1 was a crossover trial with no significant difference observed between CBT and psychodynamic-interpersonal (PI) therapy. SPP2 is interesting as it meets the 'gold standard' for methodological research: a randomised controlled trial (RCT). CBT and PI found to be equal at all three levels of depression severity. Both were effective in equal amounts of time, although 8 sessions PI did less well than 8 session CBT or 16 sessions of either CBT or PI. No differences in outcome observed at one year. The more severely depressed people were found to respond better to long-term therapy.

CPP was different because it looked at outcomes in the clinical rather than research setting. Due to this, the effects were not as good as the research setting trial. Both therapies were found to be equally good and patients did better with 16 rather than 8 sessions, but follow-up at three months and one year showed less improvement (Bateman et al, 2000).
The apparent equality of effectiveness may be because research protocols are not sophisticated enough to detect change, or it may be the commonalities in therapy that elicit therapeutic benefit. Possibly this is due to therapeutic alliance (Krupnick et al, 1996, in Bateman et al, 2000). The difference in choice of therapy may be best reflected by the patient characteristics: those who were more motivated with a stable and coherent sense of themselves did better in psychodynamic therapy, those with a poor sense of self did better with more supportive, containing therapy. Horowitz et al (1993, in Bateman et al, 2000) suggested that those who viewed their problems in interpersonal terms did better in psychodynamic therapy whilst those with a poor or more fragmented sense of self did better in supportive types of therapy.

Therapeutic effectiveness 'proving' theory is a somewhat circular logic, or as Michael Gelder says (1997): "Models of this kind are useful as they can incorporate new experimental findings, they are less good at being sources of critical hypothesis, therefore more difficult to find their weakness". Overall, these results do not conclusively 'prove' the effectiveness of any particular treatment package or "model" over another. It is possible that some flaws in underlying concepts may account for shortcomings in therapy.

Conclusions

I believe that a conception of the convergence between the two approaches can be neatly demonstrated by returning to the diagram of the two triangles in figure 1. The further development of schema theory in CBT that was required in light of the theoretical shortcomings highlighted by Haaga et al (1991) means that the circle could now be thought of as encompassing the "past" part of Malan's triangle of the person. Likewise, with the current enthusiasm for clinical effectiveness being demonstrated in therapeutic practice and research, psychoanalytic approaches could now be seen to be paying more attention to what may happen in the future, especially longer term follow up of patients (Bateman et al, 2000). Thus the circle in figure 1 could now be seen to be all encompassing, demonstrating how the two concepts have informed each other and taken on aspects of their respective strengths in order to develop. Some of these developments are still in a conceptual stage, others have already begun to be shown in
therapy: IPT draws on the focused and time limited nature of CBT treatments, whilst still falling within the broad church of psychoanalytic therapies. Similarly CAT and Dialectical-Behaviour Therapy (DBT) aim at a synthesis of both models, although these are more frequently used to treat personality disorders. There seems to be a proliferation of therapies that are targeting specific disorders. This, again, may reflect the current trend towards providing evidence bases for models that can be shown to work effectively with particular disorders and a hope of attracting funds for research in clinical psychology departments to help develop understanding further and improve the treatment of patients.
References


People with Learning Disabilities Essay

SEXUALLY ABUSED AND/OR SEXUALLY ABUSING: WHAT IS THE ROLE OF THE CLINICAL PSYCHOLOGIST IN WORKING WITH PEOPLE WITH LEARNING DISABILITIES WHO HAVE BEEN ABUSED OR ABUSE OTHERS?

July 2001

Year 1
Introduction

Sexuality in people with learning disabilities (PLD) has suffered from gross misrepresentation. Polarised between a view that clients are asexual at one extreme, and sexually dangerous at the other, there is little consideration given to an understanding of PLD having healthy sexual needs (Moss, 1998). Recently a softening of this attitude seems to be taking place, with increased concern that this client group is vulnerable to sexual abuse.

With such issues coming to the fore, it is necessary for clinical psychologists to understand all issues of sexuality in working with PLD in order to fulfil their role. Within this responsibility come the thorny issues of sexual abuse and offending behaviour. These twin concerns also represent extreme ends of a continuum, but are perhaps the necessary starting point for psychological intervention given their seriousness.

Sexual abuse and sexual offending
A number of authors have pointed to the link between sexual abuse and sexual offending, suggesting a cycle of abuse (Blackburn, 1993, Craissati, 1998). Possible explanations have been offered in the form of social learning theory and the development of an abnormal limbic association between sexuality and aggression (Sobsey, 1994). Others writers have pointed to a lack of sexual knowledge in PLD being related to both perpetration of and vulnerability to sexual abuse (McCabe and Cummins, 1996). Sinason notes that in a learning disabled sex offender group run at St. George's Hospital, all participants had experienced major trauma prior to offending (Sinason, 1997). Sobsey and Mansell (1990) suggest that effective treatment not only helps the survivor, but also decreases the chance of future offences. Interestingly, many published works look at either offenders or survivors, rather than both together. I believe that it is not possible to look only at those who have been abused, but also those who may be vulnerable to sexual offending.
Structure
This essay will address the clinical psychologist’s role in dealing with sexuality in people with learning disabilities, particularly offending and abuse. I propose a structure that looks first at fact about learning disabilities and sexual abuse, then the role of the clinical psychologist. Following this I will look at each part of the role of the clinical psychologist in turn and address issues for survivors and offenders in each.

Learning Disabilities

Definitions
Learning disability (mental retardation) is classified as a developmental disorder in DSM IV (American Psychiatric Association, 1994) and ICD-10 (WHO, 1992). The most commonly accepted method for labelling someone learning disabled is through criteria developed by The American Association on Mental Retardation (AAMR) (Hatton, 1998). These criteria are shown in table one.

Table 1: AAMR 1992 definition of ‘mental retardation’.

| Mental retardation refers to substantial limitations in present functioning. |
| It is characterised by significantly sub-average intellectual functioning, existing concurrently with related limitations in two or more of the adapted skill areas: |
| • Communication |
| • Self-care |
| • Home living |
| • Social skills |
| • Community use |
| • Self-direction |
| • Health and safety |
| • Functional academics |
| • Leisure |
| • Work |

Mental retardation manifests before age 18.
Some argue that powerful groups who wish to exclude others they see as deviant socially construct classification systems such as these. The label is thought to develop a self-fulfilling prophesy of poor performance (Clements, 1998). Others take a positivist view, suggesting that intellectual disability is a long-term characteristic of some people and should be thought of as reflecting cognitive impairments that are stable and amenable to limited environmental manipulation (Clements, 1998). Both intellectual capacity (usually an IQ below 70) and functioning in everyday life (compared with what is expected from others of a similar age) are assessed in order to meet requirements of learning disabilities. About 2% of the population are thought to score IQ's under 70, which is two standard deviations below the mean (Halstead, 1997). The criteria listed above covers a wide range of presenting needs and reflect the different ways in which a person may come to have a learning disability.

**Incidence and prevalence**

Incidence (a count of the number of new cases of a disorder arising at any one time) is complicated in PLD due to its developmental nature. Data on some specific disorders have been collected but an overall incidence has not been established. Prevalence (the number of cases existing in the population, both old and new) in PLD is thought important in the development of a needs-led service (Hatton, 1998). European and North American studies show a general prevalence rate of 3.7 to 5.9 per 1,000 for mild and 3 to 4 per 1,000 for severe intellectual disabilities with a greater preponderance of males, a ratio of 1.6:1, in mild but no difference in severe disabilities (Hatton, 1998). These figures are prone to fluctuation over time, with a fall during the post baby-boom generation, and a recent increase in life expectancy of PLD.

**Sexual Abuse and PLD**

**Definitions**

There are a number of different definitions offered by researchers in the field, a point that has a bearing on prevalence rates as it affects the methodology of studies carried out. Turk and Brown (1993) point to more ambiguous definitions leading to a lower likelihood that abuse would be recalled. Brown, Turk and Stein (1994) is an important study cited by several writers on this issue. They define sexual abuse as:
"One-off assaults or sexual acts within an on-going relationship in which the power differences are so great that they preclude the possibility of the person with the learning difficulties freely giving their consent."

They state that this definition covers non-contact abuse through to vaginal or anal intercourse. They further discuss the issue of consent within their definition, highlighting a person's level of comprehension and feelings of being forced by threat or manipulation. Fenwick (1994) suggests that:

"It is generally recognised that sexual abuse occurs when acts are performed on or with someone else who is unwilling, or unable to consent, for whatever reason, to those acts."

Fenwick also notes the similarity between these definitions and those applied to child abuse, stating that professionals must be cautious of patronising adult PLD.

Incidence and prevalence
Turk and Brown (1993) conducted the only incidence survey to date. They collected data from two points in time (1989-1990 and 1991-1992) to establish how many new reports of sexual abuse were being made. This research is a useful indicator as it was conducted across one health authority with adults of all ages and levels of disability represented. Their results showed that 84 of 119 new allegations of sexual abuse could be considered to be proven or highly suspicious. Findings indicated that 60 new cases of suspected sexual abuse were reported each year in a health region population of 3.6 million. If extrapolated to cover the UK this would mean 940 cases per year. 73% of survivors were women and 26% men with an age range of 18-61 years. 19.6% had a severe/profound learning disability, 40.2% had severe/moderate learning disability and 40.2% had a mild/borderline learning disability. Overwhelmingly (67.9%) clients raised the issue. The majority of abuse took place in the survivor's home. Perpetrators were almost exclusively men (93%), often with one perpetrator offending against several survivors. 42% of perpetrators were fellow service users, 18% family members, 17% other known adults, 14% staff/volunteers, 10% unknown adults. Prosecution occurred in only 18.2% of cases.
Prevalence studies suffer similar problems of definition to incidence studies. Moss reports on several different methods of assessing prevalence. Of clients asked directly, 83% of women and 32% of men stated that they had been sexually abused. This assumes that the person being interviewed about abuse understands what is being asked. A postal survey of consultant psychiatrists estimated that 4-5% of clients had been abused, possibly indicating a lack of knowledge among professionals. Archive research has shown a figure of 25% of a group of 87 women had histories of sexual exploitation. Ammerman, Van Hasselt, Hersen, McGonigle and Lubetski (1989, cited in Fenwick, 1994) found that of 150 multiply handicapped children in the USA, 42 had definitely or probably been abused. These figures are thought to be an under-representation by some authors. Many survivors may not be able to recognise and name abuse when it occurs (McCarthy, 1998), or abuse may take place at home or in a place where the act cannot be observed (Turk and Brown, 1993).

Sexual Offending and PLD

Incidence and prevalence

Although the rate of offending in general is lower for PLD than the general population, the rate of sex offending is higher (Lindsay and Smith, 1998). 50% of offenders with an intellectual disability have been convicted of sexual offences and a survey of offenders with a learning disability in the community found that 35% had committed sexual offences (Gross, 1984, cited in Lindsay, Neilson, Morrison and Smith, 1998). Recidivism rates are consistent with the non-disabled population at between 33% and 71% for repeat offenders and 10% and 21% for first offenders (Lindsay and Smith, 1998). It has been suggested that PLD are more likely to be caught for offences due to a lower adaptive ability and also that they are more likely to confess and plea bargain when questioned by police. Possibly this is due to manipulation or coercion. As with the literature on sexual abuse, writers in this area also believe that prevalence figures are an underestimate (Lindsay, Neilson, Morrison and Smith, 1998). Halstead (1997) reports that fewer PLD who are in care are reported for offences, but notes a tendency to tolerate and under-report suspected offences. This may have implications for the continuing policy of re-settlement pursued by the government.
The Role of the Clinical Psychologist

Philosophy and skills
The British Psychological Society (BPS) describe the role of the clinical psychologist in a document entitled: "Core purpose and Philosophy of the Profession" (Division of Clinical Psychology, 2001). This describes the philosophy of clinical psychology as follows:

"The work of clinical psychologists is based on the fundamental acknowledgement that all people have the same human value and the right to be treated as unique individuals."

The BPS document then refers to the clinical psychologist's "core skills" with which to pursue the philosophy: assessment, formulation, intervention and evaluation. Cullen, Brown, Combes and Hendy (2000) describe a similar four-fold set of "characteristics" that a clinical psychologist employs and offer some short explanations:

1. assessment - the process of gathering information about a person;
2. interpretation - relating the observations to a broader theoretical framework;
3. intervention - putting into practice a treatment plan which follows from the interpretation;
4. evaluation - monitoring change and, where necessary, reformulating the initial interpretation"

Cullen et al suggest that the four skills should progress in the order above, so that assessment and interpretation is considered before an intervention is made, followed by an evaluation and reformulation.

Interpretations
Different authors have suggested several ways of interpreting this philosophy and framework for working with PLD. These include broad philosophies such as normalisation and specific mission statements for service provision such as O'Brien's five "service accomplishments" (Emerson, Hatton, Bromley and Caine, 1998). Whilst
important in the care of PLD, these approaches are tailored more to the general provision of care rather than issues of sexual abuse and offending.

**Role of the Clinical Psychologist: Assessment**

The first core skill of the clinical psychologist is assessment. Broadly speaking an assessment could be thought of as an attempt to gather information about the issue under investigation to inform a formulation. The role of the clinical psychologist in assessing sexual abuse issues in PLD has a number of components in addition to questions asked in a standard assessment. These include, capacity, risk, impact of abuse and ethics.

**Survivors**

A clinical psychologist must assess whether a person who has been abused had the capacity to consent to sexual relations under other circumstances. This clarifies that the person knew that the abuse was unwanted sex. The dependence of PLD may mean that clients feel unsure about who is permitted to touch their bodies and in what ways. Clinical psychologists must also assess the capacity the abused person has to undertake any form of therapy or if it is more appropriate for an intervention to be directed at the context or environment in which a person lives (Moss, 1998). Time needs to be dedicated to developing an understanding of how the person feels about themselves, their sexuality, what difficulties they have and how they cope with them, how they communicate (e.g.: in words, through behaviour etc.) and whether help is being sought by the person themselves or their carers. The English Law Commission has tackled consent in PLD. They suggest that a persons ability to consent varies from one issue to another (Halsted, 1997). It is the responsibility of the clinical psychologist to ensure that they pay careful attention to the capacity of the PLD regarding consent to sexual activity as it could be easy to misperceive the persons ability.

An analysis of behaviour change is indicated in the literature on child abuse to ascertain whether abuse had taken place. It is suggested as a useful tool in PLD (Fenwick, 1994). Sexualised play and new language or knowledge about sex are suggested possibly indicative of sexual abuse. An assessment of others in the person's social world and
their opinion of the clients is also necessary in order to gain a fuller picture of the impact of the abuse. An assessment of disability may also be useful in light of ideas from Sinason (1997) who suggests that PLD may retreat into a defence of being handicapped when they are unable to tolerate feelings produced in them by the abuse.

**Offenders**

With regard to offenders the clinical psychologist must assess the capacity of the perpetrator to understand that sexual offending is wrong. A variety of psychometric measures are used by those working with child abusers (Craissati, 1998). As far as I am aware none of these have been adapted for use with PLD. Clinical interviews comprise a large part of the assessment in this area. Social history, sexual history, offending history and details of the offence are all important areas for the clinical psychologist to cover. A clinical psychologist also needs to be alive to the possibility of mis-understanding. Halstead (1997) reports findings that suggest PLD sometimes make false confessions and fail to understand the ramifications of arrest. Additionally, mental impairment may not be obvious to the police or even professional involved. Much of the assessment work reported in the literature concerns risk assessment and perceived dangerousness, with less written on understanding why the person is sexually offending. Sinason (1987) promotes a view of the individual as separate from the crime in order to assess their needs as a way of reducing psychological distress and reducing re-offending.

**Role of the Clinical Psychologist: Formulation**

Broadly speaking, formulation concerns relating information from the assessment to a psychological theory in order to develop a framework for intervention. Within this skill the clinical psychologist makes sense of the information from the assessment with established theoretical models, developing an individualised model of the clients internal world. Formulation in PLD is predominately manifest in two areas: individual and systemic. These categories are also represented in Moss’s (1998) distinction about levels of intervention, discussed in the next section.
Survivors
Models have been developed to better understand reactions to abuse. Finkelhor and Brown (1985, cited in Fenwick, 1994) suggest four “traumagenic dynamics” in children: sexualisation, betrayal, powerlessness and stigmatisation. Fenwick (1994) suggests these are also useful when considering sexual abuse in PLD. This has not yet been researched systematically.

Offenders
Models have also been developed to understand sexual offending (e.g.: Wolf, 1985, see figure one).

Figure 1: Wolf’s (1985) Sexual Assault Cycle:

Beginning with poor self-image, the person moves through the cycle of offending, unable to break out. Similarly to formulation models for survivors, this model has not been research in use with a PLD population.
Comment on existing formulation models
Whilst multi-dimensional, these models have a strong cognitive component. Research in PLD notes the use of adapted model of these formulations used to guide treatment, with some outcome success (Mansell, Sobsey and Calder, 1992). There has, however, been very little evaluative work of the models themselves with which to judge their efficacy (the internal validity that a theory is shown to hold). Indeed, Moss (1998) refers to the lack of evidence demonstrating efficacy of any particular approach, describing interventions that are taking place as being "drawn from clinical 'lore' and/or extrapolation from work with non-disabled survivors".

Part of the role of the clinical psychologist in formulation is to develop and research theoretically sound formulation models with which to guide therapeutic intervention. It has not been clearly identified how such models work in PLD, given the cognitive difficulties they face. It is recommended that clinicians use their judgement and tailor therapeutic techniques to the ability of the client (Mansell, Sobsey and Calder, 1992). Given this client groups tendency to acquiescence and compliance (Emerson et al, 1998) it may be difficult for the clinician to know when their intervention is being fully understood. A more thorough understanding and development of a model specific to offender and survivor PLD would contribute to a more cohesive intervention.

One model that is specifically tailored to work with PLD around the issue of sexual abuse is Sobsey's 1994 ecological model of sexual abuse (see figure one).
The macrosystem refers to beliefs that are held in society about PLD. The exosystem refers to the system in which people live. The microsystem describes the interpersonal relationships each person has.

Given the large number of offences perpetrated by PLD service users on their peers, it seems important to develop a model that incorporates the service delivery system, demonstrating an understanding of how survivors and offenders interact with one another to create the situation of abuse. Sobsey's model is, broadly speaking, a systemic representation of abuse, with some consideration also given to individual factors in the microsystem. Sobsey (1994) comments that compliance is correctly identified as a difficulty in implementing change, but calls for the need to recognise that compliance in PLD has been engendered by pressure from those in families and care teams as well as the broader society. Writers from other perspectives display a certain amount of crossover with this view. Sinason (1997) writing from a psychodynamic viewpoint on sex offender treatment, points to the failure of many in the system surrounding the individual offender to understand the meaning of the offending to the individual.
Reference to a model like this following assessment will aid the clinical psychologist to design an intervention for either offenders or survivors, addressing not only their individual concerns, but also the framework of the world around them. It is only by holding an understanding of the person's whole world that the clinical psychologist can hope to effect change.

**Role of the Clinical Psychologist: Intervention**

The intervention represents the action taken based on the assessment and the formulation. Moss (1998) mentions two levels that the range of interventions might be split into:

```
"Level 1 interventions, which address the physical, emotional and social context in which people live.
Level 2 interventions, which relate to the minority of people who need more specialised care to recover."
```

In this section I will discuss elements of intervention that are important to the clinical psychologist's role. A description of intervention studies and their outcome will be given in the evaluation section.

**Survivors**

Returning to Sobsï¥Á [œ ¿ ö]
Fenwick (1994) draws a parallel between challenging behaviour and sexual abuse, suggesting that the behaviour is in response to the abuse suffered. Moss (1998) suggests that carers are often better at describing the physical needs of clients than their emotional state. A teaching intervention role for the clinical psychologist here is to inform others working with PLD about changes in behaviour that may occur if an individual is being abused. Sexualised material in someone’s behaviour is often thought of as ‘challenging behaviour’ by some staff members when the person may in fact be re-enacting, or otherwise reacting to, experience of abuse. Being withdrawn or aggressive may also indicate the presence of abuse. The clinical psychologist has an important role to play in monitoring the behaviour of clients and staff members in this regard. They have skills to raise the level of consciousness to the fact that sexual abuse is more common than might be thought and also to suggest strategies that might facilitate communication between clients and carers about the issue.

Several models suggest that the process of recovery from trauma involving re-experiencing and processing traumatic memories in a safe environment gradually allows the person to move on. For PLD whose lives are often defined and dictated by the environments in which they live, the involvement of carers in their environment during recovery is important. It helps with aspects of healing such as disclosure and being believed (Moss, 1998). When carers are involved they can also plan how they are going to support the person (Moss, 1998). Discussion of abuse at an exosystem level also allows for plans to prevent future abuse. Also in this vein are sex education interventions. Such interventions often form part of a larger teaching programme that includes elements of social skills training such as communication and assertiveness (saying ‘no’) (Sobsey and Mansell, 1990). In a psychoeducative intervention, Sobsey (1994) cautions against appearing to “blame the victim” for not possessing the skills in
the first place that are now being taught. Self-esteem, which will already be damaged as a result of the abuse, can be further hurt by a clumsy intervention.

Work can also be done at level two (one-to-one therapy, Moss, 1998). Historically one-to-one therapy was not considered for PLD, with pharmacological and behavioural interventions being used. Recently, adaptations to individual work have been successfully tailored to work with PLD (Sinason, 1992). Moss (1998) highlights the importance of being sensitive to issues of differential power, focusing one's energy on empowering the client is necessary to the success of therapy. Respecting non-verbal communication and recognising the importance of silence is also important. Remaining silent is often a power dynamic in abuse, the clients use of silence may engender a feeling of control in them, equally therapists silence may remind the client of the abuse. Moss further cautions against dual roles. For example, as clinical psychologist have the skills to both assess the accuracy of an abuse allegation (assessment skills) and seeing a survivor in a supportive capacity (intervention skills). Therapeutically, these two roles are mutually exclusive.

**Offenders**

In a level two intervention (Sobsey's microsystem) Craissati (1998) comments that managing denial is a central issue. Sex offenders will often deny their involvement in a crime or minimise their role in their offending. Overcoming denial takes patience and perseverance on the part of the clinical psychologist. Care and sensitivity are required in helping an individual come to terms with the consequences of what they have done and understand the reasons behind their offending behaviour. As many of these people are also survivors of sexual abuse, and may have some or all of the difficulties associated with a learning disability, many of the skills important in intervening with survivors will also be valid.

Sinason (1997) states that PLD sex offenders less likely to reach courts and therefore treatment programmes. Suggesting that treatment should be forced upon offenders legally represents an intervention at the macrosystem level of Sobsey's model. Elsewhere Sinason (1992) talks of a “general cultural awakening to the existence and impact of sexual abuse”. As mentioned earlier with survivors, this is an important area of
intervention for the clinical psychologist. Through teaching models with staff and interaction with the multi-disciplinary team a clinical psychologist can fulfil a role of creating a macrosystem shift in understanding of abuse issues for both survivors and perpetrators, prompting others to review their practice. It is part of the role of the clinical psychologist to have macrosystem level intervention issues in their minds every time they liaise with other service providers.

Role of the Clinical Psychologist: Evaluation

This role involves monitoring change, evaluating outcomes and contributing to the research knowledge base. In this section I will comment on some of the outcome evidence from research in the area and also discuss the work of the clinical psychologist in relation to the National Service Framework.

Survivors
Treatment of PLD survivors of sexual abuse suffers from a lack of large scale validating studies. Fenwick (1994) and Mansell, Sobsey and Calder (1992) cite several studies on children with treatment aims of reducing guilt, re-engaging trust in adults, reducing depression, expressing anger and labelling feelings, suggesting that such work is replicated in PLD. Moss (1998) describes work with several coping skills gleaned from the cognitive-behavioural literature. None of this evaluation work has been printed on work with PLD. As such effectiveness of therapeutic intervention can currently only be judged by the report of clinicians on single case studies. One of the responsibilities of the clinical psychologist is to report on intervention work in such a way as to demonstrate the effectiveness of their work, for example a randomised controlled trial. This is so far lacking in interventions with PLD who have survived sexual abuse.

Offenders
In contrast to the dearth of literature on treatment of PLD survivors, the PLD sex offender literature is much larger. A number of studies exist evaluating the outcomes of specific treatment approaches (Lindsay and Smith, 1998) and several models have been
adapted from sex offender treatment programmes with non-PLD populations to meet the needs of a PLD client group. (e.g.: Cox-Lindenbaum and Lindenbaum, 1994). Treatment approaches that have been documented include pharmacological treatment, psycho-education, social skills acquisition, behavioural control using peer review and relapse prevention (Lindsay, Neilson, Morrison and Smith, 1998). Having said this, none of these treatment studies are controlled trials.

Lindsay and Smith (1998) report on treatment of PLD sex offenders who have been given one and two year probation terms, with a condition of treatment. Treatment was group therapy run along cognitive-behavioural lines addressing issues of denial, minimisation, responsibility, offending behaviour and victim awareness. Participants were in the mild learning disabled range. Those receiving two years weekly therapy showed greater improvement of measures of attitudes of denial and minimisation of the offence. Follow-up data suggested that the one-year group also had a higher recidivism rate. The authors report that most studies of this nature report treatment times of less than one year and suggest that a longer period is needed for successful treatment of this group of offenders with special needs. This research, however, involved small samples (two groups of seven men) so the results need to be treated cautiously. Lindsay, Neilson, Morrison and Smith (1998) report research on a cognitive-behavioural group that measured participants throughout therapy with a multiple baseline assessment, finding a gradual change, indicating that clients were not simply telling them what they wanted to hear. This design offers a semblance of a controlled within-participants study. Lumley, Miltenberger, Long, Rapp and Roberts (1998) report on the success of a treatment group for PLD women who sexually abused being measured in part by a naturalistic assessment of the use of skills learnt in the group. This approach offers an evaluation of intervention outcome in real life.

These research studies offer hope that productive research may be carried out in this area. It is an important role of the clinical psychologist to ensure that meaningful research is conducted, so that models of intervention with proven efficacy and effectiveness are available.

National Service Framework: The Macrosystem of the NHS
Published in March 2001, the government's white paper entitled "Valuing People" details the government's policies on service provision for PLD. It emphasises tackling social exclusion, developing "life chances" for service users, getting value for money, reduce variation in service provision, promoting a person centred approach and raising standards. As it is these criteria by which clinical psychology service provision will be judged, evaluation of effectiveness will be assessed by these criteria both inside and outside the profession. Clinical psychologists have many skills with which to meet these challenges, with National Institute for Clinical Effectiveness (NICE) and the Committee for Health Improvement (CHIMP) looking on, it is now an important part of their role to ensure that they do. The European Human Rights Act may be seen as acting in tandem with these ideals, giving PLD who have not been treated fairly in their service right to have a voice and be heard. This may include appropriate treatment for PLD who have been abused or abuse others and also the right to independent sexual friendships. Clinical psychologists have a difficult yet crucial role in helping educate and police people of all abilities to further the aim of guaranteeing PLD their rights

Conclusion

As the issue of sexual abuse in PLD has grown in prominence, clinical psychologists have had to take stock of their role. Within the core philosophy of the profession are skills that should enable it to meet these challenges. There is, however, some ground to be made up, as theoretical models, treatment protocols and efficacy and effectiveness research bases are currently lacking. New proposals from the government and an increased awareness of the issue in society at large may help speed the process of therapeutic development. "To be a human being is to be a sexual being" wrote Ann Craft (quoted in Downs and Craft, 1999). Hopefully in the future PLD will have their needs as sexual beings addressed fully and appropriately.
References


ANXIETY DISORDERS IN CHILDHOOD ARE FUNDAMENTALLY DIFFERENT TO ANXIETY DISORDERS IN ADULTHOOD. DISCUSS WITH REFERENCE TO THE THEORY AND TREATMENT OF TWO ANXIETY DISORDERS.

December 2001

Year 2
Introduction

Interest in anxiety disorders in children has increased recently (Ollendick, 1998). Traditionally the majority of psychological research with children has looked at externalised disorders such as Attention Deficit Hyperactivity Disorder (ADHD) with little thought given to internalised disorders such as anxiety, maybe because they seldom bothered people in the adult world (Lodge and Tripp, 1995). With increased attention come two important questions for service provision:

1. Do conventional anxiety disorders exist in children?
2. If so, what is the appropriate thing to do with anxiety disorders in children?

Structure

To answer question one the current diagnostic criteria and prevalence rates from a number of studies will be examined. This section will hope to describe what anxiety is, in general terms, for both adults and children.

Question two has two component parts: theory and treatment. Theory and treatment for each anxiety disorders in turn will be described as applied to adults followed by a discussion of the appropriateness of their application to children. Following this there will be a discussion of current treatment practices.

Ages

Much of the research literature suggests that there are differences between adolescents and younger children with regard to anxiety disorders, with adolescents presenting similarly to adults (Ollendick, 1998, Carr, 1999). Despite this, most of the literature represents both children and adolescents in reviews and research articles. Accordingly, both will be discussed here.

Choice of theory and treatment model

Obviously there is not enough space for an exhaustive account of all the theories and studies, therefore discussion will be limited to cognitive-behavioural therapy (CBT)
theories and treatments of anxiety. CBT is currently the "treatment of choice" (Clark, 1998) being used most frequently for both adults and children with anxiety disorders (Carr, 1999; Ollendick, 1998; March, Franklin, Nelson and Foa, 2001). CBT also offers the most rigorously researched efficacy and effectiveness studies (Roth and Fonagy, 1996) and thus lends itself more obviously to a discussion that covers theory and treatment. Other theories, including neuropsychiatric and psychodynamic theories, although useful in understanding anxiety disorders in children and adults, do not make predictions that are as readily testable (Shafran, 1998) and will not be discussed here.

Choice of anxiety disorders
A central theme in the discussion of this topic will be the existence of cognitions in childhood. For this reason the anxiety disorders of Panic Disorder (PD) and Obsessive-Compulsive Disorder (OCD) will be discussed as they both have models of eitiology and treatment that relay heavily on cognitive factors. Both disorders in children have been conceived of as Separation Anxiety (Ollendick, 1998; Riddle, 1998), and much rich debate exists about their applicability to younger children.

Do conventional anxiety disorders exist in children?

Diagnostic criteria
The definitions from DSM-IV are given here, as they are the understandings used in the vast majority of research studies (Roth and Fonagy, 1996). DSM-IV offers the following definition of panic disorder:

"A discrete period of intense fear or discomfort that has an abrupt onset, reaches a peak within 10 minutes and is accompanied by at least 4 of 13 somatic or cognitive symptoms" (American Psychiatric Association (APA), 1994, p. 394)

Somatic symptoms of anxiety mentioned above include shortness of breath, accelerated heart rate, chest pain, choking sensations, dizziness, tingling or numbing sensations, hot/cold flushes, sweating, trembling and nausea. Cognitive symptoms include fear of dying, derealisation/depersonalisation and losing control (APA, 1994).
DSM-IV also notes PD sufferers to vary considerably in age of onset, stating explicitly that it occurs in childhood as well as adulthood.

DSM-IV defines OCD as:

"...recurrent obsessions or compulsions that are severe enough to be time consuming or cause marked distress or significant impairment. At some point during the course of the disorder the person has recognised that the obsessions or compulsions are excessive or unreasonable." (American Psychiatric Association (APA), 1994, p. 394)

DSM-IV asserts continuity between childhood and adulthood OCD and notes a higher lower level of insight into the bizarreness of obsessions among children.

Comment on diagnostic criteria
It is salient that DSM-IV does not make a distinction between childhood and adulthood in these definitions. In a technical sense children can be diagnosed with either disorder just as readily as an adult, meaning that they are thought to experience the same range of physiological, affective, behavioural and cognitive symptoms that adults do. The only proviso made for children is in the Separation Anxiety Disorder (SAD) entry, where it mentions that PD and OCD must be ruled out before a diagnosis of SAD is given. Saliently, Lodge and Tripp (1995) note that, whilst presently unclear, a link has been postulated between SAD and manifestations of anxiety disorder in adulthood. The inference might be made that symptoms of specific anxiety disorders might be detected in children if SAD were more closely scrutinised.

Prevalence - PD
DSM-IV lists a lifetime prevalence rate of 1.5-3.5% and a one-year prevalence rate of 1-2%. Roughly one-third to one-half of PD patients also suffer from agoraphobia in a community sample (APA, 1994). DSM-IV also notes PD sufferers to vary considerably in age of onset, stating that it occurs in childhood and adulthood.
Ollendick, Mattis and King (1994) in a review article found that PD among adolescents was more common than was conventionally thought. They display findings that among community samples of adolescents, 35.9%-63.3% reported experiencing panic attacks during their lifetime and 0.6%-4.7% reporting current or past symptoms severe enough to justify a DSM-IV diagnosis of PD. Furthermore they report that 10% of adolescents referred to an outpatient anxiety disorders clinic and 15% of inpatient adolescents warranted a PD diagnosis. Kearney and Silverman (1992) hold strong reservations about this research citing methodological problems of sample size and the use of questionable assessments (i.e.: non-validated questionnaires designed by the researchers). Perhaps more interestingly, King, Ollendick, Mattis, Yang and Tongue (1997) in a study of 649 unselected Australian adolescents (12-17 years) found 16% reported at least one panic attack (4 or more APA symptoms). They conducted a path analysis that enabled them to examine direct and indirect effects, thereby constructing a predictive model. They found that female gender, lack of family support during times of stress and heightened levels of stress in the family were related to panic attacks whilst age was not. They also found that adolescents were less likely to seek help for their distress until symptoms became quite severe, in contrast to their adult counterparts. Taken in the round, argue King et al (1997), this may suggest that age is not related to developing PD. Ollendick (1998) goes one step further and boldly suggests that:

"In sum, it is evident that panic attacks and PD can and do occur in childhood and adolescence" p.243.

By contrast Anderson, Williams, McGee and Silva (1987, quoted in Nelles and Barlow, 1988) in a sample if 792 children aged 11 found none that met the DSM III (APA, 1987) diagnostic criteria for PD. A review by Nelles and Barlow (1988) mentions very few cases of PD in under 18's, all of which occurred in adolescents.

Much of the controversy around PD in children revolves around the use of retrospective research methods (Nelles and Barlow, 1988; Abelson and Alessi, 1992). Many such reports show evidence of adults reporting that their PD began as young as five years old (Nelles and Barlow, 1988; Ollendick, 1998). Abelson and Alessi (1992) call into question
the validity of this retrospective questioning research method, suggesting that memories recalled as an adult are too unreliable to provide a strong evidence base.

Prevalence - OCD
DSM-IV lists the estimated lifetime prevalence of OCD in the general population as 2.5% with a one-year prevalence of 1.5%-2.1%. These are the same results reported by Roth and Fonagy (1996) of the National Institute of Mental Health Epidemiological Catchment Area (ECA) survey. Riddle (1998) notes that rates for adolescents are similar to those for adults but that there are no rates available for children, although Shafran (2001) suggests that between 0.5%-2% of children and adolescents have OCD. March, Franklin, Nelson and Foa (2001) report on an epidemiological study suggesting an incidence rate of 1 child in 200 suffering from OCD. Perhaps the most thorough review comes from Geller, Biederman, Jones, Park, Schwartz, Shapiro and Coffey, (1998). They identified six epidemiological studies, all of which were conducted with adolescents with prevalence rates ranging from 2%-4% across four western countries. Henin and Kendall (1997) suggest that these figures may be an under-estimate as children are reluctant to report their symptoms. Shafran (1998) presents a review of epidemiological studies with large numbers of participants that between 2.3% and 3.6% of community samples met the diagnostic criteria for OCD.

Shafran (1998) notes that differences between normal developmental repetitive behaviour that can be part of a childhood game and ego dystonic compulsions are not made explicit in every case in the available research. Some authors (Carr, 1999) consider OCD along with tic disorders as “repetition problems”. Shafran argues against this, suggesting the there may be a cognitive difference between the behaviours that are compulsive and the “empty” repetitive behaviours of Autistic spectrum disorder symptomatology and tic disorders. It is not clear in the research evidence whether this has been accounted for in every case.

Course and Chronicity
Course and chronicity are less well covered in the research literature, perhaps as a result of a lack of agreement on whether anxiety disorders are in fact the same for adults and children. Some studies (Geller et al, 1998) suggest that there is a bimodal incidence
of OCD, indicating perhaps a neuro-developmental stage of childhood causing the first peak. Ollendick (1998) proposes that adult anxiety disorders have been continued on from childhood, where the problem was either not noticed or given another name. With such divergence of opinion present in the literature, a clear description is not possible.

Comment on prevalence studies

The prevalence studies above appear to show somewhat similar rates of occurrence of PD and OCD in children and adults, but are dogged by methodological difficulties, in particular problems of poorly defined criteria, insufficient numbers of participants, invalidated research scales and retrospective questioning (Ollendick, Mattis and King, 1994; Roth and Fonagy, 1996). Additionally many research studies have focused only on adolescents. Future research must address these issues in order to establish a fair and accurate picture of the number of children who might have PD. Without such research refinements, it is not possible to be definite that the cluster of symptoms observed in children account for the same diagnosis as is given to adults and the question of PD and OCD existing in children can be answered only in part.

Despite this, or perhaps, with appropriate caution, researchers and clinicians have gone on to implement CBT with anxious children. The question that must be addressed is: what is the appropriate thing to do with childhood anxiety disorders?

What is the most appropriate thing to do with childhood anxiety disorders?

In order to state that there are no fundamental differences between childhood and adulthood in the cognitive theory of PD or OCD, children must be shown to fit the model as well as adults. This section will begin with a description of the CBT models for PD and OCD and will move on to discuss their applicability to children. An overview of treatment will then follow.

Description of the CBT theoretical model of PD

The cognitive-behavioural theory of panic was first articulated by Clark (1986). Following Beck's (1983) cognitive theory of depression it was suggested that the affect of anxiety
was mediated by cognitive states, particularly a catastrophic mis-interpretation of bodily sensations. Clark’s model of events in a panic attack are shown in figure one.

Figure one: Clark’s (1986) Cognitive Model of Panic

```
Trigger stimulus
(internal or external)

↓

Perceived threat

Interpretation
of sensations
as catastrophic

Body sensations

↑

Apprehension
```

As can be seen in the model, a person who experiences a trigger event, a shortness of breath after climbing some stairs for example, may become apprehensive. This may cause changes in the autonomic arousal system preparing it for a ‘fight or flight’ response. The consequent physical sensations may be interpreted by the person as proof that something is seriously wrong and that they are in imminent danger. This model represents a vicious circle in which the person becomes increasingly anxious until they have a full-blown panic attack. As Clark (1989) says:

"...it is not events per se but rather people’s expectations and interpretations of events which are responsible for the production of negative emotions such as anxiety" p.54
Description of the CBT theoretical model of OCD

The CBT model of CBT comes from Salkovskis (1996). Similarly to Clark's (1986) model of panic, it owes its origins in part to Beck's (1983) cognitive theory of depression. Salkovskis (1996) cites Rachman's (1971) observation that obsessional thoughts could be thought of as conditional stimuli as contributing to his model. Often in the literature a distinction between obsessions and compulsions is drawn, suggesting that the obsessive thought may motivate the compulsive behaviours (Salkovskis, 1996). Salkovskis argues that intrusive thoughts are a phenomena observed in normal cognitions (Salkovskis, 1996). What makes intrusive thoughts obsessional thoughts (with associated compulsive behaviours) is the meaning that is given to the thought. Salkovskis believes that individuals who develop OCD, attribute a meaning to intrusive thoughts that they are in some way responsible for harm, or responsible for the avoidance of harm:

"According to the cognitive hypothesis, an obsessional pattern would occur if intrusive cognitions were interpreted as an indication that the person may be, or may come to be responsible for harm or its prevention." p. 59

This obsessional pattern, which helps to maintain and even worsen the experiences of OCD, is shown in figure two.
Figure two: Salkovskis' (1999) model of the origin and maintenance of OCD.

EARLY EXPERIENCES
(making you vulnerable to OCD)

CRITICAL INCIDENTS
(what started the OCD off)

ASSUMPTIONS, GENERAL BELIEFS
(e.g.: Not preventing disaster is as bad as making it happen; Better safe than sorry)

INTRUSIVE THOUGHTS, IMAGES, URGES, DOUBTS

NEUTRALISING ACTIONS
(rituals, reassurance, mental argument)

ATTENTION AND REASONING BIASES
(looking for trouble)

MISINTERPRETATIONS OF SIGNIFICANCE OF INTRUSIONS – RESPONSIBILITY FOR ACTION

COUNTERPRODUCTIVE 'SAFETY' STRATEGIES
(thought suppression, impossible criteria, avoidance)

MOOD CHANGES
(distress, anxiety, depression)
Another important aspect of Salkovskis' model is the idea of thought-action fusion. This involves the individual believing that they might cause unpleasant or bad things to happen by thinking about them. Salkovskis (1996) gives the example of a mother who had obsessive thought about killing her baby, an event which she believed would come to pass because she had the thoughts. Another version of thought-action fusion involves the person believing that their thinking of the thought was morally equivalent to or as bad as the event itself. The notions of responsibility and thought-action fusion are important when considering the application of this model to children (see below).

Application of the theoretical models to children
To examine the applicability of these models to children, four questions must be answered:

1. Do children experience physiological and affective symptoms of PD and OCD?
2. Do children experience identifiable stressors that cause them to suffer anxiety?
3. Do children exhibit behaviours symptomatic of PD and OCD
4. Do children experience cognitions of panic/intrusive obsessions?

Do children experience physiological and affective symptoms of anxiety?
Much of the nosological debate here centres on whether anxiety and fear reactions are the same (Lodge and Tripp, 1995). Fear is thought to be an innate emotion that accompanies neurological action in the hypothalamus that prepares the organism to respond to situations of danger with a fight or flight response (Izzard, 1977, quoted in Nelles and Barlow, 1988). This type of reaction is commonly seen very early on in development and includes the physiological criteria mentioned in DSM-IV (Carr, 1999). In the prevalence studies listed above, several authors have found good support for the existence of DSM-IV affective symptoms of anxiety disorders. Nelles and Barlow (1988), however, question whether children are indeed panicking when experiencing these symptoms or whether the phenomena are better accounted for by a diagnosis of hyperventilation disorder. Recent review articles seem to concur that in essence, the somatic symptoms are the same (Shafran, 1998, Ollendick, 1998), perhaps indicating that the differences that have been highlighted are too slight to be considered 'fundamental differences'. Clinically, however, it would be important to rule out
hyperventilation disorder before making a diagnosis of an anxiety disorder (Ollendick et al, 1994).

**Do children experience stressors that cause them to suffer anxiety?**

In the cognitive model of panic, stress is seen as the precursor to the panic attack cycle (figure 1). In children, the most frequently studied stressor is separation from parents (Nelles and Barlow, 1988). Gittelman and Klien (1984) found that separation distress was common in the histories of adult PD patients, concluding that separation disorder may be a developmental antecedent to PD. Separation anxiety has many features in common with PD (physiological reactions, avoidance behaviours). What is not certain is whether the child is able to infer cognitively the attributions necessary to justify a diagnosis of PD. Rather the sensations that are being experienced are being attributed to an external cause (I miss my parents) (Ollendick, 1998). Gittelman and Klien (1984) comment that whilst children could be observed to panic in the presence of feared stimuli, the uncued panic attacks that are a core feature of PD were less readily observable. OCD is also triggered by a critical incident (see figure two). This has not been commented on in the literature, possibly as it is hard to disentangle from the repetitive play noted as developmentally normal children (Shafran, 2001) i.e.: it is hard to judge when the repetitive behaviour became ego-dystonic and therefore hard to judge what might have been a stressor. Greater understanding of the stressors leading to the triggering of anxiety disorders is needed in order to make firm conclusions. Many of these questions will carry over into the section on cognitions in children (see below).

**Do children exhibit behaviours symptomatic of PD and OCD?**

Shafran (2001) reports that almost all cases of OCD noted in children are accompanied by compulsive behaviours (i.e.: behaviours that purposefully avoid anxiety) similarly to those observed in adults. Kearney, Albano, Eisen, Allan and Barlow (1997) in a study of high school children found a significant difference between the avoidant and escape behaviours of children thought to have PD and controls. It seems fair to conclude that it is probably the externalised behaviour (rather than the internal feeling) that leads a child to be referred for psychological help. As such it is likely that many of the behaviours that are noted in adults are also in evidence in children. What may be less clear is what is motivating the behaviour.
Do children experience cognitions of PD and OCD?

Developmental psychology theories play an important part in this discussion. Nelles and Barlow (1988) refer to Piaget's theory of cognitive development in children. Piaget's last stage, the formal-operational stage (at around age 12), sees the development of hypothetical and abstract thinking. Prior to this the child is in the concrete-operational stage of development. The marker of this stage is the child's ability to differentiate the self from the rest of the world, what is internal and external. Whilst the child is able to make this differentiation, their understanding is very 'concrete', their view of the world rooted only in objective events. This shift from external (concrete-operational) to internal (formal-operational) thinking represents a change in ability in the child, moving from concrete thinking that can only consider facts about the world around them at the present time, to abstract, conceptual thinking, that incorporates more sophisticated notions of the past and present relating to the future (Piacentini, 1999). This lack of a sense of future makes children less motivated to engage in difficult therapeutic activities to achieve a future reward (Piacentini, 1999).

For example, a young child may notice physiological symptoms of an anxiety response and attribute the phenomena to an external cause (my heart is beating fast because I am going to school). A teenager with formal-operational thinking may attribute the cause internally (my heart is beating fast, I must be having a heart attack or going mad) (Ollendick, 1998). Nelles and Barlow (1988) argue that if children are not able to make inferences of internal causality, they do not fit the cognitive model of panic. Similarly, children who do not posses the ability to have abstract thought may not be able to experience a sense of future responsibility or more complex cognitive distortions such as thought-action fusion necessary to fit the CBT model of OCD.

Evidence to rebut this argument has been growing in recent years (Prins, 2001). Mattis and Ollendick (quoted in Prins, 2001) demonstrated that children as young as 8 years old could attribute somatic symptoms of panic to internal, catastrophic cognitions. Brown et al (1987, quoted in Prins, 2001) found catastrophizing thoughts common in 8 year olds and that these thoughts did not decrease with age. What did appear to change was an increase in the number of coping thoughts. Prins (2001) relates this to developments
in social-cognitive domains. From this perspective, anxious cognitions in childhood might be seen as deficits in metacognitive skill (Prins, 2001). Lodge and Tripp (1995) discuss cognitive research with anxious children, perhaps showing that such evidence that does exist suggesting a link between negative self-talk and anxiety reactions has only been shown to occur in situationally anxious children (e.g.: dental phobia). Prins (2001), whilst stating that there is evidence to suggest that cognition may be a concomitant of anxiety in children, notes the equivocation of research into the causal nature of cognition in childhood anxiety. He also notes the lack of research into areas of information processing which are important to the understanding of the formation of core cognitions, such as selective attention and memory bias.

Fewer studies have examined coping in children than in adults (Shafran, 2001). Lodge and Tripp (1995) report findings that children who report physiological symptoms of anxiety frequently report positive self-talk as a means of coping. Kendall and Chansky (1991) suggested that a difference exists between adults and children with this phenomenon, as adults will use self-talk directly to alter how they feel, whereas children will use it to distract themselves from a negative situation.

**CBT treatment models for adults**

CBT has been acknowledged as a useful treatment of anxiety disorders in adults, and has been proven to be marginally more effective than behavioural therapy alone (Roth and Fonagy, 1996). With PD, this usually takes the form of relaxation training in tandem with restructuring of cognitions when faced with panic situations. This involves helping clients to identify, evaluate, control and modify their negative thoughts and avoidance and escape behaviours (Clark, 1989). Therapy sessions are highly structured and should have the atmosphere of "collaborative empiricism". Homework assignments are set that focus the client on 'catching' negative automatic thoughts that can then be modified so as to be less threatening. Information about anxiety is given usually early on in treatment. With a more behavioural rationale in mind, activity schedules are sometimes given to prevent the client from avoiding anxiety-provoking situations.

OCD is treated by similar, but slightly different means. The mainstay of treatment is exposure and response prevention (ERP). This involves having the client expose
themselves to previously avoided situations and their obsessional thoughts without engaging in the safety behaviours of compulsive rituals. Part of the therapist's role is to give as much reassurance to the client as is needed (Salkovskis and Kirk, 1989). Cognitions are not directly challenged, but rather an alternative, less threatening explanation is sought. An example is provided by Salkovskis (1999): a thought of "I have contaminated things and am therefore dangerous" could be re-framed as "Maybe you are not dangerous but are worried about being dangerous". Goal setting is used to demonstrate to the client the progress that they have made in changing their behaviour and the therapist engages in normalising the behaviour for the client, so that they change their understanding of the significance of the cognitions from being terrifying thoughts for which they are responsible.

Application of the treatment models to children
There are many more articles on treatment of OCD in children than of PD in children. There is no reason given for this in the literature, but it may be the case that children with OCD are brought for treatment more frequently as their symptoms are more obvious to adults around them than children with PD who may be suffering in silence.

Shafran and Somers (1998) suggest that the extension of CBT for OCD with children is desirable as:

1. The childhood version of the disorder is similar to the adult version
2. Treatment outcome with medication is poor
3. Outcome trials indicate that ERP at least is effective

Shafran (1998) suggests that the emphasis of CBT in treating OCD in children is almost exclusively in the behavioural domain (ERP and extinction). March et al (2001) in their treatment programme entitled "How I Drove OCD off my Land" present a cognitive component to CBT for OCD in children, which consist of cognitive self-statements aiming to "boss back" the OCD. Although these could be seen as challenges to negative automatic thoughts, they do not expressly address the issue of appraisal and responsibility for harm (Shafran, 1998). As with adults, children are encouraged to
identify and evaluate their level of anxiety, often in creative ways such as the 'fear thermometer'. ERP is then used to tackle the OCD symptomatology.

There have been no randomised controlled trials of March et al's (2001) programme from which its effectiveness might be properly judged. Results reported from case reports and single case studies (March et al, 2001) are encouraging, but do not prove the fact of an effective therapy and do not show themselves to be superior to behaviour therapy (Shafran, 1998). The question of whether a therapy that relies on cognitive change be given to children when its efficacy has not been proven remains.

CBT treatments of PD for children have even less to recommend them. Labellarte, Ginsburg, Walkup and Riddle (1999) report CBT as being more effective than wait-list comparisons, non-specific treatment controls and other active treatments (such as family therapy) but neglect to describe what they mean by CBT. Similarly Carr and Moore (2001) in a review article report that parental input in CBT treatments of anxiety disorders in general appear to be useful. As there is no reference to precisely which disorders are being treated, it is difficult to comment on either the efficacy or the effectiveness of CBT treatments with children with OCD and PD.

Ollendick (1995) reports on four adolescents assessed by a number of validated measures who were treated for PD with a CBT approach. Treatment consisted of coping skills, breathing training, applied relaxation, cue-controlled relaxation, positive self-instruction training and cognitive coping procedures, all applied in an interoceptive conditioning exposure paradigm (Ollendick, 1998). This procedure appears similar to treatment programmes used with adults. Treatment success was established by a two-week symptom free period. It is not clear if the psychometric measurements were administered again at the end of the intervention. Ollendick claims that treatment gains were maintained at six months follow-up for all four teenagers. He suggests that this result is promising and that more research is required with childhood populations to further develop CBT treatments of PD. Whilst this is an interesting avenue of research to explore, caution needs to be taken in the extrapolation of these results given the very small sample size.

Kendall (1994) in an article presenting the results of a randomised clinical trial for anxiety disorders in general describes success with a programme of treatment that emphasised
recognition of anxious feelings, clarification of negative automatic thoughts, development of self-statements and self-reinforcement. It is not clear whether the participants used the self-talk as a distraction, as anxious children have been noted to do without input from a mental health professional (Kendall and Chansky 1991) or whether the self-talk was developed as a method of challenging negative automatic thoughts. Neither is it clear if there were any children in the study suffering from PD. Several other authors have developed Kendall's protocol for treatment of general anxiety (e.g.: Ronan and Deane, 1998, in Shafran, 2001) or looked at it to evaluate the effectiveness of CBT for treatment in anxiety disorders generally in children (Carr and Moore, 2001) but there appears to be little in the CBT literature pertaining to children that specifically addresses PD.

It is difficult to comment on the appropriateness of CBT interventions to treat PD and OCD in childhood as the research base at present is lacking in sufficiently rigorous studies. There does appear to be some support for the use of ERP in different form for the treatment of OCD, and preliminary work on application of CBT to adolescents with PD and children with general anxiety presentations may develop into a useful field of research in the future.

Conclusion

Within a CBT framework, PD and OCD in children can only be considered to be the same as adulthood disorders if they meet the same criteria. This discussion has shown that whilst children and adults might be thought of as similar in the physiological, affective and behavioural domains, there is debate about the nature of childhood cognitions. Whilst this debate continues, it is difficult to be certain about the efficacy and effectiveness of CBT treatment of PD and OCD in children. Treatment of adolescents is slightly more convincingly supported by both developmental theories and smaller scale research conducted in clinical setting. A fuller understanding and larger scale randomised clinical trails are needed before firm conclusions may be drawn. Future research must examine the cognitions of children presenting with physiological, affective and behavioural anxiety symptoms bearing in mind the methodological shortcomings of previous research, in particular the problems of poorly defined criteria, insufficient
numbers of participants, invalidated research scales retrospective questioning and focusing only on adolescents.
References


Older People Essay

“DEMENTIA CANNOT BE CURED. IT TAKES IT’S COURSE.” CRITICALLY EVALUATE WITH A DISCUSSION OF KNOWN THEORIES OF CAUSES AND TREATMENT APPROACHES.

July 2002

Year 2
Introduction

The psychological and psychiatric literature regarding dementia covers a number of syndromes (APA, 1994). This essay will focus on Alzheimer's disease (AD), as it is the most common in western countries Erkinjuntti (1999). The exact etiology of dementia is not currently known. Two theories about the causes of dementing behaviour in people are well represented in the literature, the biomedical model and the Malignant Social Psychology (MSP) model. This essay will begin with a description of the clinical features of AD followed by a discussion of the biomedical model and treatments arising from it. Then there will be a discussion of the MSP model and associated psychological treatments. Following this a conclusion will be offered.

Clinical features of AD

Definitions

DSM-IV (APA, 1994) places AD in the Organic Mental Disorder category along with other dementias such as Vascular Dementia and Lewy-body dementia, proposing that AD has an organic cause. It describes a syndrome where a disease of the brain leads to multiple cognitive impairments, including memory and at least one of the following: aphasia, apraxia, agnosia or disturbance in executive functioning. These need to be of such a degree that they cause significant impairment in social functioning, representing a decline from previous levels of functioning. The course of AD is characterized by gradual onset and a continued cognitive decline. AD is something of a diagnosis of exclusion, as other conditions of the central nervous system must be ruled out (e.g.: Parkinson's Disease). Additionally, the symptoms must appear independently to the similar syndrome of Delirium and must not be better accounted for by another Axis one disorder (e.g.: Major Depressive Disorder). Lishman (1987) suggests that AD should only be diagnosed if the person's consciousness is not clouded. ICD-10 (WHO, 1987) states that the condition must be present for at least six months.

Gustafson (1996) draws a distinction between primary and secondary symptoms. Primary symptoms are spatial disorientation (getting lost-agnosia), language disturbance
(aphasia), reduced practical abilities (difficulties in carrying out activities of daily living-apraxia) and personality changes including judgment (executive functioning). Gustafson cites these as primary symptoms as they are most closely associated with localised brain damage. Gustafson goes on to describe the clinical syndrome of AD as having secondary symptoms such as anxiety, depression, delusions etc. These are described as owing more to the reaction of the individual experiencing the disease process, yet are still thought of as part of the clinical manifestation of AD.

Prevalence
Prevalence increases with age, with cases below the age of 50 rare. Between 2-5% of the population over 65 are estimated to have AD rising to 20% in those over 80 (APA, 1994). Risk factors are thought to be advanced age and genetic predisposition (Zurad, 2001). Other risk factors that might play a part are Down's syndrome, head injury and aluminium poisoning (Burns, Howard and Pettit, 1995). Rocca et al (1991, in Burns et al, 1995) found the following prevalence rates across age ranges in Europe:

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>35-59</td>
<td>0.2</td>
</tr>
<tr>
<td>60-69</td>
<td>0.3</td>
</tr>
<tr>
<td>70-79</td>
<td>3.2</td>
</tr>
<tr>
<td>80-89</td>
<td>10.8</td>
</tr>
</tbody>
</table>

Evans et al (1989, in Burns et al, 1995) found the following rates in the USA:

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total over the age of 65</td>
<td>10.3</td>
</tr>
<tr>
<td>65-74</td>
<td>3.0</td>
</tr>
<tr>
<td>75-84</td>
<td>18.7</td>
</tr>
<tr>
<td>85 and above</td>
<td>47.2</td>
</tr>
</tbody>
</table>

Course
AD has an insidious onset and a slow progression leading to death in an average of 8-10 years (APA, 1994). Erkinjuntti (1999) describes typical neuro-pathological stages
corresponding to clinical stages. First, episodic memory is impaired with associated
atrophy in the temporal lobes. This is followed by loss of language and visuospatial
deficits and loss of functional independence, which can in turn lead to behavioural
difficulties. Zurad (2001) describes the effects of AD in practical terms as affecting three
domains of daily life: activities of daily living (ADL), behaviour and cognition. Breinter
(1999) discusses the importance of early intervention as a way to prevent these
changes, as slowing change is easier than reversing it. This makes understanding
course and etiology all-important. AD was thought untreatable, however, recently several
treatments have been shown to slow the progress of symptoms. These will be discussed
later in relation to the models proposed.

**Biomedical model of AD**

Zurad’s (2001) review gives a good account of the biomedical understanding of the
cause of AD. Neuroimaging is used to observe atrophy in the brain. In AD this is usually
(but not always) seen with enlarged ventricles and sulci and narrowed gyri—essentially a
shrinking of the brain. Neuronal loss is the main finding of brain investigations with AD
sufferers, particularly in the hippocampus, substantial innominata, locus ceruleus
tempoparietal and frontal cortex. What is thought characteristic of AD in particular is
presence of senile plaques and neurofibrillary tangles (NFT’s). Senile plaques are made
up of extracellular deposits of filamentous β-amyloid, which is a product of a protein
found in the brain’s chemistry. NFT’s are formed intracellularly by the rearrangement of
microtubule-associated proteins, such as tau. These features are common in the brains
of all elderly people, however, in those with AD they are clumped together rather than
diffuse, creating a compact β-pleated conformation that is thought to be neuro-toxic and
associated with dystrophic neuritis (Zurad, 2001).

Neurotransmitter systems are also though important in AD, as recent research suggests
that degenerative diseases of the central nervous system are often due to abnormalities
in specific proteins (Rogan and Lippa, 2002). In AD the cholinergic neurotransmitter
system most closely correlated with the presence of senile plaques and NFT’s. Specific
enzymes in brain chemistry that work to synthesize and degrade the neurotransmitter
acetylcholine are decreased in the brains of people with AD. This is especially true in the
cortex and hippocampus, areas of the brain associated with memory and cognition. Therefore, the decrease in acetylcholine neurotransmission is thought to cause some of the functional impairment seen in AD, much in the same way that deficits in dopamine neurotransmission lead to the clinical manifestation of Parkinson's disease. Another enzyme that is responsible for the maintenance of acetylcholine is butyrylcholinesterase. Whereas this is found in low levels in the brains of normal older people, AD sufferers have significantly raised and more widely spread amounts. There is a suggestion that butyrylcholinesterase causes senile plaque maturation as it becomes localized to them at the same time that they become compacted. These findings seem to suggest that an action that could block butyrylcholinesterase might slow the progress of AD. Drug treatments developed to treat AD have focused in recent years on blocking the degradation of acetylcholine at the synaptic junction. These have been found more effective than previous efforts that had used precursors of acetylcholine. The most commonly used of the recent drugs is donepezil (trade name Aricept). The effectiveness of donepezil will be evaluated later.

Experimental evidence supporting the biomedical model
Rogan and Lippa (2002) refer to pathologic examination of brain tissue as being the “gold standard” of diagnosing AD. Neuronal loss has been established in brain studies of patients suspected of having AD with atrophy found in areas that relate to symptoms of AD. Specifically: the hippocampus (related to memory), the amygdala (emotions and personality), parietal cortex (visuospatial), temporal cortex (agnosia and aphasia, also memory) and the frontal cortex (executive functioning). Doody (1999) examined the cholinergic neurotransmission system and found that the declines in transmission progresses at the same rate as the disease process. Doody also reports on a study by Winkler, Suhr, Gage, Thai and Fisher (1995) that experimentally induced cholinergic deficiency resulted in cognitive impairment (no elaboration of this is given). Treatment with a cholinergic agonist reversed this impairment.

Biomedical treatments of AD
Donepezil is a cholinesterase inhibiter that has recently been licensed in the UK and is the most commonly prescribed drug treatment for AD (Byrne, 2000). It is custom made to relieve the symptoms of AD. Erkinjuntti (1999) and Zurad (2001) suggest that any
interventions effectiveness should be judged by its ability to interrupt or stall the progression of AD's clinical manifestation of decreased abilities in three major areas: cognitive impairment, ADL and behavioural disturbance. Byrne reports on three large, multi-centre, randomized, double-blind, placebo controlled trials of Donepezil evaluated by the Alzheimer's Disease Assessment Scale-cognitive subscale (ADAS-Cog). Burns et al (in Byrne, 2000) report a 24-week randomized, double blind, placebo-controlled trial with 818 patients diagnosed with mild to moderate AD. Those in the treatment group achieved a mean improvement over placebo group of 1.5 (5mg/day dose) and 2.9 (10mg/day dose) at end point. These results on the ADAS-Cog are thought to be highly significant. Greenberg et al (in Byrne, 2000) reports a cross-over trial with 60 patients with probable AD given 5mg/day of Donepezil for six weeks followed by six weeks placebo washout. The mean ADAS-Cog following six weeks of treatment was 2.9 points higher than placebo control. Rogers, Farlow, Doody, Mohs and Friedhoff (1998) found similar results but report that side-effects of diarrhorea, nausea and vomiting troubled some patients. These were generally mild. They also reported benefits of donepezil over similar drugs, as its half-life of seventy hours required only one dose per day. All three of the studies mentioned above reported global improvements over control group, including improvements in ADL. No difference was noted between dosages in this regard.

These studies appear to support the use of Donepezil as a treatment for mild and moderate AD and offer some support for the biomedical model of AD.

Zurad (2001) reports on other drug treatments for AD. Anti-inflammatory drugs received attention after retrospective studies found that patients treated with these for arthritis had a reduced risk of developing AD. Studies have found benefits in terms of time to death, rates of institutionalization and ADL and significantly improved cognitive performance when compared with a placebo group. Similar findings have been observed for patients taking vitamin E and monoamine oxidase inhibitors. Oestrogen and ginko biloba have also been studied with more modest findings.

Shortcomings of the biomedical model

Kitwood (1999) has questioned the biomedical model. He believes that the current organization of healthcare in westernised societies relies too much on neuroscience at
the expense of the personhood of the patient. On theoretical grounds Kitwood questions
the biomedical model's paradigm that:

\[ X = \text{dementia} \]

saying that in the case of AD what constitutes \( X \) is not well known, the case for genetics
being so far unproven. With a major part of the theoretical paradigm missing, the
biomedical model does not provide a complete theory. Kitwood also suggests that at a
conceptual level the biomedical model is too individualistic and does not take adequate
account of the complexity of human beings. Additionally Kitwood suggests that no
account is made in the biomedical model of how neurology and human behaviour in
dementia as a clinical syndrome are related, with very little offered to explain how the
two are related.

Three major empirical flaws are noted by Kitwood (1999) in addition to the theoretical
flaws cited above. Firstly, weak correlations between measures of AD and indices of the
extent of neuropathology. Kitwood (1989) suggests that 80% of the variance is left
unexplained in moderate and severe dementia when brains are examined at
postmortem. Kitwood (1999) also cites studies of patients who have gone through the
'classical' course of AD with no neurological abnormalities detected at postmortem,
leaving the link between correlation and causation in the biomedical model obscure.
Secondly, Kitwood (1999) states that some people have been documented as
deteriorating faster than can be attributed to the consequences of progressive
degeneration of nervous tissue. This argument is strengthened by observations of
people moving from moderate dementia to severe dementia following admission to a
nursing or residential home, or becoming worse in a step-wise fashion following
admission to respite care. Thirdly, Kitwood mentions the biomedical models inability to
explain the documented arrest of the disease process under certain circumstances.
Kitwood goes even further, describing a process of "rementing" in some patients who
apparently regain some lost skills. This argument is supported by Sixsmith, Stilwell and
Copeland (1993) who observed increases in cognitive ability, ADL and behavioral
disturbance in person-centered environments.
For the last number of years Tom Kitwood has expounded the idea of malignant social psychologies as an alternative explanation for the presence of dementing syndromes. The main thrust of his argument is that the biomedical model, whilst it can make a useful contribution to the understanding of what is happening in the case of dementia, is restrictive in its view of the problem. To better understand the process of dementia, a model must encompasses the complexities of the person and the many factors that might influence them. Rather than a single factor etiology of dementia that the biomedical model suggests, where dementia=neuropathology, Kitwood (1993) proposes a different 'equation':

Dementia=personality+biography+health+neurological impairment+social psychology

Kitwood (1999) argues that an analysis of these factors offers a fuller explanation of dementia syndromes. Kitwood does not suggest that pathology in the brain does not exist, rather that, although there is a neuropathology that leads eventually to changes in cognition, ADL and behaviour, environmental and psychological factors may explain the rate of progress of the disease.

In the 'equation' shown above Kitwood (1999) defines personality as the person's resources for action and repertoire of skills. This factor also refers to the person's patterns of avoidance behaviour and defense mechanisms. With the onset of a dementing process the person may find they have fewer internal resources to call on, resulting in a change in behaviour as they struggle to cope. Biography is closely related to personality and is probably most significant in the area of losses the individual has experienced, be it through bereavements or loss of status. Loss in old age is pervasive and can cause a constant assault on the person's self-esteem. Health problems in old age can contribute much to the person's sense of themselves, with anxieties about failing health and confusion that is induced by problems at the metabolic level. Neurological impairment can be of varying type and severity, causing changes to the data-processing abilities. Social psychology refers to how the person acts in their environment in the ways that they feel are appropriate given the meaning they derive from the context they are in.
Rather than a behavioural cause and effect model of interaction, this notion views the person as a creative agent in their environment who makes choices about how they behave given the cues they receive from their environment and others around them.

Some of these factors are not amenable to influence, particularly biography, personality and neurological impairment. Health and social psychology might be influenced. Obviously everything should be done to enhance a person's health. Kitwood believes that much can be done with the "social psychology of dementia" to offer a greater atmosphere of reassurance rather than one which negates people's remaining competencies and self-esteem. Kitwood talks of the interplay between neurological impairment and social psychology as being crucial to the course of the disease. In some cases Kitwood believes that malignant social psychologies can actually worsen and speed up the disease process. This notion is supported by Lawton's model of "environmental docility" (in Woods 1999) that suggests that the lower a person's level of functioning the more likely they are to be shaped by environmental contingencies.

Kitwood sees social psychology as malignant if it destroys personhood. He believes that this is often the case for people suffering AD. He describes the principle components of the malignancy in the social environment around the patient as treachery, disempowerment, infantalisation, condemnation, intimidation, stigmatization, outpacing, invalidation, banishment and objectification. These categories have been arrived at via a systematic observation that Kitwood terms Dementia Care Mapping. Kitwood is at pains to point out that he believes that it is extremely difficult to avoid many of the elements of malignant social psychology rather than suggesting that care staff are malicious.

Kitwood also suggests that it is possible to identify alternative social psychologies that promote well-being. He goes on to suggest that spending half an hour practicing beneficial social psychology can restore the persons confidence and personhood and allow them to cope better for two to three hours afterwards. He gives five examples of how this may be achieved.

Firstly there is holding. This is related to the ideas of Winnicott, where a therapist 'holds' the patient in a safe and secure place in order that frightening and powerful emotions
can be experiences without the person becoming overwhelmed. Kitwood suggests that, similarly to children, the appropriate action when working with those who have dementia might be to physically hold them. The second example is validation. This concept owes a lot to other ideas in psychotherapeutic work that strive to validate the feelings of the client, such as a social role valorization in people with learning disabilities and unconditional positive regard as recommended by Rodgerian therapy (Woods, 1999). The central tenant is to accept the personal truth of the other's experience. Thirdly, there is facilitation, which aims to fill in the missing "action schemata" (Kitwood, 1999) that are missing to enable people to interact with their social world through gestures which are responded to in such a way that they evoke a further response. Fourth is celebration, where the patient and the carer are together participating in something they sincerely enjoy, for example laughing or having a good meal. Kitwood (1999) relates this process to Bern's ego state of the free child, which contrasts with most of the interactions the dementia sufferer usually faces with carers, which are of the parent-child type. Finally, Kitwood suggests stimulation, a neologism that refers to a process of pleasurable sensory stimulation, for example, massage, or "the creation of a personal conversation through music" (Kitwood, 1999).

The examples listed above require a lot from the caregiver, requiring dedication and a personal change on their part. Whilst there may be obvious benefits of such intense "positive person-work" and good theoretical grounds for supporting it, there are no large-scale outcome studies to date documenting its effectiveness. Interventions in this model of working are idiosyncratic in nature, with each case requiring different types of input. As such, comparison with the placebo trials of drug treatments are difficult. Several other psychological treatments for dementia follow a more structured protocol and have been scrutinized. These will be presented here.

**Psychological Treatments for Dementia**

**Reality Orientation (RO)**
This is a long-standing psychological treatment with evaluative literature available. There are two types: Firstly, 24 hour RO which involves changing the environment so that labels and other memory aids as well as prompts from staff members help the patient to
feel orientated. Secondly, RO sessions, which usually happen only once a week and cover material thought to enable cognitive functioning, such as names of others group members, orientating information about the date, time, place, followed by perhaps a numbers game and discussion of a relevant current topic of interest. A white board is used to help people to remember what is happening in the group and act as a tangible focus for the session. Despite methodological differences between papers, Zanetti, Oriani, Geroldi, Binetti, Frisoni, Giovanni and De, Vreese (2002) found improvements on measures of cognitive functioning (as measured by the mini-mental state exam-MMSE) in 38 mild-moderately AD patients who participated in group sessions everyday for a month at an outpatient clinic. Gatz, Fiske, Fox, Kasl-Godley, McCallum, and Wetherell, (1998) provide a review of all studies they deem effective according to criteria developed by the American Psychological Association which required randomized controlled trials demonstrating effective change in cognition, ADL and behaviour. They report two studies showing improvements on MMSE scores, with one suggesting gains were maintained following treatment (Zanetti et al, 1995) and one suggesting a return to baseline (Baldelli et al, 1993). Improvements on behavioural measures have shown less encouraging results (Woods, 1999), although as RO is largely a cognitive intervention perhaps one should not expect its effects to generalise to ADL behaviours such as dressing.

**Reminiscence**

Haight and Burnside (1993, in Woods, 1999) point out the confusion that often occurs between reminiscence and life review, the later, they say, describes interventions where the therapist is helping the person achieve a sense of inner integrity, whereas the former can be use as simply a point of contact. Reminiscence can be practiced in a group or in individual session with or without prompts of things from the earlier life of the person such as old newspapers and photographs. As people with AD have more memories from earlier in their life they are more able to access these and engage with the therapist whom in turns gets to know them better. Outcome research on reminiscence is in its infancy (Woods, 1999) with perhaps the most promising development being in the area of staff perceptions. Bains, Saxby and Ehlert (1987, in Woods, 1999) compared reminiscence with RO among patients with a moderate to severe degree of cognitive impairment. They found some degree of improvement on cognitive and behavioural
measures (reduction in scores on problem behaviour scale and increase verbal orientation) among clients who had previously responded well to a course of RO. Goldwasser, Auerbach and Harkins (1987, in Gatz et al, 1998) found significant improvements in depression among clients in a reminiscence group compared with no treatment control.

Validation therapy
This therapy grew from a belief that RO was often too confrontive for AD patients. It works instead to honour what the person believes and validate their feelings. Behaviour is viewed as resulting from unresolved conflicts that the person cannot now express in any other way rather than as a result of triggers in the current environment (Feil, 1993, in Woods, 1999). For example, if a patient speaks about their dead mother as though she were still alive, the therapist would not correct them by informing them about their mother's death (as in RO) but rather would rather acknowledge the person's need for a strong attachment at a frightening time. An expression of need is identified rather than evidence of confusion. It is thought that responding at a cognitive level would miss important emotional issues for the person concerned. Williams (1995, in Woods, 1999) suggests that the cognitive subsystems model developed by Teasdale and Barnard (1993) may help explain how validation therapy works. The model proposes two systems of meaning, propositional and implicational, reflecting cognitive and emotional understandings respectively. As the propositional system is impaired in AD, the implicational uses events from years ago to communicate needs in the present. Practitioners of validation therapy are encouraged to be empathic and reflect the person's view of reality rather than focus on the here and now. Techniques are discussed by Woods (2001) and include touch, eye contact, reassuring tone or voice. Some aspects of reminiscence are also thought appropriate. Painful feelings from the past that are expressed are thought to dissipate and leave the patient in less distress. Outcome studies on validation therapy have thus far yielded inconclusive findings, although anecdotal and single case reports describe positive outcomes (Woods, 1999). Kitwood raises a criticism of validation therapy. He suggests that by emphasising uncoped with events in the past the therapist may be heightening the sense of criticism a patient may feel, thus contributing to the malignant social psychology surrounding the patient.
Resolution therapy
Similar to validation therapy, resolution therapy attempts to understand the emotions being communicated by the patient employing verbal and non-verbal counseling skills. The difference is that whilst validation therapy focuses on painful memories from the past, resolution therapy concentrates on how the person is responding to their current situation and how they are coping and making sense of their new circumstances. There are no outcome studies assessing the effectiveness of resolution therapy (Woods, 1999).

Stimulation therapy
The idea that people with dementia are understimulated and need to have added sensory input came about with research into the deleterious effects of sensory deprivation (Holden, and Woods, 1995, in Woods, 1999). Recreational practices are now widely thought of as good practice in care environments. A variety of methods of doing this are reported in the literature including use of pets, music, and simple physical exercise. Lord and Garner (1993, in Woods, 1999) conducted a study using music therapy with 20 AD patients over six months with two control groups receiving either puzzles or “standard” recreational activities. They found that those in the music group had better recall of personal information and were rated as having improved mood and social interaction. Gaebler and Hemsley (1991, in Woods, 1999) conducted a study of the effect of music on six people with severe dementia. A definite positive response was noted in these non-verbal patients, highlighting the importance of careful observation in research and recognition that non-verbal, severely demented patients are still able to interact with their surroundings. Woods (1999) suggests that these studies have not been well controlled, so, despite some positive findings with regard to behaviour and cognitive functioning, firm conclusions are not yet discernable. ‘Snoezelen’ is another form of sensory therapy that uses lights, pleasant smells, vibrating cushions and other sensory props to develop a relaxing atmosphere. Outcome research suggests that ‘snoezelen’ therapy leads to increased relaxation, improved mood, and a decrease in disturbed behaviour (Woods, 1999).
Cognitive management

It has been hypothesized that reducing the cognitive load will allow people with AD to use their remaining cognitive abilities better (Woods, 1999). Reducing stimuli to a minimum and providing external memory aids (e.g.: signs, diaries) and training in their use has been shown to be effective in improving ADL task performance (Josephsson et al, in Woods, 1999). A high degree of planning is needed in order to ensure that the person will receive the prompt at the appropriate time. Techniques to enhance learning have been used with some success. Spaced retrieval is used to teach people new skills by learning one item at a time with the retrieval period being gradually increased each time the person remembers correctly and reduced if they do not remember correctly. Errorless learning is thought to be an important aspect of this approach, so that the feelings associated with failure do not interfere with the learning process. A new item is taught when the first item can be remembered for more than ten minutes, the time after which rates of forgetting are thought to be relatively unimpaired (Woods, 1999) It is thought that some generalization of these skills may occur. Quayhagen, Quayhagen, Corbeil, Roth and Rodgers (1995, in Gatz et al, 1998) found significant improvements in overall cognitive function, word fluency, general memory, in a cognitive stimulation treatment group compared with waiting list control, although a trend to decline to baseline at follow-up was noted. Woods (2001) reports success with this technique in helping AD patients learn how to use memory aids and thereby increase their competence in ADL.

Behavioural management

Woods (1999) reports the dearth of studies reporting behavioural management in AD. This may be due to the tendency among psychologist to view challenging behaviours in AD less as a 'problem' and more as an important means of communication (Stokes, 1996). AD sufferers display a wide range of unusual behaviours. A particular behaviour, for example, aggression, may communicate different meanings from one person to another and have different underlying cause (e.g.: physical health problems, neurological problems, hallucinations, anger, environmental factors etc). A detailed analysis of triggers and consequences is frequently undertaken in order to elucidate the communicative function contained in the behaviour. Gatz et al (1998) in a review of the literature report meta-analyses found support for behavioural work in self-care skills,
although the intervention was less effective with older clients. Some work has also been published documenting success with cues to prompt the person to use the toilet with the spaced-retrieval method (Woods, 1999). Other common challenging behaviours that receive intervention in AD sufferers are wandering, self-stimulatory behaviour, accusations, shouting and self-care skills.

**Conclusion**

Drug treatments for AD show slowing in deterioration and occasional reversal in the key domains of cognition, ADL and behaviour. Whilst encouraging, these treatments only work for patients with mild to moderate AD and are only effective while the drug is being taken. This symptomatic relief is of benefit to the person and those caring for them, however, the effects can only delay the progression of the disease and eventual progressive decline is still inevitable. Additionally, there is no concrete theoretical understanding of the pathogenic process that leads to the manifestation of the disease within the biomedical model. Benefit of drug treatments include the methodological rigor with which research into their effectiveness has been conducted and the large numbers of participants involved. Speigel and Irwin (1996) suggest that research could be improved by developing harmonization between the guidelines in Europe, USA and Japan regarding which variables are required for efficacy claims.

Psychological therapies have also shown effectiveness in reducing the symptoms of AD in terms of management strategies and offer a comprehensive theoretical framework to better understand the world of the person suffering from AD. Psychological research into dementia treatment suffers from a lack of clarity in the theoretical application of therapy, with different techniques being reported across a number of small-scale studies making meta-analysis difficult (Orrell and Woods, 1996). The description of standardized treatment packages would add specificity to what interventions worked effectively, although Gatz et al criticize this approach as manualised therapies do not always translate well to the idiosyncracies of clients presenting for treatment. Orrell and Woods (1996) suggest the use of different measures across studies has made comparison complicated, it is suggested that future psychological research use the same measures as those used in drug trials (e.g.: MMSE, ADAS-Cog). Changes in the environment in
which the person lives and developing more positive attitudes towards their care, whilst not curative, are also useful ways to help mollify AD symptoms and improve the quality of life for the sufferer.

Dementia perhaps cannot be cured, however, the course it takes may well not be set in stone. A variety of therapies (medical, social and psychological) now offer symptomatic relief and a potential slowing of the course of the disease, enhancing quality of life for sufferers.
References


Ageing: Assessment, Treatment and Care. Chichester: John Wiley and Sons.


Zanetti, O., Oriani, M., Geroldi, C., Binetti, G., Frisoni, G. B., Giovanni, G. and De,

Clinical Dossier

This section contains chronological summaries of clinical experience gained across the four core placements and year-long specialist placement along with summaries of the five clinical case reports. The five clinical case reports are submitted in full in Volume Two of this portfolio, along with placement contracts, supervisor evaluation forms and full record of clinical activity.
Summary of Clinical Experience Adult Mental Health Placement

Placement details

Dates: 11/10/00-23/3/01
Supervisor: Mr. Brain Turton
NHS Trust: South London and Maudsley NHS Trust
Based at: The Lind Clinic, Deptford, London.

Client demographics

Men and women aged between 32 and 48 years old from black and white ethnic backgrounds. Seven were women and seven were men.

Presenting problems/issues worked with

Family difficulties
Depression
Anxiety
Grief/bereavement
Recovery from psychotic episode

Settings

This was a primary care service with clients seen in an outpatient clinic. Additionally meetings were attended at GP surgeries and CMHT bases.

Assessment procedures

Interview assessment
WAIS-III

Interventions

Psycho-dynamic counselling
Cognitive-behavioural therapy

Other experience

Attended team building day with Conductor from the Institute of Group Analysis
Adult Mental Health Case Report Summary

The psychodynamic assessment, formulation and treatment in a primary care setting of a 36 year old woman suffering stress and anxiety whilst adjusting to life following a brief period of psychotic experiences.

March 2001

Year 1
All names and other information that could be used to identify the individual described in this report have been amended to ensure anonymity.

Reason for referral
Eve was a 36 year old Afro-Caribbean woman who had recently recovered from a brief psychotic episode. She was referred by her GP.

History of presenting problem
Eve had no previous history of mental health difficulties until a year previously when she had what she described as "the plunge" which was diagnosed as a brief psychotic episode. She stated that she believed that this had come about as a result of a build-up of stress in her life related to the long hours that she worked. Eve reported that she had a constricted experience of childhood, as she had grown up between the UK and Nigeria in a very strict patriarchal family unit. She was not allowed to go out and play as a child and was not allowed to talk to boys as a teenager. Her mother died when Eve was 22 and Eve had to take over all the duties that her mother used to do, looking after her father and younger siblings. When she was 25 her father re-married and Eve was sent back to live in London alone. She took a job in the fingerprints division of the police force and consistently attended evening classes in 'A' levels or Btec's and would work all weekend on college work rather than going out. She had one relationship with a man, which lasted a few weeks at the age of 27. It ended when he stopped calling her.

Assessment
Eve was interviewed by the trainee's supervisor, as was standard practice on the placement. She also completed the CORE questionnaire, which indicated that she met a caseness level of disturbance. Eve also completed the department's pre-assessment questionnaire that asked clients to state what they wanted help with. Eve stated that she wanted guidance in how to change her current life-style for the better.

Formulation
Eve had already received a medical formulation of her difficulties with the diagnosis of psychosis. The author and supervisor, from a psychological stand-point, formulated Eve's difficulties as a breakdown in her defences. Brief psychodynamic therapy was
thought an appropriate model for helping Eve to gain insight into her behaviour from which she could make changes she wanted to to meet her goal of changing her life-style for the better.

**Intervention**

Eight 50-minute sessions were agreed with one follow-up session. Using Malan’s triangle of the person and triangle of conflict the author interpreted comments made by Eve to highlight hidden feelings of resentment and anger that she might be experiencing. The author also used transference and counter-transference concepts to highlight to Eve her anger at her father and how her fear of going out to meet people led her to avoid social situations.

**Outcome and Critique**

Re-testing on the CORE assessment measure showed that Eve’s scores had fallen below the cut-offs for caseness following the intervention. She had made some new friends at the gym and had been on nights out with them as well as attending drinks after work which she never used to do. She had arranged to go to Nigeria to see her father, whom she had not seen for a long time as she had avoided him. Eve’s feelings about men in general and sex and sexuality in particular had not been addressed in therapy, neither had many of the issues surrounding her father.
People With Learning Disabilities Placement

Placement details
Dates: 4/4/01-21/9/01
Supervisor: Dr. Gill Koheeallee
NHS Trust: South West London and St. George’s NHS Trust
Based at: Merton and Sutton Community Team for People with Learning Disabilities

Client demographics
Range of ages from 7 year old child to 66 year old woman. Range of ethnic backgrounds including English, Tamil, Croatian, Afro-carribean, Anglo-Japanese. Three were women and 16 were men.

Presenting problems/issues worked with
Challenging behaviour
Avolition
Anxiety
Depression
Capacity to consent
Aspergers syndrome
Intellectual assessment
Screening for dementia
Phobia

Settings
Community Team for People with Learning Disabilities
Group homes
Clients homes
Schools for children with learning disabilities
Assessment procedures
Interviews with clients, family members and carers
WAIS-III
Behavioural Observation
LIPS
Assessment of Cognitive Deterioration in People with Learning Disabilities

Interventions
Programme planning
Behavioural modification
Supportive counseling
Staff Support
Systematic desensitisation

Other experience
S.I.G. Training day
People with Learning Disabilities Case Report Summary

The assessment and management of a challenging behaviour in a woman with moderate learning disability.

September 2001

Year 1
All names and other information that could be used to identify the individual described in this report have been amended to ensure anonymity.

Reason for referral
Eve was a 54 year old white woman referred to the psychology service by her community psychiatric nurse for “severe challenging behaviour with unidentifiable triggers every four months”.

History of presenting problem
File review showed that Eve had been in care since the age of four, consistently scoring more than two standard deviations below the mean on measures of IQ and social maturity. Several entries in the file mentioned episodes of hitting and throwing objects as a child, but described calmer behaviour as an adult in institutional care settings. Eve had moved out of full time institutional care to live with her adult family carer almost two year prior to the referral to the psychology department. During this time Eve was reported to have had outbursts of anger every 4-6 weeks with behaviours of throwing things and shouting.

Assessment
File review, psychometric assessment measures and interviews with Eve, Eve’s adult family carer and staff at the day centre Eve attended were conducted. The interview with Eve’s carer suggested that the atmosphere at home was tense as a result of arguments between Eve and the carer’s daughter, who was temporarily staying at her mother’s house. Eve’s carer reported that she had become aware that Eve tended to have outbursts when she was quiet upon returning from the day centre. Staff at the day centre were aware of the difficulties at home as Eve’s carer would at times telephone the centre up to four times a day with complaints about Eve’s behaviour. When Eve was asked about these behaviours and their precipitants Eve reported that she was aware of feeling upset and then mentioned the names of several people who had hurt her feelings. In further interviews with care staff it transpired that these were individuals who were current or previous clients with whom Eve had contact. The HoNOS-LD was completed by the author, in which Eve scored a subjective rating of “severe problem”.
Formulation
The author was aware that Eve presently had a 'problem' label. The formulation sought to understand the difficulties faced as an interaction between Eve's vulnerability factors of resettlement issues and precipitants such as inability to vent her feelings in response to the behaviour of others who had treated her badly, either recently or in the past. Eve's behaviour was reinforced by the attention she received from her carer following outbursts. A formulation of unresolved feelings about previous hurt feelings was arrived at. An action plan was made to offer Eve a chance to discuss her feelings in relation to others who had upset her previously and to offer support and suggest coping strategies to Eve's carer.

Intervention
The author met with Eve for five sessions of approximately thirty minutes each at the day centre. These sessions gave Eve a chance to express her feelings in relation to how hurt she had been when people had hurt her feelings (such as calling her 'stupid' or 'fat'). Eve was encouraged to see a link between these memories and how she responded with outbursts of anger and to talk about her feelings with her carer or day-centre staff when she was upset.

A shorter intervention was implemented with Eve's carer. She was encouraged to begin a practice of spending half an hour with Eve when she returned from the day centre to discuss how her day had been and how she was feeling over a cup of tea. She was also encouraged to view Eve's behaviour as a long-term way of being, that Eve had established as a child and to be realistic about how much change might be expected.

Outcome and Critique
The day centre staff reported a reduction in phone calls from Eve's carer. On the HoNOS-LD Eve had moved from a subjective rating of "severe problem" to a rating of "moderate problems". Eve's carer reported a great improvement in how able she felt to cope with Eve and how the rapport between them had deepened as a result of daily conversations.
Further assessment, such as a functional analysis or an ecological assessment could have yielded more information. These were not conducted due to practical/time constraints.
Child, Adolescent and Family Placement

Placement details

Dates: 10/10/01-22/3/02

Supervisor: Dr. Liz Croft and Dr. Sarah Allcock

NHS Trust: West Kent NHS Trust

Based at: Child and Family Mental Health Team, Homeopathic Hospital, Tunbridge Wells

Client demographics

Children and their families from white English backgrounds between the ages of 3 and 15. Four were girls and six were boys.

Presenting problems/issues worked with

School refusal
Anxiety
ADHD
Challenging Behaviour
Eating Disorder

Settings

Child and Family Mental Health Team Outpatients appointments
Schools
Family Homes

Assessment procedures

Family relations test
Interview with children, family members and teachers
WISC-III
WORD
Strengths and Difficulties Questionnaire
Interventions
Family therapy
CBT
Behavioural modification
Systemic counselling
Play therapy

Other experience
Attended team building day
Child, Adolescent and Family Case Report Summary

The extended assessment of a ten year old boy referred for an assessment of inattentive behaviour at school.

May 2002

Year 2
All names and other information that could be used to identify the individual described in this report have been amended to ensure anonymity.

Reason for referral
Adam was a ten year old white boy referred by his GP on the advice of his head teacher who was concerned he may suffer from ADHD. These concerns had followed observations from a number of teaching staff that Adam had problems staying in his seat and appeared to experience difficulty concentrating in class despite being considered to be an intelligent pupil. Adam's GP stated that his parents did not Adam's behaviour as a problem, but did acknowledge that he fidgeted a great deal at home.

History of presenting problem
Adam's previous school reports described erratic scholastic achievement, with some results very high and others much poorer. Previous teachers had noted his consistently untidy appearance and inability to sit still and observed that, whilst bright, his work was consistently messy and disorganised. Additionally Adam was noted to be popular with his peers and not thought of as defiant or naughty by teachers. Adam's mother stated in interview that she was similar to her son, as she was considered forgetful and disorganised by others. Adam's parents believed that their son's difficulties stemmed from demands the school made upon him that were unrealistic and believed he would improve when he moved on from primary school.

Initial Assessment
The Connors Rating Scales (revised) (Connors, 1996b) was completed by Adam's teacher and by his parents. Adam's teachers rated his inattentive behaviour at 9/10 and his hyperactive-impulsive behaviour at 10/10, indicating caseness for ADHD as described in the DSM-IV. His mother rated him with 6/9 for inattentive behaviour and 3/10 for the hyperactive-impulsive scale.

Formulation
Following this initial assessment several hypotheses were formulated for extended assessment. Hypotheses of ADHD, learning problems, emotional disturbance and poor
social functioning as well as co-morbidity of a number of childhood problems were all explored.

**Intervention – extended assessment**

The strategies for extended assessment were, interviews with Adam, his parents and his teachers, behavioural observation of Adam at school, the WISC-III, the WORD and the Strengths and Difficulties Questionnaire.

Adam's parents reported that Adam had always been an energetic child who was 'always into everything' as a baby. They stated that he had been noted to be lively at reception class and that he engaged in great many after school activities and hobbies with a large amount of energy. In interview Adam stated spontaneously that he had problems in concentration compared with his peers, stating that he tried to listen the same way that everyone else did but was aware that he found this more difficult. Adam's teacher and head teacher both reported that Adam was a bright child who could often answer a question from his general knowledge but was 'losing huge chunks of method'. They reported that he was almost constantly disorganised and messy appearance and was impulsive, shouting out without putting up his hand.

Adam's WISC-III scores showed a large difference between verbal and performance IQ, such as is frequently seen in children with ADHD. He was better on measures of verbal comprehension and expression and longer-term memory than on tests of non-verbal thinking and visual-motor co-ordination. Tests of working memory and timed performance were also poorer. Overall, these results fit with the picture of Adam described by his teachers. Adam's WORD scores were all within the normal range.

On the Strengths and Difficulties Questionnaire Adam was rated above the normal range on the hyperactivity scale by himself, his parents and his teachers. He was within the normal range for other pro-social behaviours and showed no difficulties in interaction with peers.

**Outcome and Critique**

Adam's parents and teachers established an improved rapport, with both sides understanding that there may be elements a ADHD process evident in Adam's behaviour. This led to recommendations of reports being sent to Adam's new school and
more realistic expectations being fostered with regard to his scholastic achievements. The assessment could have been further help by the use of behaioural observatin diaries.
Older People Placement

Placement details
Dates: 27/3/02-20/9/02
Supervisor: Dr. Farzad Shamsavari
NHS Trust: South West London and St. George's NHS Trust
Based at: Tolworth Hospital Surbiton

Client demographics
Clients from white English backgrounds covering an age range from 55 to 86. Six were women and four were men.

Presenting problems/issues worked with
Bereavement
PTSD
Depression
Stroke
Depression/dementia differential diagnosis
Depression
Family/social stress
Challenging behaviour

Settings
In-patient acute and chronic settings
Nursing homes
Clients' homes
Out-patient services
Assessment procedures
Interviews with patients, family members and carers
CAMCOG
WAIS-III
WMS-III
MEAMS
Behavioural Observation
Liason with other professionals

Interventions
Reality orientation
Reminiscence therapy
CBT
Life review
Psycho-dynamic
Behavioural
Systemic counselling

Other experience
Group work with in-patient population
Training day on personality disorders
Older People Case Report Summary

Life review and systemic therapy with a 79 year old woman presenting with depression.

September 2002

Year 2
All names and other information that could be used to identify the individual described in this report have been amended to ensure anonymity.

Reason for referral
Eve was a 79 year old white English woman referred to the psychology department by the CMHT for “a period of supportive counselling to address, in particular, family issues which appear to have contributed to the depressive episode”. Staff at the nursing home where Eve lived had initially become concerned as Eve had lost a great deal of weight.

History of presenting problem
The nursing home manager reported that Eve had seemed depressed since leaving her home, where her husband still lived and moving into the home. This move, three years previously, had been occasioned by a stroke, which had left Eve partially paralysed and unable to walk or care for herself. Eve had been treated once before for depression the previous year with Citalopram.

Assessment
Interviews were conducted with Eve, her husband Adam and members of nursing staff at the home. Eve responded to many enquiries about her internal state by saying “fine” and she and Adam both played down the impact of one of her daughters breaking off contact with her parents. Staff at the nursing home reported that Eve would frequently respond in this way when asked about how she was feeling an was also noted to spend long periods staring out of the window, even when her husband was visiting and also was noted to sleep very little at night in addition to having a poor appetite.

In interview Eve described herself as someone who had always had a lot of energy, and was really the driving force in her family. For many years she had worked from early in the mornings cooking breakfasts for lorry drivers before coming home and getting her children up for school then going to her second job running the kitchens in a hospital. She would cook and clean for the whole family and help the children with their homework. She stated that any problems that occurred were not talked about, but dealt
with in practical ways. This had been the pattern in her family of origin. This was the style adopted when one of her daughters committed suicide in her early thirties.

**Formulation**

It was suggested to Eve that she might benefit from talking about many of the things that had happened in her life in a supportive way. She agreed, although she said that the thought of it made her "feel funny".

**Intervention**

Eve was seen on 12 occasions, with a review session following the first six. In these first six sessions Adam had been present and had become angry when discussion about the past was initiated, such as feelings about the suicide of their daughter. He stated that he believed discussion of such matters was counter-productive and such things were best "left in the past". Eve stated that she had found these discussions helpful and the second set of six sessions was set up for Eve on her own. In these sessions Eve was much more forthcoming and raised topics such as her shortcomings as a mother and her anger and sadness that her daughter Mary was not currently in touch with her. Narrative and life review techniques were employed in this intervention.

**Outcome and Critique**

Eve reported feeling as though several shifts in meaning had occurred during the sessions and she now thought in less critical ways about her mothering skills. She still felt somewhat depressed but felt that things might be as good as they could get in the current circumstances. She reported that she and Adam had begun a practice of more telling each other about how they felt, something hitherto ignored, and this had made their relationship "better than ever".

No psychometric measures were used in this intervention. Their use would have allowed for greater objective measurement of change in relation to therapy.
Specialist Placement

Placement details

Dates: 23/10/02-26/9/03 (one-year placement)
Supervisor: Professor Ian Robbins
NHS Trust: South West London and St. George's
Based at: Traumatic Stress Clinic, St. George's Hospital

Client demographics

Clients from a wide range of ethnic backgrounds, including Iranian, Sri Lankan, white English, back English, Iraqi, Kosovan and Afghani. There was one woman and nine men ranging in age from 20 to 68.

Presenting problems/issues worked with

PTSD
Refugee issues (housing, benefits, asylum applications)
Depression
Anxiety
Agoraphobia

Settings

Out-patient appointments
Local Refugee agency

Assessment procedures

SCID
BDI
BAI
IES-R
Interviews with clients and family members

Interventions
CBT

Other experience

Running a group for refugees at local refugee agency
Working therapeutically through an interpreter
Co-facilitated de-briefing sessions at local hospital for staff on an in-patient unit following the murder of a colleague at work
Specialist Placement Case Report Summary
(Traumatic Stress Service)

The cognitive-behavioural treatment of a 43 year old Iranian man suffering from Post-traumatic Stress Disorder.

April 2003

Year 3
All names and other information that could be used to identify the individual described in this report have been amended to ensure anonymity.

Reason for referral
Adam was a 43 year old Iranian man referred by the CMHT for treatment of PTSD related to his experiences in the Iranian army. He was being treated for depression with fluoxetine at the time of referral.

History of presenting problem
Adam reported experiencing involuntary memories that were distressing to him 3-4 times per day regarding war trauma when serving during the Iran-Iraq war. He also experienced nightmares 3-4 times per week with a similar content. War films, news about Iran and scenes of people arguing all served a triggers for these experiences. Additionally Adam found that he was excessively startled when he heard loud bangs. He had experienced these symptoms for 15 years and had been treated with a weeks stay in hospital with unknown drugs when still in Iran. He had come to the UK fleeing persecution in Iran and was referred to the community team by his GP.

Assessment
An interview assessment was conducted in the presence of an interpreter. From this is appeared that Adam fulfilled the criteria for PTSD and was psychologically minded and an appropriate candidate for psychological therapy. He described not being able to remember many aspects of his childhood but that his father was a strict, career military man. He had a large family who all still live in Iran. He had not married or had a long-term relationship. He had no forensic history and had no other psychiatric history. He had left school at the age of 16 to go into the army and was selected to join the elite parachute regiment. He had a long period of service in the Iran-Iraq war, during which time he frequently saw friends being killed, was wounded twice and attempted a coup with colleagues in the army. Adam had a number of thoughts relate to these experiences regarding a belief that he should be able to cope without needing any help and cognitions of guilt regarding many of his actions during wartime. He had been granted permanent leave to remain in the UK. Adam had responded to these symptoms with
safety behaviours of cleaning his house repeatedly and avoiding any stimuli associated with Iran or with his past. This included avoiding other Iranians he met who wanted to be friends with him.

The Structured Clinical Interview for DSM-IV classification (SCID-IV) was administered. This measure does not have established norms for diverse cultural backgrounds, however, Adam's scores placed him well within the clinical range for PTSD.

**Formulation**

Adam met the criteria for PTSD and it was thought that this clearly described his present problems. These symptoms were seen as being maintained by his safety behaviours of cleaning his house and avoiding stimuli associated with Iran and his past.

**Intervention**

Following Ehlers and Clark (2000) a combination of imaginal reliving and dropping of avoidance and safety behaviours along with encouragement to re-connect with daily life and sense of future was employed. Imaginal reliving was completed with Adam closing his eyes and recounting the details of the events that traumatised him in the present tense. Exposure of this type helped reduce the frequency, intensity and duration of symptoms of anxiety experienced by Adam. The thought suppression experiment was also suggested to Adam as a homework assignment. Cognitive 'hot-spots' related to guilt were particularly salient for Adam and were tackled with cognitive therapy techniques.

**Outcome and Critique**

Adam rated himself as having improved by about 70% after involvement in treatment. His SUDs in relation to anxiety symptoms moved from 10/10 to 4/10 in the first few weeks. Adam had begun attending college to learn English and had enrolled to train as a mechanic and had reduced his safety behaviours. He had also begun to read Iranian newspapers and made contact with some Iranian family friends whom he knew lived locally to him.
No outcome measures were administered, as there were no norms for culturally diverse groups. As such it is not possible to offer an objective assessment of how Adam's symptoms had changed.
Research Section

This section contains a Log of Research Experience and three research projects. First, is the Service Related Research Project (SRRP) carried out in Year One. The second, is the Qualitative Research project (QRP) carried out in Year Two. The third, is the Major Research Project (MRP) carried out in Years Two and Three.
Service Related Research Project

A study of attendance and ethnicity in a primary care psychotherapy service.

July 2001

Year 1
Abstract

Background
This paper examines factors that might influence attendance rates of black and white clients referred to a primary care psychotherapy team in an inner-city area.

Method
Data about the clients and therapists were collected from the service and statistically analysed using the Chi-square statistic.

Results
The results indicated that there was no significant effect for ethnicity of the client, ethnicity of the therapist, gender of the client, gender of the therapist, model of therapy used in treatment, use of psychotropic medication or social variables on treatment attendance.

Conclusion
Current practices in primary care in the service described do not appear to deter people from ethnic minorities from attending treatment. It is important to conduct more research, including randomised controlled trials and qualitative, reflective studies to more fully understand the issues in psychotherapy with clients from ethnic minorities.
Introduction

White and black clients have been shown to be effectively treated with psychotherapy with no significant differences in rates of drop out in large samples in the USA (Brown, Schulberg, Sacco, Perel and Houck, 1999). Very few studies have gone beyond simple questions of whether or not referrals from ethnic minorities drop-out to look at what aspects of current working practices might affect drop-out rates. This study examines variables in a primary care psychotherapy clinic to see if drop-out is related to aspects of service provision, including the ethnicity of the therapist.

Treatment drop-out

Client non-attendance at psychology out-patient service appointments has been estimated at between 10 and 50 percent (Henry, Ball and Williams, 1998) with several studies suggesting that the average is somewhere in the middle of this range (Shalan and Palmer, 1998; Fox and Skinner, 1997). Non-attendance is not always well defined in studies, but broadly refers to both non-attendance for initial assessment and/or treatment drop-out. Several researchers have tried to tackle this problem of non-attendance. These studies have varied in approach. Some have looked at client variables, such as unemployment and socio-economic status (Trepka, 1986). Others have looked at more psychological reasons for non-attendance such as motivation (Hughes, 1995). More research has focused on strategies to encourage attendance such as pre-assessment information leaflets sent to potential clients (Webster, 1992), time-limited therapies (Sledge, Moras, Hartley, and Levine, 1990). and pre-appointment questionnaires (Henry, Ball and Williams, 1998). A consultancy model, whereby clinical psychologists assist other professionals to solve problems and plan interventions, has also been documented as an approach to reducing non-attendance (Shalan and Palmer, 1998).

Several studies have also included ethnicity as a variable in their analysis of what contributes to client drop-out. Largely, these have all concluded that it has no significant effect (Hershorn, 1993; Henry, Ball and Williams, 1998; Loumidis and Shropshire, 1997;). One exception here is Deane (1991) who found that referrals from the Maori
community in New Zealand were less likely to attend consistently for appointments. Factors more consistently shown to be associated with treatment attrition are younger age, socially disadvantaged background and “chaotic lifestyle” (Henry, Ball and Williams, 1998; Neeleman and Mikhail, 1997; Loumidis and Shropshire, 1997). Indeed, Henry, Ball and Williams (1998) suggest that for client non-attendance: “The picture generally is one of younger, economically and socially more disadvantaged clients”.

This definition is thought provoking as it might describe the circumstances of many black people referred for out-patient psychological treatment in inner city areas (Brown, Schulberg, Sacco, Perel and Houck, 1999). This study is interested in following Hambridge’s (1990) suggestion, that each population of clients will differ in terms of characteristics for non-attendance and that studies on very specific groups of clients may be required. Specifically under investigation here is the interaction between ethnicity and variables of service provision, something absent from earlier work in this area.

The issue of ethnicity

The issue of the efficacy of psychotherapy to help black people is controversial (Sue, 1988). Much of the published work challenging current working practices covers theoretical issues of institutionalised racism (Fernando, 1991) and comments on how many psychotherapies are Eurocentric in orientation and may not be applicable to working with the world view of black clients (Lloyd and Bhugra, 1993). It has also been noted by several authors that clients from the black community who enter the mental health system are less likely to receive psychological treatment (Lloyd and Bhugra, 1993). Bhugra (1997) points to the over-representation of black people in prisons, psychiatric hospitals and special hospitals as evidence of the need to properly understand the needs of this group of people in order to provide adequate care in the community. Coleman, Brown, Acton, Harris and Saltmore (1998) have also noted that psychology services use individual rather than community based interventions and have a lack of resources with which to liaise with local ethnic minorities agencies. It is argued that this results in services that are not seen as being intended for use by black people within local communities.
Aim of this study: What makes it different?

Gill Aitken (1998) notes the lack of reporting on the process of clinical psychology service provision in relation to race issues. No study has looked at the dynamics and structure of a service as a possible factor in ethnic minority non-attendance. This study aims to offer a description of the uptake to a service by people from ethnic minorities, and to look at factors that might contribute to attrition rates among this group within the structure of a primary care psychotherapy and counselling service. The variables specifically under investigation in this study are: Ethnicity of therapist; gender of therapist; model of therapy; use of psychotropic medication and social variables (e.g. marital status, employment).

Why is this relevant to the practice of clinical psychology?

Working in Primary Care settings has grown in prominence for clinical psychologists with benefits identified such as reducing the stigma of mental health and opportunities for early intervention. It also promotes a psychological rather than medical model, allowing clients to develop coping strategies that extend beyond therapy. Additionally, there are service related benefits such as reducing pressures on over-stretched General Practitioners (GPs) (Brunning and Burd, 1993). Education, training and working within teams to share knowledge are also recognised as important roles for the clinical psychologist in primary care, particularly as GPs have been noted to fail to recognise ethnic diversity in considering mental health problems (Odell, Surtees, Wainwright, Commander, Sashidharan, 1997). Despite this, referrals to clinical psychology services are increasingly more representative of the ethnic diversity in some areas (Coleman, Brown, Acton, Harris and Saltmore, 1998). In order to respond reflexively and fulfil its role in the primary care setting, clinical psychology needs to understand the difficulties people from ethnic minorities may be experiencing in accessing services and communicating effectively in psychotherapy.
Initial Research Hypotheses

This study examined attendance rates of clients from different ethnic backgrounds in a primary care psychotherapy service. The research hypotheses were:

1. Clients referred from ethnic minorities are more likely to drop out of treatment
2. Clients referred from ethnic minorities are less likely to drop out of treatment if they are being treated by a therapist of a similar ethnic background
3. The relationship between ethnicity and attendance may be related to gender of therapist
4. The relationship between ethnicity and attendance may be related to gender of client
5. The relationship between ethnicity and attendance may be influenced by model of therapy used (CBT, Psychodynamic counselling)
6. The relationship between ethnicity and attendance may be influenced by use of psychotropic medication
7. The relationship between ethnicity and attendance may be influenced by social variables (e.g.: marital status, occupation)

Method

Setting

The service comprises a team of Psychologists and Psychotherapists taking referrals for psychological therapy from GPs in an inner city area. The team offer treatment to people with emotional problems that they believe might benefit from psychological therapy. The team comprised three male and three female therapists. One member was a cognitive-behavioural psychotherapist, one clinical psychologist, two counselling psychologists and one psychotherapist. The cognitive-behavioural psychotherapist was the only member of the team who exclusively practised CBT, other members of the team worked psychodynamically. The clinical psychologist was largely psychodynamic in orientation.
Currently all members of the team are white. The cognitive behavioural psychotherapist had been in post for one year and had replaced a black cognitive behavioural psychotherapist who had been with the team from the start. Both were women.

Design
The results of this study are based on archive research. Demographic information from people referred to the service is routinely entered onto a database for audit purposes. The data used in this research comprises 1,161 people referred in the first three years of the service. This information was coded by the author and entered onto a SPSS database for statistical analysis. Additional information about the ethnicity of clients was sought from files held at the clinic.

Procedures
Information on ethnicity of clients and attendance at appointments recorded from files held at the service was statistically analysed. Census data were obtained in order to judge the number of clients accepted into treatment proportional to the numbers in the catchment area.

Statistical procedures
The data from the files represented frequencies (counts) of demographic information. As such the chi square statistical test of significance was used. The large numbers involved in each analysis helped reduce the chance of type II error.

Participants
1,161 primary care clients who had been offered an appointment following a letter from their GP or by self-referral in response to advertising in local GP surgeries.

Classification of participants for research
Black clients referred to the service were categorised as either black African, black Caribbean, black British or black other. White clients were categorised as white British, white Irish, white European, white non-European or white other. For the purposes of this study, “white” refers to white British and white Irish people living in the area. Black refers
to categories of black African, black Caribbean and black British. This was done so as to have groups for comparison that were similar both in colour and size.

Results

Missing data
Some missing data were discovered. A proportion of this was due to those who did not respond to an invitation to come for assessment and those who did not attend their assessment when an appointment had been made. In such situations it was not possible to establish an individual’s ethnicity unless it had been indicated by the referrer. There were some additional missing data from individuals who had not yet come to the end of treatment who might have dropped-out. Data were entered onto the database when the client was discharged and therefore information on the database was incomplete in some instances. Future research might want to exclude these individuals from analyses.

White and black referrals
The projected census data for 2001 show this area as having 165,419 (68.2%) white and 56,910 (23.4%) black people (Office for National Statistics, 2000). In the research group 486 (40.8%) were white and 135 (11.3%) were black. This is obviously an under representation of both groups, and may be accounted for by two reasons. Firstly, there is a proportion of missing data on the database. Secondly, there were a number of refugees from different cultural backgrounds in Eastern Europe, small when taken individually, but large in combined numbers, who were being referred to the service.

Importantly, the numbers of black and white referrals are roughly proportional to the numbers in the community. This suggests that the service is receiving a similar number of referrals from the black community proportional to the white community.

Attendance
A breakdown of attendance rates is given in table one.
Table One: A breakdown of attendance rates to the service during its first three years

<table>
<thead>
<tr>
<th>Final outcome</th>
<th>White</th>
<th>Black</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriate referral</td>
<td>5 (1.1%)</td>
<td>3 (2%)</td>
<td>16 (1.4%)</td>
</tr>
<tr>
<td>No response to invitation to opt in</td>
<td>53 (11.3%)</td>
<td>17 (11.6%)</td>
<td>199 (17.1%)</td>
</tr>
<tr>
<td>Negative response to invitation to opt in</td>
<td>40 (0.9%)</td>
<td>0 (0%)</td>
<td>8 (0.7%)</td>
</tr>
<tr>
<td>Non-attendance at assessment</td>
<td>55 (11.8%)</td>
<td>16 (10.9%)</td>
<td>176 (15.2%)</td>
</tr>
<tr>
<td>Attended assessment only - agreed</td>
<td>46 (9.8%)</td>
<td>14 (9.5%)</td>
<td>90 (7.8%)</td>
</tr>
<tr>
<td>Attended assessment only - then dropped-out</td>
<td>51 (10.9%)</td>
<td>20 (13.6%)</td>
<td>104 (9%)</td>
</tr>
<tr>
<td>Treatment begun - dropped-out</td>
<td>66 (12.8%)</td>
<td>26 (17.7%)</td>
<td>103 (8.9%)</td>
</tr>
<tr>
<td>Treatment completed</td>
<td>139 (11.7%)</td>
<td>34 (23.1%)</td>
<td>210 (18.1%)</td>
</tr>
</tbody>
</table>

n=1,161, total missing data=283 (23.8%)

Research hypotheses

Table two shows the analysis and results of initial research hypotheses
Table two: Analysis and results of initial research hypotheses

<table>
<thead>
<tr>
<th>Initial research hypothesis</th>
<th>Analysis</th>
<th>Result (Chi-square)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clients from ethnic minorities are more likely to drop out of treatment</td>
<td>Drop-out at assessment (after opting in to service) compared with ethnicity</td>
<td>Non-significant ($\chi^2 = 0.149$, df=1, $p = 0.698$)</td>
</tr>
<tr>
<td></td>
<td>Drop-out at first treatment session (after attendance at assessment) compared with ethnicity</td>
<td>Non-significant ($\chi^2 = 0.526$, df=1, $p = 0.468$)</td>
</tr>
<tr>
<td></td>
<td>Drop-out during treatment compared with ethnicity</td>
<td>Non-significant ($\chi^2 = 3.304$, df=1, $p = 0.690$)</td>
</tr>
<tr>
<td>2. Client drop-out will be affected by ethnicity of therapist</td>
<td>Therapist ethnicity compared with treatment drop-out</td>
<td>Non-significant ($\chi^2 = 2.568$, df=1, $p = 0.108$)</td>
</tr>
<tr>
<td>3. Client drop-out will be related to gender of therapist</td>
<td>Therapist gender compared with treatment drop-out</td>
<td>Non-significant ($\chi^2 = 0.009$, df=1, $p = 0.920$)</td>
</tr>
<tr>
<td>4. Client drop-out will be related to gender of client</td>
<td>Gender of client compared with treatment drop-out</td>
<td>Non-significant ($\chi^2 = 0.847$, df=1, $p = 0.357$)</td>
</tr>
<tr>
<td>5. Client drop-out will be related to model of therapy used</td>
<td>Model of therapy used compared with treatment drop-out</td>
<td>Non-significant ($\chi^2 = 0.162$, df=1, $p = 0.686$)</td>
</tr>
<tr>
<td>6. Client drop-out will be related to use of psychotropic medication</td>
<td>Use of psychotropic medication compared with treatment drop-out</td>
<td>Non-significant ($\chi^2 = 1.818$, df=1, $p = 0.177$)</td>
</tr>
<tr>
<td>7. Client drop-out will be influenced by social variables</td>
<td>Living situation (with parents, with partner, alone etc.) compared with treatment drop-out</td>
<td>Non-significant ($\chi^2 = 6.008$, df=6, $p = 0.422$)</td>
</tr>
<tr>
<td></td>
<td>Employment status compared with treatment drop-out</td>
<td>Non-significant ($\chi^2 = 3.560$, df=1, $p = 0.591$)</td>
</tr>
</tbody>
</table>
Treatment drop-out referred to any client who had begun treatment and dropped out at any stage of therapy. Chi square analysis of this data showed no significant difference between white and black clients. Similarly, drop-out at the assessment stage (once a client had responded to a letter, indicating that they would like to opt-in to the service) showed no significant differences between white and black clients. Similarly again, clients who had opted-in, attended assessment and then not attended any appointments for therapy did not differ significantly by ethnicity. There was no significant difference observed in treatment drop-out when considering the gender of the therapist (there were three therapists of each gender), therapist ethnicity (the black cognitive-behavioural therapist was compared with her white replacement who was also a woman) or gender of client. Use of psychotropic medication was found to be non-significant in treatment drop-out, although an effect may be masked here as this category contained both anti-depressants and anti-psychotics. When comparing those who completed or dropped out of treatment by who they lived with (single, with partner, with parents etc.) no significant difference was found. There was no significant difference observed when cognitive-behavioural and psychodynamic models of therapy were compared (the white cognitive-behavioural therapist was compared with a psychodynamic therapist who had seen a similar number of clients). The only result that approached significance was an analysis of the clients employment status, which might correspond to the findings of other researchers that clients with more stable life situations are less likely to drop-out of treatment. Given the large numbers involved in this analysis, however, statistical power was not compromised and the non-significant finding should be thought of as robust.

**Additional research questions**

Some additional research questions were raised by the results detailed above as to whether there may be a selection bias in accepting referrals, or in offering treatment following assessment. The hypotheses were:

1. The service is only accepting referrals for clients who are more likely to attend, i.e.: clients with less chaotic lives
2. The service is rejecting after assessment clients who are more likely to drop-out of therapy, i.e.: clients with more chaotic lives
Chi square showed no significant difference in ethnicity between those who were considered appropriate and inappropriate referrals ($\chi^2=0.927$, df=1, $p=0.335$). Likewise, there was no significant difference between clients who had only an assessment and were not offered therapy and those who were offered it ($\chi^2=0.0157$, df=1, $p=0.900$).

**Discussion**

None of the research hypotheses were supported by the observed results. The results showed no significant differences in treatment drop-out and non-attendance to assessments on any of the variables examined.

These results raise a number of issues that warrant discussion

**GP referral patterns**

The referral patterns of GPs warrants further scrutiny. In the present sample there was a large number of practices referring to the clinic, meaning that comparatively few referrals came from each practice. This made any analysis of referral patterns in the present data difficult. Given that proportionally similar numbers from both black and white ethnic groups were referred overall to the clinic, it seems likely that the referral patterns of GPs reflected the ethnic mix in their catchment areas across the borough. Further research could usefully examine the referral patterns of GPs to establish if the referrals made were representative of the local population.

**Black cultural diversity**

Diversity within black culture was not addressed in this study. In order to achieve greater similarity in numbers for statistical analyses, black Caribbeans, black Africans and black British people were all considered as one in the category of “black”. As the issue was one of sensitivity to ethnic differences, thought to manifest in treatment drop-out or otherwise not opting in to the service, it was felt that all three of these groups were equally likely to experience such difficulties.
Is the opt-in procedure discriminatory?
It is possible that operating an opt-in system discriminates against those who feel less confident in dealing with professional agencies, or are anxious about going for help with a ‘mental problem’. As many ‘non-engages’ in treatment are thought to have more chaotic backgrounds (Henry, Ball and Williams, 1998) it may be that they move from different addresses and so may not have received the letter inviting them to opt in, or may not have easy access to a telephone.

Why is the Clinic so successful?
The Clinic appears to engage and maintain in treatment a number of black people proportionally similar to the number in the catchment area. The clinic also has drop-out rates of 25%, similar overall to the average rates for out-patient clinical psychology services in the UK (Shalan and Palmer, 1998; Fox and Skinner, 1997). The clinic’s success may in part be due to the fact that it had strict criteria given to referrers about who would be considered an appropriate referral. The team leader had also made efforts to develop good relationships with referrers so that they were properly aware of the criteria that had to be satisfied in order to make a referral. Venue is thought to be associated with drop-out (Loumidis and Shropshire, 1997). The clinic may have benefited from not being part of another agency, but a building dedicated to the provision of psychotherapy services.

Other (Confounding) variables
It is possible that diagnosis may have an effect on attendance rates. Diagnosis was not considered as a variable in the present study as data were available in too few cases. Many clients were referred to the service by their GP without a formal diagnosis and it was the practice of the service to assess suitability for treatment rather than diagnose.

Future research recommendations
Strong conclusions are noted to be lacking in the area of treatment efficacy for different cultures and ethnicity (Sue, 1988; Brown, Schulberg, Sacco, Perel and Houck, 1999). A
randomised controlled trial and use of a regression model for statistical analysis might lead to a clearer predictive model of treatment drop-out.

Future research could also examine matched ethnic pairings of therapist and client to see if any differences exist in drop-out rates between black clients treated by a black therapist and white clients treated by a white therapist.

Future research could also usefully tackle the issue of cultural awareness and its impact on psychotherapeutic efficacy.

Patel (1998) makes the point that black therapists might be perceived negatively by white clients due to the image they have in the media. Future research could usefully examine the attitudes of white clients to black therapists as well.

**Feedback of results to service**

The results of the report have been sent to the service team leader. A feedback session involving the whole team has been scheduled for later in the year.

**Conclusion**

The National Service Framework (NHS, 2000) suggests that there are to be increasing numbers of clients treated in the community. Research has shown the benefits of primary care psychotherapy over routine GP consultations with benefits such as reduced admission rates and easier tracking of clients mentioned (Gask, Sibbald and Creed, 1997). The issue of how to set up and run a culturally sensitive primary care mental health service should be addressed by all.

Sue (1988) states that posing questions comparative attendance rates for black and white patients is over-simplistic. Bartlett (2000) notes that ethnic categories are social categories rather than biological givens. In an increasingly polyglot society, all healthcare professionals have a responsibility to re-assess their own social constructions of ethnic difference and increase their level of cultural awareness.
References


Qualitative Research Project

What influence do religious or spiritual trainee clinical or counselling psychologists perceive their religious or spiritual beliefs have on their training, with particular reference to choice of model.

June 2002

Year 2
Acknowledgements

I would like to thank the research participants, with out whose willingness to engage in discussions of a personal nature, this research would not have been possible.

I would like to thank my colleagues in the research group for all their efforts.

I would like to thank Adrian Coyle, the research supervisor for his support and guidance.
Abstract

Interpretative Phenomenological Analysis (IPA) was used to explore the influence that religious or spiritual trainee counseling and clinical psychologist's beliefs have on their experience of the training process, particularly their choice of therapeutic model. Six participants were interviewed and the transcriptions were analysed by a group of researchers. Themes resulting from the analysis are given and a discussion around the nature of the relationship between psychology as a scientific method and faith-based beliefs is undertaken.
Introduction

Myers and Baker (1998) discuss the professional neglect of the issue of religiosity among professional psychologists. They comment that it is not until recently (1992) that the American Psychological Association expanded its Code of Ethics to cover religious belief as well as age, gender, disability, ethnicity and sexual orientation. This despite the findings of a Gallup poll suggesting that 93% of the American population describe themselves as religious with two-thirds stating that it was a “very important factor in their lives and one-third saying that it was the most important factor. (Gallup 1994, cited in Shafranske, 1996).

Smiley (2001) suggests that although the current culture of clinical psychology “assumes that most clinical practice is ‘value-neutral’”, therapists beliefs and attitudes affect therapy in a number of different and largely unavoidable ways (Parrott, 1999). Traditionally psychology as a scientific discipline and religion as a faith-based understanding of events have been thought of as incompatible (Myers and Baker, 1998). Whilst in a strict sense this may be true, Smiley raises the objection that such a situation may be unworkable as religious or spiritual beliefs or values may be of great importance to both some practitioners and many clients of psychological services. A common understanding on the realities of the situation is needed.

Myers and Baker (1998) found in their interviews with 12 British religious or spiritual clinical psychologists that they often perceived colleagues to have derogatory attitudes towards their beliefs and that they were forced to cope with this internally. Several participants did this by “keeping separate their two hats”, others found a way to integrate their dual belief modalities into a personal viewpoint that encompassed necessary features of both understandings of the world. Myers and Baker (1998) argue that the latter way of managing the conflict was more positive as it would be unrealistic to maintain two different understanding of the phenomena of life.

Interestingly, Zinnbauer and Pargament (2000) suggest that the religious or spiritual belief of individual psychologist can influence the model of therapy in which they chose to work. Bilgrave and Deluty (1998) found that 72% of 237 American Psychologists given
a 65 item purpose made (and therefore non-standardised) self-report measure, stated that they felt that their religious beliefs influenced their practice of psychotherapy. They further found that respondents who identified themselves as Christians tended towards a cognitive-behavioural orientation, those with eastern and mystical spiritual beliefs tended towards humanistic psychotherapy and those who were Jewish, atheist or agnostic tended to lean towards psychodynamic models.

Myers and Baker (1998) make a further point, suggesting that the culture of mainstream psychological theories, which emphasises a materialistic worldview at the expense of spiritual or religious issues, is filtering down into training, resulting in a an important professional issue in training being neglected.

The issue of different religious and spiritual beliefs influencing choice of model and the impact of potentially ignoring religious or other metaphysical beliefs in the training process are provocative issues. The present study approaches the issues of tension between belief and psychology and choice of model among trainees from a qualitative research perspective, in the hope that a fuller understanding of how religious or spiritual beliefs affects trainees understanding of themselves, their chosen discipline and their choice of therapeutic model.

Method

Participants
Trainee clinical and counseling psychologists were recruited by the six researchers using personal contacts. Before taping began, participants were informed that their interviews would be recorded and transcribed and submitted with the assignment but that they would be anonymised (see appendix one for this author's transcript). They were also told they could withdraw from the study at any time. There was a de-briefing session at the end of the interview with the tape switched off in order to ensure the participant was not left with any negative emotions regarding the interview. The definition used by the researchers in this study focused on whether the participant described themselves as believing in religious or spiritual ideas rather than being agnostic or atheist in outlook. Questions about religious or spiritual practice were not asked.
Interview schedule (appendix two)
Willig (2001) suggests that when asking questions for analysis with IPA a semi-structured interview schedule with open-ended, non-directive questions supplemented by prompts, allows the participant to share openly personal views regarding the research question. The research schedule was designed by the group with these factors in mind.

Procedures
Two pilot interviews were conducted by two members of the research group in order to assess the quality of data generated by the research schedule. This was found to be the case and the remaining group members conducted interviews based on the same research schedule. Each interview lasted approximately 20 minutes and was tape-recorded and transcribed. All six interviews were then analysed in group sessions by all six researchers.

Analytic strategy
IPA explicitly acknowledges the role of the researchers own beliefs in the analytic process (Willig, 2001), and focuses on the analyst drawing personal meanings from the accounts given (Coyle and Rafalin, 2000). Transcripts were read several times in the group with unfocussed notes relating to themes generated. Connecting themes within a transcript were then identified, followed by identification of similar themes in other transcripts. Themes from across the transcripts were then organised into natural clusters of similar meaning or content by the group and labeled. Finally a summary table of themes with reference to the texts was decided by the group. Constant reference to the transcripts ensured that the themes being generated related to the evidence available in the responses from participants.

Themes were identified in part because of their prevalence in the transcripts but also identified according to the amount of emotional significance afforded to certain statements. This was often judged by the presence of pauses where the participant was thinking, or from occasions where a lot of paralanguage was present, indicating that the
Comment on evaluation of research efficacy
IPA’s idiographic approach does not fit with the kind of quality control criteria for research that would be appropriate for quantitative research methods (Willig, 2001). Rather, qualitative research needs to be judged as credible according to how well it is grounded in the examples provided in the data (transcripts) and the degree of transferability the conclusions have (Willig, 2001). Chenwitz and Swanson (1986, cited in Golsworthy and Coyle, 1999) refer to criteria of evaluating qualitative research as having elements of “evidence” and “credibility” which are akin to the qualitative criteria of validity and reliability and note that many of criteria used for both qualitative and quantitative research methods pursue similar aims.

Researchers in the group used discussion of the transcripts as a way of ensuring that emerging themes were supported by the data. The presence of six researchers meant that hopefully, given the possibility of shared beliefs among the researchers, that what is described in the findings is a representation of the participants phenomenology and not those of any individual researcher.

Analysis

Background information
Six female participants (mean age 35, range 24-51; SD10.35) who were engaged in doctoral level training to become counseling or clinical psychologists in the UK were interviewed. They were in either the first, second or third years of training. Three were married, two engage and one single. Two identified themselves as British, one German, One half-German and half-Egyptian and one American. Three identified themselves as Christians, one as Jewish, one as Muslim and one as adhering to eastern religions.
Findings

Analysis of the data by the research group identified eleven themes within three clusters (see table one). References are made with page and line numbers.

Table one: Clusters, themes and reference to evidence form the transcripts

### Cluster I: Nature of Relationship Between Beliefs and Psychology

<table>
<thead>
<tr>
<th>Themes:</th>
<th>Participant 1</th>
<th>Participant 2</th>
<th>Participant 3</th>
<th>Participant 4</th>
<th>Participant 5</th>
<th>Participant 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compatibility</td>
<td>8.8-13</td>
<td>5.1-2</td>
<td>7.27-28</td>
<td>2.5-8</td>
<td>3.22-25</td>
<td>6.17-19</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5.14-17</td>
<td>9.17-19</td>
<td>3.16-22</td>
<td>4.6-9</td>
<td>7.9-13</td>
</tr>
<tr>
<td>Conflict</td>
<td>5.3-11</td>
<td>7.1-10</td>
<td>4.1-6</td>
<td>3.23-24</td>
<td>5.4-6</td>
<td>6.15-18</td>
</tr>
<tr>
<td></td>
<td>10.8-10</td>
<td></td>
<td>4.9-12</td>
<td>6.15-18</td>
<td>8.20-28</td>
<td></td>
</tr>
<tr>
<td>Integration of Beliefs into Self</td>
<td>7.1-3</td>
<td>3.9-10</td>
<td>3.18-19</td>
<td>2.5-8</td>
<td>7.27-28</td>
<td>6.17-19</td>
</tr>
<tr>
<td></td>
<td>7.14-15</td>
<td></td>
<td>4.9-10</td>
<td>9.16-18</td>
<td>10.8-9</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6.36-37</td>
<td>5.24-25</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>10.14-17</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Cluster II: Impact of Beliefs on Therapy

<table>
<thead>
<tr>
<th>Themes:</th>
<th>Participant 1</th>
<th>Participant 2</th>
<th>Participant 3</th>
<th>Participant 4</th>
<th>Participant 5</th>
<th>Participant 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Search for Meaning</td>
<td>4.17-18</td>
<td>3.15-16</td>
<td>6.7-10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7.9-12</td>
<td>8.21-22</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power</td>
<td></td>
<td>7.16-18</td>
<td></td>
<td>8.4-8</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>8.7-11</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>9.6-9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shared Journey / Mutuality</td>
<td>4.20</td>
<td>5.13</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.1</td>
<td>5.22-23</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8.17-21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empathy / Understanding / Acceptance</td>
<td>7.9-12</td>
<td>7.14-15</td>
<td>9.16-18</td>
<td></td>
<td>4.6-9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7.14-15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9.12-13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10.4-5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conceptualisation of Client / Model</td>
<td>5.1-9</td>
<td>5.14-18</td>
<td>4.1-6</td>
<td></td>
<td>5.2-7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.5-14</td>
<td></td>
<td></td>
<td></td>
<td>6.25</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5.2-7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6.25</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Cluster III: Perceived Image

<table>
<thead>
<tr>
<th>Themes</th>
<th>Participant 1</th>
<th>Participant 2</th>
<th>Participant 3</th>
<th>Participant 4</th>
<th>Participant 5</th>
<th>Participant 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure</td>
<td>4.4-5</td>
<td></td>
<td>6.1-3</td>
<td>6.6-8</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>8.1-6</td>
<td>9.8</td>
<td>4.9-12</td>
<td>4.18-23</td>
<td>5.19-20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9.30-31</td>
<td></td>
<td>4.25-27</td>
<td>5.22-25</td>
<td></td>
</tr>
<tr>
<td>Defensiveness</td>
<td>6.1-3</td>
<td>4.9-12</td>
<td>5.22-25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fear of Criticism</td>
<td>3.3-5</td>
<td></td>
<td>6.1-3</td>
<td></td>
<td></td>
<td>5.22-25</td>
</tr>
</tbody>
</table>

Due to the constraints of this project's word limit, only one cluster will be focused on in depth here, that of the nature of relationship between beliefs and psychology. This is because it is a theme that covers several of the interesting findings from the previous research. The issue of compatibility is mentioned by Myers and Baker (1998) as being the most useful way to cope with the different demands of a faith-based belief and a scientific-method discipline. Researchers were interesting to see how trainee's comment on the compatibility of these two positions in their own phenomenology as they are in the process of training and may be confronted by many ideas that test their faith. The choice of model mentioned by Bilgrave and Deluty (1998) is another major component of this research and comes with in the first cluster, as trainees may chose a model which more neatly fits with their beliefs as a way of making their religious or spiritual beliefs and their professional training compatible.

The other themes in the table will be discussed in brief first here.

Impact of beliefs on therapy

There were a number of issues represented in the themes in this cluster that were important to the participants: search for meaning, power, shared journey/mutuality, empathy and conceptualisation of client. Many of the comments in this cluster centred on the belief that there was meaning in life beyond the physical and that clients and therapists were on a shared journey and that there was a mutual or reciprocal gain to be
made by both parties when religious or spiritual issues were present. The notion of compatibility is also in evidence when discussing conceptualisations of clients and models:

Participant 4: "I don't feel that my religion of culture influences my conception of any clients at all, I am fully able to detach myself from my own beliefs, values et cetera for the sake of my clinical work but I am able to draw on these to help me understand things from the perspective of my clients who are themselves religious, I mean, people who believe in life after death or seek alternative explanations such as spiritual explanations for their illness or difficult life circumstances." (page 4, lines 1-6)

This statement illustrates Myers and Baker's (1998) findings that therapists sometimes "keep separate their two hats" and the desire to integrate religious beliefs into the therapeutic process in a way that is seen as compatible.

Perceived image

Similarly to Myers and Baker's (1998) findings, many of the participants felt that their beliefs would be perceived negatively by their peers:

Participant 2: "I think it's hard to talk about this stuff because you don't know how people are going to view it and I'm very aware of the fact that people can have quite strong views about religion." (page 6, lines 1-3)

Such perceived attitudes gave rise to a number of themes with negative emotions associated with them: exposure, defensiveness and fear of criticism.

Nature of relationship between beliefs and psychology

The themes of compatibility, conflict and integration of beliefs into self received a higher number of references from all the researchers in the group across participant data sets that either of the other clusters of themes. The salience of this issue was therefore obvious. Data points to areas of both conflict and compatibility within this cluster, suggesting again that Myers and Baker's (1998) findings of religious psychologists
wearing "two hats" and also striving to integrate their beliefs and training. Examples of conflict, compatibility and integration into self will be offered here.

Participant four gives a clear representation of the conflict faced by religious psychologists:

"I feel that there are many aspects of my religion that I identify with that area at odds with many aspects of psychological theory, such as life after death and belief in God. I mean, obviously, psychology is a very scientific, working from an evidence-based stance and these are certainly not things that can be proven." (page 4, lines 9-12)

Many participants saw their belief as being compatible and indeed complimentary to their therapeutic work.

Participant 5: "[I have] come across similarities and I have found that it helps. Ehm, and if we're talking about, I don't know, person-centred, Islam does teach, ehm, to find the goodness in other people and to be good to other people and to empathise with other people, so you've got all the core conditions within Islam as well." (page 4, lines 6-9)

All the participants offered some understanding of their phenomenology that involved an integration of their religious or spiritual beliefs within themselves as a person, which included their professional life as well as their private life. Participant four gives a good example of this:

"Em, well, Jewish law emphasises that you should be a good person and always try to do your best for your fellow man. These are values that I have was taught to me as long ago as I remember and have, by which I have always tried to abide. I guess that this is one of the reasons that led me into a career in clinical psychology." (page 2, lines 5-8)

This idea of reconciling the different understandings of the world offered by faith-based beliefs and psychology by seeing the two as elements of an overall personality is used by all the participants. Perhaps this indicates a situation where, although conflict exists between the "two hats" the two understandings of the world are not seen as mutually exclusive by those who hold religious or spiritual beliefs and are able to practice
professionally within the bounds of a scientific discipline. It may be that at times participants were able to integrate the different aspects of their character more easily than at other times. Future research might examine whether it is at times of pressure that religious or spiritual psychologists feel they need to retreat into a way of coping that involves a split in their understanding of themselves into two different parts.

Interestingly, it is in the theme of integration that participants were most able to note the benefits of their beliefs in terms of their conceptualisation of therapy and their choice of model to work with. Participant two illustrates this:

“There are aspects of the person-centred model that are very appealing to me because I do believe in the sort of human capacity for relationship and sort of a bent towards growth, actualisation, human development and a lot of it does come out of this sort of religious orientation” (page 5, lines 14-17)

Participant four makes a direct link to a narrative therapeutic model based on their beliefs:

“I’ve found that from my religious identity that there is a very historical perspective, quite often, with stories passed down from generation to generation. This has led me to the belief that everyone has a tale to tell, that is, everyone has their own life story or script if you like which is to do with their own life history, but also to do with the experiences that their parents and grandparents which so often incorporates Jewish cultural issues. All this has made me think that narrative therapy is particularly useful because people can tell their stories and it is a really useful intervention.” (page 3, lines 18-24)

Identifying compatibilities and integrations of this nature may be seen as a positive way for religious and spiritual psychologists to hold a cohesive sense of self.

Overview

This research demonstrated a complex interaction between religious or spiritual belief and psychological scientific method among trainee clinical and counselling
psychologists. The results suggest that many of the ways in which they deal with this to maintain a sense of self are similar to those outlined by Myers and Baker (1998). The results of this study appear to go further, suggesting that in many instances participants saw their views not only as compatible with psychological models but as complimentary to them. This is interesting in the light of previous research that has often sought to focus on the perceived differences or tensions between faith-based and psychological understandings (e.g.: Myers and Baker, 1998; Bilgrave and Deluty, 1998). This is a situation which is complicated by the awareness among participants that they might be judged negatively by their peers for holding views that were not within the scientific method. In managing this tension it appears that many participants choose at times to view the two as separate, whilst at other times they were able to describe them as integrated. It is not clear from the present study what factors might modulate this difference and further research could usefully explore this.

Critique

Limitations in this study include the assumption made by the research question that faith-based beliefs were a discrete entity that could be separated out from the overall personality for analysis. Beliefs of any nature are interwoven to personality and are not easily dissected for examination, or easily left behind when engaging in therapy (Parrott, 1999). As such it was difficult for participants to say to what extent they believed that their beliefs influenced or clashed with their professional training. This study is also limited as it contained only female participants, only covers issues around individual therapy and the values and beliefs of the participants were poorly defined. A subject area of this depth requires a great deal more time devoted to questioning the participants in order that the complex issues of personal meaning be properly explored. In the debrief sessions it became clear that as the participants were unaware of the religious beliefs of the interviewers, a power balance was struck in which the participants often assumed that they were being judged by the interviewer. Future research should address these issues.
Qualitative Research Project

References


Appendix One

What influence do religious trainee counselling and clinical psychologists perceive their religious beliefs have on their training, with particular reference to their choice of model. - Interview Transcript

Qualitative Research Interview

Age: 28
Gender: Female

Interviewer (I) Hi. Thanks for agreeing to do this interview. You know the topic, and it should only take about 10-20 minutes. We can have a short de-brief at the end if you would like. Does all that sound OK to you?

Respondent (R) No problem

(I) What way would you describe your religious identity?

(R) I wouldn't say that I was a religious person, in terms of following all the Jewish laws or anything. It's a bit like, I would say for me that it's more about cultural issues and more about religion. So I don't for example keep the Sabbath, but, erm, I follow, I do like celebrating Jewish festivals in a traditional manner. Ehm, I also feel that my religious identity provides me with a set of values that I have to live my life. I also feel that having a close and loving relationship with my family is a strong part of my Jewish identity.

(I) Right
(R) Ehm, well, I suppose having said this I do follow some of the Jewish laws, inasmuch as I do follow a strict kosher diet, although, ehm, I believe that this is more about strengthening my Jewish identity whilst living in a secular society.

(I) OK. How does your identification with the Jewish religion and culture relate to your experiences on training?

(R) Em, well, Jewish law emphasises that you should be a good person and always try to do your best for your fellow man. These are values that I have was taught to me as long ago as I remember and have, by which I have always tried to abide. I guess that this is one of the reasons that led me into a career in clinical psychology.

(I) Working with clients you mean?

(R) I feel that my identification with the Jewish religion and cultural definitely helps me in my clinical work. I feel that it puts me in a privileged position of being able to understand how ethnic minorities may feel. Like, there was this one time when I was working with a Bangladeshi girl who had an acute psychotic episode, during which she engaged in some bizarre behaviours. Once she had been admitted to hospital and had been treated and was very well again and she was incredibly embarrassed about her behaviours but the thing that troubled her most was who knew these behaviours as she lived in a small close-knit community where news got around very quickly and easily. So, y’know, she felt extremely embarrassed and humiliated to go out for a long while because she felt that everyone knew what had happened to her and what she had done.

(I) And you felt that you could identify with that?

(R) Yeah, because of my Jewish identity and knowing what it is like living within a community like this I guess that this is an experience that is quite difficult to understand and empathise with unless you have actually experienced it yourself.

(I) Does a sense of religious cultural community help, or does it hinder with the process of training?
(R) I feel that it does help in terms of social support.

(I) In what ways?

(R) Well, being part of the local Jewish community means that I have all my friends living nearby and many members of my family living nearby and I find that this is a very good support network. With the pressures of the course this is something that is very important to me.

(I) So it is a positive thing?

(R) Actually this very same thing does hinder my process of training, like, when I got my place on the course I had to decide whether to move house to be near the course which would take the pressure of in terms of travelling, or stay involved in the Jewish community, which is very important to me. I stayed local to my community in the end because I felt that it was so important to me, but this means that I have an added pressure in terms of the amount of travelling that I do.

(I) Do you feel that any aspects of your religious identity prompt you towards any particular model of therapy or technique of therapy?

(R) I've found that from my religious identity that there is a very historical perspective, quite often, with stories passed down from generation to generation. This has led me to the belief that everyone has a tale to tell, that is, everyone has their own life story or script if you like which is to do with their own life history, but also to do with the experiences that their parents and grandparents which so often incorporates Jewish cultural issues. All this has made me think that narrative therapy is particularly useful because people can tell their stories and it is a really useful intervention.

(I) Does the religious culture influence your conception of clients at all (e.g.: anti-social personality disorder looked on as lack of morality or a neurological deficit)?
(R) I don't feel that my religion of culture influences my conception of any clients at all, I am fully able to detach myself from my own beliefs, values et cetera for the sake of my clinical work but I am able to draw on these to help me understand things from the perspective of my clients who are themselves religious, I mean, people who believe in life after death or seek alternative explanations such as spiritual explanations for their illness or difficult life circumstances.

(I) Right. Do you feel that the beliefs of the religious culture that you identify with are at odds at all with any aspects of psychological theory?

(R) I feel that there are many aspects of my religion that I identify with that area at odds with many aspects of psychological theory, such as life after death and belief in God. I mean, obviously, psychology is a very scientific, working from an evidence-based stance and these are certainly not things that can be proven.

(I) So they are at odds with each other?

(R) Well, I don’t believe that holding these beliefs influences my clinical work in any way at all and may be beneficial in that they are beliefs held by many different people.

(I) Thank you very much we will now have an informal debriefing interview with the tape off.
Appendix two

Interview Schedule

What influence do religious trainee Clinical and Counselling Psychologists perceive their religious beliefs have on their training, with particular reference to their choice of therapeutic model.

1. Religious Belief

♦ What is your religion? (e.g. Jewish, Christian, Muslim)
♦ How, if at all, does this belief affect your views about human nature? (e.g. are people essentially good or bad? Do we have free will?)
♦ How if at all does this belief affect your views about the purpose of life (e.g. freedom and responsibility, fate and destiny)
♦ How, if at all, do you think about the ‘proof’ of your religious beliefs?

2. Therapeutic Models

♦ What are the therapeutic models that most appeal to you and why?
♦ What therapeutic tools are used within this model?
♦ How are clients conceptualised within this model? (e.g. pathologised, faulty, having the potential for growth)
♦ How do you formulate within this model?
♦ What views about the purpose of therapy does this model suggest?
♦ How does this model suggest that change occurs? (e.g. insight, correcting faulty cognitions)
♦ How, if at all, do you think that we should/ do seek ‘proof’ for this model?

3. Religious Beliefs and Choice of Therapeutic Model

♦ In what ways are your religious beliefs and your choice of therapeutic model compatible?
♦ In what ways, if at all, are your religious beliefs and choice of model at odds with each other?
Major Research Project

Vicarious Traumatisation and Secondary Traumatic Stress Among Interpreters and Translators.

Word count: 18,966

July 2003

Year 3
Abstract

Title: Vicarious Traumatisation among interpreters and translators.

Main objectives: To assess vicarious trauma among interpreters and translators, assess potential risk factors for the development of vicarious trauma in this population and examine the link between cognition and vicarious trauma.


Setting: Four large interpretation/translation agencies in the Greater London Area.

Participants: 110 translators and interpreters currently employed on a sessional basis in the Greater London Area. Of the participants, 22 were men, 76 were women and 12 did not specify their gender on the questionnaire. Participants worked across a range of settings such as trauma clinics, legal firms, hospitals and refugee agencies.

Main Outcome Measures: Participants completed the Secondary Trauma Questionnaire (STQ), the Post-traumatic Cognitions Inventory (PTCI), the Maslach Burnout Inventory (MBI), and the Impact of Events Scale – Revised (IES-R).

Results: 6.4% of the sample reported IES-R total scores of severe levels, similar to other community studies. Previous personal history of trauma, younger age and number of different places of work were correlated with higher scores on the dependent measures in this population. A comparison of measures showed that overlap exists, but also sufficient discrepancy between measures of Burnout and Vicarious Trauma, suggesting they are related but distinct constructs. PTCI results were significantly correlated with the STQ, suggesting some support for the theory that cognitive factors underlie symptoms of Vicarious Trauma.

Conclusions: The mental health of interpreters and translators may be at risk as a result of the work in which they engage and could be helped by a psycho-social intervention similar to those seen in other professions.

Introduction

This quotation from Judith Lewis Herman reflects the concern among those involved in working with people who are emotionally traumatised that this work may cause trauma in the worker (Figley, 1995a). This is thought to be different to work place factors that are thought to contribute to ill health, such as long hours and bullying managerial styles, to specific aspects of the work done. Research is sparse and theoretical understandings of the psychological mechanisms underlying any such phenomena are in their infancy. Overall this area of study and research lacks clarity. The literature regarding service provision to date also has shortcomings, as it has tended to examine workers with professional status and qualifications (psychologists, social workers etc) with less emphasis on auxiliary staff (nursing assistants, etc.).

Recent Home Office official reports suggest that there are currently 71,365 refugees a year entering the UK (Heath and Hill, 2002). Many are fleeing persecution and have suffered severe trauma in their home country. Upon arrival in the UK many will require interpreters to help them tell their stories in many different settings, such as legal, medical, therapeutic and other settings. This brings into question the occupational health of interpreters who are frequently exposed to traumatic stories involving refugees.

Structure
As a guide to understanding the need for research in this area, a description of the background will be offered, followed by a discussion of how different models have sought to understand the process of experiencing trauma reactions related to work. Evidence for the existence of the phenomena will then be reviewed. Following this, the aims of the current study will be laid out in detail and a summary offered.
Background

History

It is recognised by many researchers and clinicians in the mental health field that working in emotionally demanding circumstances can take a toll on workers. Freud first introduced the notion of therapists being affected by their clients in 1910 with the concept of counter-transference (Bateman and Holmes, 1999). This became a prevailing way of understanding the interaction between therapists and clients until research in the field began to expand in the late 1970's with the literature regarding emergency services (Iliffe and Steed, 2000). Interestingly, the increase in research coincided with the introduction of Post-traumatic Stress Disorder (PTSD) into clinical diagnostic systems (Allt, 1999). Since that time, therapists have been reported to take on symptoms of their clients, even to dream the same nightmares as their clients (Danieli 1988, Cerney 1995, Wilson and Lindy, 1995). Sexton (1999) evaluated the limited research evidence and found support for anecdotal accounts by therapists, suggesting vulnerability towards Vicarious Traumatisation (VT) exists when therapists are overly empathically engaged with clients. These phenomena alerted mental health professionals to the necessity of monitoring their reactions to their work. Systematic research has begun more recently.

Relationship to Post-traumatic Stress Disorder (PTSD)

According to the Diagnostic and Statistical Manual (4th edition) (DSM-IV) (American Psychological Association (APA), 1994), in order to be diagnosed with PTSD, a person must have experienced a recognisable stressor or trauma that would have been distressing to almost anyone. The symptoms of distress are re-experiencing of the trauma in the form of persistent recollections of the event, repeatedly dreaming about the event or suddenly acting or feeling as though the event were recurring. Emotional numbing is also required, including a marked diminishment of interest in activities, feeling of distance from others and constricted affect. Finally, evidence of physiological or behavioural change following the traumatic event must be present, such as hyperalertness, sleep disturbance, feelings of guilt, memory blanks, avoidance of activities associated with the trauma. For a full list of diagnostic criteria see appendix one.
VT is thought to occur when the indirect exposure to another person's experience acts as the stressor. Several groups of people have been studied regarding their reactions to working with traumatised individuals, including police officers (Carlier, Voerman and Gersons, 2000), ambulance workers (Clohessy and Ehlers, 1999), body handlers (Alexander, 1993), soldiers (Deahl, Srinivasan, Jones, Thomas, Neblett and Jolly, 2000) disaster support workers (Hodgkinson and Shepard, 1994) workers in emergency room settings (Lowe, 2002) and therapists (Danieli, 1988; Figley, 1995; Stamm, 1997; McCann and Pearlman, 1990). Interpreters are exposed to hearing harrowing material from clients in psychotherapeutic, legal, medical and other settings. No study to date has systematically examined how interpreters are affected by their work.

Comparison data for this study
With regard to VT, the work of interpreters/translators is perhaps closer to that of mental health workers than other groups: Both hear about traumatic experiences from the past rather than observing traumas in a 'here-and-now' fashion as with other groups mentioned above (who, through being present at traumatic events, may themselves physically witness or experience events that would fulfil PTSD criterion A). Therefore, the literature on VT and other conceptions of secondary-PTSD phenomena related to therapists will be explored here.

Theories on negative effects of listening to traumatic material
Definitions
Although the existence of the phenomena is yet to be proven rigorously (Sabin-Farrell and Turpin, 2003), concern has arisen from anecdotal reports and some qualitative research that the existence of some sort of VT process has merit (Sabin-Farrell and Turpin, 2003; Sexton, 1999). There are different understandings in the literature on the nature of the phenomena (Sexton, 1999). Stamm (1997) wrote: "The great controversy about helping-induced trauma is not 'can it happen?' but 'what shall we call it?' “ (p.1).

Three main terms exist at present in the literature to describe the phenomena (Stamm, 1997; Salston and Figley, 2003; Sabin-Farrell and Turpin, 2003): Compassion Fatigue (originally termed Secondary Traumatic Stress (STS), Baird and Jenkins, 2003); Countertransference; and VT. A conceptually similar construct, Burnout, has been used
in many research studies in this area and will also be discussed in relation to VT/STS. More general concepts of "work stress" will be touched on in passing.

**Similarities and differences**

To add to the confusion, as well as authors using different terms for the phenomena, authors have used both the same term and different terms to apply to different populations (e.g.: VT has been used for both therapists and emergency workers, Allt, 1999). This makes it difficult to distinguish between the terms, and therefore assess their validity, in the research literature (Sabin-Farrell and Turpin, 2003). All these terms, however, cover similar symptoms that can arise in workers. Considerable overlap exists between the theoretical constructs that attempt to explain this phenomenon. An integrated understanding has not yet been established, perhaps due to the relative recency of research interest (Sexton, 1999). Furthermore, Sabin-Farrell and Turpin (2003) discuss whether a new concept is needed at all. They caution against the danger of pathologising a normal reaction to traumatic material in an otherwise healthy workforce and also against creating new and possibly superfluous diagnoses, when PTSD might be used to understand the extreme negative reactions of some workers faced with hearing distressing material. Some understanding of the differences in conceptualisation of the phenomena is needed before reviewing the evidence.

**Compassion Fatigue/Secondarv Traumatic Stress (STS)**

Figley, (1995a) views STS as a normative occupational hazard. He described three areas of symptoms: re-experiencing of the primary survivors trauma; avoidance of reminders/numbing in response to reminders; and arousal. Figley (1995a) contends that relatives of PTSD survivors suffer "STS reactions". He suggests that family members, exposed to their relatives traumatic reaction and stories told about the traumatic event, become emotionally vulnerable. Evidence for this is cited in the research by Mikulincer, Florin and Solomon (1995). They found that wives of combat veterans had higher levels of psychiatric diagnosis than a control group. Mikulincer et al. conclude that this is evidence of secondary traumaticisation, although they point out that it is unclear how the experimental group of wives compared to wives with husbands suffering from other types of psychiatric diagnosis (other than PTSD). It is also left unclear how this finding
Major Research Project

relates specifically to symptoms of PTSD (Allt, 1999), or whether the psychiatric morbidity pre-dated their husbands return from combat/PTSD symptoms.

Figley (1995a) suggests the same phenomenon applies to therapists, a conception that has face validity but lacks large-scale empirical evidence (Allt, 1999). Figley furthers this concept by citing DSM-IV criterion A (APA, 1994). This criterion includes: "Learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate." (Criterion A1, DSM-IV, APA, 1994, p424).

Figley (1995a) argues this shows that no direct exposure to a trauma is required. Examination of the reactions of others who are exposed to trauma through hearing descriptions of traumatic events is, therefore, warranted and has been conducted among therapists in the past (see below). Figley used Kahill's (1988, cited in Figley, 1995a) four factors with regard to occupational burnout: physical; emotional; behavioural; work-related; and interpersonal. These cover a wider range of responses to work stress than Maslach and Jackson's (1981) three areas of emotional exhaustion, depersonalisation and personal accomplishment. Figley has developed the Compassion Fatigue Self-Test, which assesses both PTSD type symptoms and Burnout. Despite little empirical evidence to support it, scores have been related to greater vulnerability for STS among those with personal history of trauma and lower level of education (Jenkins and Baird, 2002).

Burnout

VT/STS are conceptually similar to Burnout, which is also used to describe work-related stress. Originally this concept came about in response to staff attitudes in health care settings. Several different definitions exist, all referring to the emotionally draining nature of work. Maslach and Jackson (1984) describe burnout as a syndrome of emotional exhaustion, depersonalisation of clients and reduced feelings of personal accomplishment with regard to working life. Figley (1995) argues that Burnout, although related to VT/STS, is different as it emerges gradually over time, whereas VT/STS can have a sudden onset. He also states that the psychological symptoms are different, as VT/STS is characterised by helplessness and isolation, Burnout is characterised by cynicism and exhaustion.
From a social learning perspective, McCann and Pearlman (1990) consider Burnout as simply a situation where a worker's goals are too high and his or her working life consequently does not positively reinforce the worker. Symptoms of depression, cynicism, boredom, loss of compassion and discouragement have been noted in therapists as a result of emotional exhaustion through always having to be empathic and tolerating ambiguous types of success in therapeutic situations (Freudenberger and Robbins, 1979, cited in McCann and Pearlman, 1990). McCann and Pearlman believe that the chronic, entrenched patterns seen in some trauma patients may precipitate Burnout in clinicians. McCann and Pearlman propose that Burnout in clinicians may be analogous to trauma patients numbing and avoidance patterns, representing an inability to process trauma material. They suggest, however, along with Danieli (1988), that although the Burnout literature is relevant to working with trauma survivors, the emotionally shocking nature of the trauma images that a therapist has to face lead to potentially more serious effects (such as taking on the patients nightmares and avoidance behaviours). Ultimately, they suggest, this may lead to changes in core schemas.

McCann and Pearlman (1990) further suggest that Burnout may be the “final common pathway of continual exposure to traumatic material” but that cognitive processes and the meaning behind the behavioural symptoms are different for VT. There is some limited research evidence to support this suggestion of Burnout and VT working as an additive model. Shauben and Frazier (1995) found that the caseload of trauma patients among therapists made no difference to Burnout scores, but did affect measures of VT/STS. Arvay and Uhlemann (1996) found a slightly different result, that higher scores on VT and PTSD measures were related to higher scores on the emotional exhaustion sub-scale of the Maslach Burnout Inventory. They also report that 52% of the participants who scored high on the IES were three times more likely to score high on the emotional exhaustion sub-scale. It may be that that the process of VT/STS makes people more vulnerable to chronic Burnout, or visa versa. VT/STS are also thought to be specific reactions to trauma work, whereas Burnout can describe reactions to a broader range of work experience (Claire, 2002). More research is needed to establish how these two factors interact with each other.
Countertransference

Countertransference has for many years been linked to trauma work through the psychoanalytic literature (Neumann and Gamble, 1995). McCann and Pearlman (1990) suggest that, in trauma work, countertransference means more than the unresolved conflicts and feelings the patient arouses in the therapist that can be used by the therapist to better understand what is being communicated by the patient’s unconscious, as suggested by Storr (1979). Rather, they suggest that in the victimisation literature the term refers to a broader experience incorporating the painful feelings, thoughts and images of the patient. This reaches a magnitude where it affects much of the therapist's cognitive world, resulting in lasting alterations to cognitive schema and consequent impact on feelings, relationships and life. Blank (1987, cited in McCann and Pearlman, 1990) describes cases where therapists experience resonance with their own traumatic histories. Herman (1997) suggests that in sexual violence trauma treatment, Countertransference reactions may take the form of women over-identifying with victims and men over-identifying with aggressors. If left unacknowledged, feelings of identification with helplessness or rage may manifest in longer-term personal and professional effects (Sabin-Farrell and Turpin, 2003).

Salston and Figley (2003) believe this older understanding has little to offer the study of VT/STS, as it describes a different quality of feeling. Wilson and Lindy (1994) suggest that countertransference reactions are limited only to therapeutic encounters and are not the same as VT, which in thought to affect the whole of the workers life. Pearlman and Saakvitne (1995a) view two processes being different but interlinked. They suggest that strong countertransference reactions can leave the worker more vulnerable to VT reactions to their work if these countertransference reactions are not recognised and understood. Likewise, the presence of VT in a worker may make them more vulnerable to negative countertransference reactions. Countertransference could, therefore, be seen as a vulnerability factor to developing VT reactions that affect all aspects of a workers life, rather than a competing theory on the development of PTSD-type symptoms.
Vicarious Traumatisation (VT)

McCann and Pearlman (1990) suggest that Burnout and Countertransference represent two different conceptions of the effect of trauma therapy on the therapist: Burnout focuses on the external factors of the work environment, Countertransference focuses on the individual personal internal characteristics of the clinician. They propose a model that incorporates therapist's unique responses to what a client presents, shaped by the situation and the therapist's personal psychological needs and schemas: a constructivist self-development theory. Steed and Downing (1999) suggest that VT is conceptualised by the authors to be different from Burnout and Countertransference as it is specifically related to trauma work, whilst Burnout and Countertransference can be experienced in any setting.

Pearlman and Saakvitne (1995a) see both VT and STS as being a normal reaction to therapeutic work with trauma survivors, but go further to explore what underlies the symptoms observed. VT, by comparison to STS, emphasises the role of cognitive schemas in the development and maintenance of the phenomena observed in those working with the traumatised. Jenkins and Baird (2002), in a validation study, distinguish between STS and VT, suggest that STS is primarily concerned with post-traumatic symptoms and Burnout while VT is focused on cognitive schemas. Saakvitne (2002) defines VT as: "The negative transformation of the therapist's inner experience as a result of his or her empathic engagement with and responsibility for a traumatised client." (p.31). Other writers describe empathy as an important component of both therapeutic work and a possible avenue through which the worker becomes vicariously traumatised (Clare, 2002; Sabin-Farrell and Turpin, 2003). Within the VT model, McCann and Pearlman (1990) argue that this process results in changes in the therapist's core schemas about themselves, others and the world. These changes in turn are hypothesised to manifest in the PTSD-type symptoms observed in vicariously traumatised workers. This conception, in its most basic form, appears similar to cognitive models of anxiety (Clark, 1989), where thoughts are hypothesised to underlie feelings and behaviours. Similarly, McCann and Pearlman's model suggests that change at the level of belief alters how a person experiences the world following exposure to harrowing material. This emphasis on cognitive factors gives a greater theory on the aetiology of
VT than any of the other conception. For this reason, the VT model is explored in the present study.

From a review of the literature, McCann and Pearlman (1990) argue that there are seven areas related to psychological needs that are changed in schema representation as a result of exposure to traumatic stories. They argue that these are: Dependency/trust; safety; power; independence; esteem; intimacy; and frame of reference. They call this model constructivist self-development theory and suggest that intrusive memories and other PTSD type symptoms occur as disruptions to the therapist's memory and imagery systems, resulting in negative emotions that can become chronic.

This theory of VT has grown out of McCann and Pearlman's work on development of a theory of personality to explain victimisation (Illiffe and Steed, 2000). They argue that a complex relationship exists between traumatic events, cognitive schemas about the self and world and psychological adaptation. They believe that human beings construct their own realities through the way that they make sense of the life events that they face. Constructivism is based on the theory that people construct their realities through evolving mental frameworks shaped by their experiences (Illiffe and Steed, 2000). These complex cognitive structures are used to interpret events as the person goes through life, giving meaning to the new environments and situations the individual experiences. Piaget (1948, cited in Padesky, 1994) called these structures schema. These structures contain beliefs, assumptions and expectations about the self and others and the belief in an orderly world (Janoff-Bulman, 1985). These can include understandings of causality, identity and self-world relations. An individual's sense of 'reality' is derived from the information they have assimilated into schemas through their experiences in life (Beck, 1976). These schemas can be altered by new information but are generally thought to be stable and make up an individuals consistent way of experiencing the world (Beck, 1995).

McCann and Pearlman's (1990) seven psychological needs in relation to trauma (dependency/trust, safety, power, esteem, intimacy, independence and frame of reference) are hypothesised to manifest in schemas, which in turn underlie self-protective beliefs (Pearlman and Saakvitne, 1995b). These beliefs relate to the areas of
self, other and world as outlined by Beck (1976) in relation to psychological disorders in general and by Janoff-Bulmman (1985) in relation to trauma in particular. These self-protective beliefs are that others can be trusted, the world is a basically safe place and that the self has an effective control over the world (McCann and Pearlman, 1990). These beliefs allow an individual to function in the world confidently and effectively without persistent fear. McCann and Pearlman believe that, similar to those who experience traumatic events, therapists who listen to repeated stories of trauma are at risk of having these self-protective beliefs and underlying schema damaged or altered in a negative way through threatening the individuals sense of security. Pearlman and Saakvitne (1995a) and McCann and Pearlman (1990) argue that the effects of this process are cumulative, and can become resistant to change if unchecked.

The unique way in which trauma is experienced and understood depends upon the schema pattern the individual has built up in their past and how much discrepancy there is between these schemas and the material with which they are being presented. VT occurs when experiencing a trauma second hand causes disruption to schemas. The memory and imagery system of the individual and their coping resources are also considered within this model and are thought of similarly to the model proposed by Brewin, Dalgleish and Joseph (1996). Verbal and situational memory systems may be altered in response to hearing traumatic material. Steed and Downing (1999) point out that VT does not seek to blame the client for the reaction the clinician is having, rather VT may be inevitable for the clinician with predisposing schemata, taking place over time, across therapeutic relationships. Challenges for the therapist in this process include acknowledging the prevalence of trauma and the hurtful behaviour that humans are capable of inflicting. They suggest that people with a personal history of trauma may need to prepare themselves to potentially be affected. Additionally, re-enactment within therapy of projected roles such as bystander or victim can lead to strong negative reactions (Pearlman and Saakvitne, 1995a). These difficulties can lead to problems in the therapeutic empathic engagement with clients if not recognised and dealt with (Sexton, 1999).

The literature on the course and development of VT/STS is less well developed, although some authors have made theoretical suggestions in this regard. Remer and
Elliot (1998a) suggest that secondary victims may go through a similar “accommodation-assimilation process” (Piaget and Inhelder, 1969, cited in Remer and Elliot, 1998a) to sexual assault victims, or an adjustment process not unlike that described by Kubler-Ross (1969) that may include stages of shock, denial, anger/depression, bargaining and acceptance. As no longer-term follow-up studies have yet been reported, it is not possible to describe the course and chronicity of any such phenomena.

Evidence for negative effects of listening to traumatic material

There are three bodies of research in this area, laboratory based experiments, questionnaire measure surveys and comparison studies. These will be looked at in turn here.

Laboratory research evidence

Some experimental evidence of physiological reactivity to listening to traumatic stories has been found. In a laboratory experimental study, Shortt and Pennebaker (1992) noted the difference between talking about and listening to traumatic experiences of holocaust victims. They hypothesised that whilst talking about experiences brought about relief for the patient, listening to these stories induced a state of stress in the listener. They experimented on 66 psychology undergraduates (42 female, 24 male) between 17 and 30 years old (mean=19) who watched one-to-two hours of video footage of one of 33 different holocaust survivors recounting their traumatic experiences. Skin conductance levels (SCL) and heart rates were recorded at the time of interview for the survivors in the videos and were subsequently recorded for the listeners. They were then averaged into one-minute blocks for pair-wise comparison.

Thirty-three participants (50%) evidenced significant correlations with holocaust survivors SCL, well above the 5% that would be expected by chance. 70% of those who correlated significantly evidenced an inverse pattern of SCL to survivors. In other words, as the physiological arousal of the survivors decreased as they told their stories, the physiological responses of the listeners increased in kind. The results for heart rate fluctuations were non-significant and not commented upon by the authors. Participants with this inverse SCL pattern also scored lower on the Epstein Feelings Inventory compared with the smaller group whose SCL were similar to the holocaust survivors.
This may suggest that those with an inverse SCL had a lack of empathy with the survivors. The authors comment that this may be as a result of the unnatural nature of videotaped interview, where it is not possible to engage with the person and offer support through empathy, but it is still possible to identify with their pain. They point to other studies that found SCL increases in participants watching video footage of people in pain and watching violent films. They concluded that physiological anxiety is at risk of being elevated through a process of listening to the traumatic experiences of others. The authors did not report any long-term follow-up of these participants and it may be that the effects were short-lived and did not cause the participants any lasting distress.

Allt and Dunmore (1999) in a small-scale experiment found that intrusions could be induced from hearing, rather that witnessing, emotive material. They randomly allocated non-traumatised participants either to a group who watched 'clients' (actors) giving a personal account of a car accident or 'police officers' (actors again) giving an impassive account of the same accident. They found no difference between the groups. Both groups, however, experienced a significant increase in intrusions related to the material presented in the experiment. They conclude that hearing about trauma is sufficient to induce trauma symptoms of intrusion under experimental conditions.

Field research evidence
Much more of the research in this area has been conducted with questionnaire measurement of internal emotional states. Schauben and Frazier (1995) hypothesised, consistent with McCann and Pearlman (1990), that the amount of trauma work on a therapist's caseload would be positively correlated with disruptions in beliefs, PTSD symptoms and negative affect, leading to a suggestion that a vicariously traumatising process was occurring. They analysed questionnaire packs returned to them by female psychologists (n=118) and sexual violence counsellors (n=30) in the mid-west of the USA. The age range was 21-69 (mean=44). Participants completed questionnaires about their workload and work experience along with information about their own experience of trauma. They were also given the Maslach Burnout Inventory to assess level of job satisfaction and Burnout and the Traumatic Stress Institute's Belief Scale to assess cognitive schema about themselves and others. PTSD symptoms were assessed with a 16-item checklist covering PTSD symptoms as listed in DSM-III(R). Coping
strategies were assessed by the COPE (Carver, Scheiner and Weintraub, 1989, cited in Schauben and Frazier, 1995) and also by asking participants to provide a qualitative list of ways in which they coped. Participants were additionally asked to rate how much they felt they suffered from VT on a 1-5 scale. Correlations were calculated by the authors between the percentage of trauma cases on a therapist's workload and measures of psychological functioning. Those with higher percentages of trauma cases reported greater disruption in schemas about themselves and others (r=0.16), more symptoms of PTSD (r=0.27) and higher ratings of VT (r=0.26). These results were not related to personal history of trauma. Trauma work was not significantly correlated with any of the MBI scales, suggesting, consistent with Pearlman and Saakvitne (1995a), that VT and Burnout are distinct constructs. Drawbacks of this research include the fact that all members of the sample were women and almost all the trauma work referred to sexual violence therapy. The correlations observed are also not strong and inferences based on them should be made cautiously.

Arvay and Uhlemann (1996) used the Impact of Events Scale (IES), the Maslach Burnout Inventory (MBI) and a self-rating of how much their work negatively affected them to assess VT in a randomised sample of 161 mental health workers (80% women, 20% men, ages 22-67). They found that 16% of participants had high levels of Intrusions and 37% had high levels of avoidance. Two-thirds of the sample felt that their work negatively affected them “often” and 64% of the total sample thought that this had led to difficulties in their work with clients. Less experience significantly correlated, although not strongly, with higher scores on the IES scales (r=-0.33 for the intrusion sub-scale and r=-0.24 for the avoidance sub-scale). High scores on the Depersonalisation sub-scale of the MBI (26% of the sample) were significantly correlated with younger, less experienced counsellors and males. This adds weight to Pearlman and Maclan’s (1995) finding that younger age was related to higher levels of job-related distress. Similarly to Schauben and Frazier (1995), larger trauma work caseload was positively correlated with the emotional exhaustion subscale of the MBI, where 14% scored in ‘high’ range. One drawback of this study was the assumption that participants formed a homogenous group. Pearlman and Maclan (1995) suggested that amount and type of education and training affects vulnerability to VT. As such the training, and indeed the job responsibilities of Psychiatrists, Psychologists and Nurses may occasion protective or
vulnerability factors to various degrees in relation to VT. Additionally, no measure of change in schema or beliefs was included (Allt, 1999).

Arvay and Uhlemann's findings are similar to Kessler, Sonnega, Bromet, Hughes and Nelson's (1995) report of PTSD in the national co-morbidity study of 5877 community participants which found modestly lower levels of PTSD in those exposed to trauma as age increased. Other authors have found evidence that, rather than their being a direct correlation, a U-shaped distribution may exist with regard to age. Steed and Bicknell (2001) used the Revised Impact of Events Scale (IES-R, Wiess and Marmar, 1997) and the Compassion Fatigue Scale (Figley, 1995, cited in Lindall and Bicknell) to examine the relationship between VT and exposure to clients in a sample of 67 Australian therapists. None of the participants met even the lower threshold of 26 points on the IES-R, although, they found a U-shaped distribution between years of experience and avoidance such that therapists with the least and the most years of experience had more avoidance symptoms. The authors suggest that their findings may have been compromised by having insufficient power with a sample of 67 participants. It is possible some effect of sampling error is contributing to this finding.

Kassam-Adams (1994) surveyed 100 psychotherapists finding that the percentage of sexually traumatised clients seen over a career was significantly related to PTSD symptoms as measures by the IES \( r=0.36 \). Female gender, personal experience of trauma and exposure to this client group were all significant predictors of higher scores on the IES in this sample. Interestingly higher scores on PTSD measures were not associated with those therapists treating other disorders (Depression, Schizophrenia and Personality Disorder). Generic work stress was not found to be significantly related to work with sexually traumatised clients, suggesting a qualitative difference in the experience of VT and other types of work related stress when working with sexually abused clients.

Baird and Jenkins (2003) surveyed 101-trauma counsellors aged 21-65 in the USA. They found that those with more education and training and those seeing more clients had lower levels of VT. Indeed, a negative relationship was observed between number of clients seen and scores on the TSI Belief Scale \( r=-0.21 \). The authors suggest that it
may be that the therapists who have a higher number of trauma clients on their caseload are the one's who have had more training. Younger therapists and volunteers, both of whom saw fewer clients, had higher levels of emotional exhaustion, as measured by the MBI ($r=0.23$). The authors discuss the possibility that this finding results from these workers becoming bored, causing the sensation of burnout, rather than to mean that the notions of VT or Burnout were not valid.

Pearlman and Maclan (1995) surveyed 136 female and 52 male self-identified trauma therapists with an age range between 23-74 years (female mean=42, male mean=47), with the aim of developing dependent variables that might indicate the existence of VT, and independent variables that might predict it. Independent variables in the study were assessed via a questionnaire developed by the authors. It examined exposure to retellings of trauma when working with trauma cases (e.g.: how many hours do you spend listening to trauma each week?) and details of personal trauma history and demographic variables. Dependent measures comprised the Traumatic Stress Institute's Belief Scale (Pearlman, in press, cited in Pearlman and Maclan, 1995), which measures disrupted cognitive schemas on a six-point Likert scale with questions such as "You can't trust anyone". The subscales identified by the authors were (internal consistencies (Cronbach's alpha) given in brackets): Safety (0.79), Self-esteem (0.84), Other-esteem (0.65), Self-trust (0.78), Other-trust (0.80), Self-intimacy (0.71) and Other-intimacy (0.82). The overall internal consistency was 0.93 (Cronbach's alpha). All these internal consistencies would be considered good (Tabachnik and Fidell, 1996). The authors also included the IES, with the rationale that traumatology picked up by this measure would suggest VT. The Symptom Check List-90-Revised (Derogatis, 1977, cited in Pearlman and Maclan, 1995) was used to separate general distress from trauma specific distress reflected in the dependent measures. Lastly, they administered the Marlowe-Crowne Social Desirability Scale (Marlowe-Crowne, 1964, cited in Pearlman and Maclan, 1995) to assess whether participant responding was shaped by a need for approval from authority figures.

Using analysis of variance, the authors found a significant difference ($F(1, 182)=9.41, p<0.01$) between the mean scores for therapists with and without a personal history of trauma. They performed a stepwise multiple regression analysis in order to
discover what dependent variables might predict vulnerability to VT. Independent variables of gender, personal trauma history, personal experience of therapy, age, length of time doing trauma work, income, level of education and work setting were selected. Taken together these scores predicted dependent measures of: SCL-90-R ($R^2=0.22, p<0.001$); total, IES total score ($R^2=0.14, p<0.01$); and TSI Belief Scale total score ($R^2=0.12, p<0.01$), describing modest proportions of the variance. Single variables that contributed at least the 0.05 level, were: personal therapy and personal history of trauma. It may be that therapists who had experienced trauma and were receiving therapy had higher levels of distress that may or may not have been related to or exacerbated by their work. Therapists in this sample who had answered “yes” to the question “Do you have a trauma history” (60%, n=80 women, 32 men) showed significant negative correlations with length of time doing trauma work and total TSI Belief total score ($r=-0.22$, $p<0.05$) and TSI sub-scales of: Safety ($r=-0.07$, $p<0.05$); self-trust ($r=-0.20$, $p<0.05$); self-intimacy ($r=-0.14$, $p<0.05$); and self-esteem ($r=-0.15$, $p<0.05$). Percentage of trauma cases on caseload correlated negatively with: Self-trust ($r=-0.05$, $p<0.05$); self-intimacy ($r=-0.22$, $p<0.05$); and self-esteem ($r=-0.12$, $p<0.05$) for all participants. Analysis of variance showed significant differences were found between those with and without a personal trauma history on: Safety, Self-trust, Self-esteem, Other-trust and Other-intimacy, the SCL-90-R and the Intrusions sub-scale of the IES with those who had personal trauma histories evidenced more disturbance. Less experienced therapists (i.e.: with less that two year’s experience) were shown to have more disrupted schemas ($r=-0.22$, $p<0.05$). The authors suggest this is due to newer therapists either not enjoying trauma work and moving their career in other directions, or having less disruption as they become more experienced. This is consistent with findings from the literature of Burnout in mental health settings, which suggests that clinicians newer to their mental health work with inadequate supervision have higher Burnout (Ackerley, Burnell, Holder and Kurdek, 1988). As there was no measure of pre-existing schema, however, these results need to be treated cautiously.

In the non-personally traumatised group (40%, n=57 women, 19 men) only the Other-esteem subscale of the TSI Belief Scale correlated with length of time doing trauma work, i.e.: doing more trauma work correlated significantly with more negative feelings towards others. The use of a significance level of 0.05 in this study will have increased
the risk of Type One error (stating that an effect exists when it does not), particularly as a large number of correlation analyses appear to have been conducted. Additionally, no power analysis results are reported. As such it is not possible to be confident about whether any Type Two error occurred (saying there is no significant difference when there is one). More significant results might, therefore, have been achieved with a higher number of participants. Another drawback of this study is that scores on the IES are not reported, as such it is not possible to know how many therapists were suffering more extreme reactions (Allt, 1999).

Joseph (1998) used the Secondary Trauma Questionnaire, the Impact of Events Scale-Revised, the Modified PTSD Symptom Scale and the Maslach Burnout Inventory to assess VT in 261 mental health professionals. Results indicated that therapists working with people with HIV/AIDS did not experience VT, however perceived social support was predictive of lower scores on the Secondary Trauma Questionnaire. Social Workers reported lower sense of Personal Accomplishment than Psychologists and were more likely to report intrusions related to HIV/AIDS without them becoming so severe so as to justify a label of VT.

Comparison studies
Follette, Polusny and Milbeck (1994) studies 558 mental health workers and law enforcement officers in the USA who worked with cases of child sexual abuse. Among mental health professional they found that those with personal trauma histories of sexual abuse (29.8% of the sample) they were more likely than their non-personal trauma history peers to report a higher number of PTSD-type symptoms, as assessed by the Trauma Symptoms Checklist. Interestingly, however, in a stepwise multiple regression analysis, previous trauma was not found to be predictive of these scores. Rather, negative coping styles, personal levels of non-work related stress and negative therapeutic outcomes were found to be predictive. In the same study, personal history of child sexual abuse was found to be predictive of higher scores on the Trauma Symptoms Checklist among law enforcement officers with personal histories of sexual abuse (19.6% of the sample). The authors suggest that this difference is due to the training and support that therapists get directly concerning working with mental health issues, which is not available to law enforcement officers. What makes this study
particularly useful is the fact that it compared a mental health professional group who receive tailored support and training in their work environment with a group who encounter broadly similar traumatic material in the absence of such support. The implication for this study is that interpreters with personal histories of trauma could be helped by training and support in the work that they do to experience less VT symptoms. This is supported by Dickes (2001) who found higher perceived quality of supervision was related to lower levels of VT.

Lee (1995) compared marriage and family therapists who were treating trauma patients with medical students on the Traumatic Stress Institutes Belief Scale and the IES-R. Results showed that therapists had higher scores on the IES-R intrusions sub-scale than medical students and that cognitive schemas were correlated with STS and therapists level of satisfaction with total caseload. More hours spent listening to traumatic material was correlated with higher intrusions scores.

**Conceptual validation of VT in relation to Burnout**

Shauben and Frazier (1995) see VT as being distinct from Burnout as the latter described stress reactions to working environments that might occur in many settings, whereas VT is specific to trauma. McCann and Pearlman (1990) add to this by stating that VT differs from Burnout, as VT is the direct result of schema change in relation to shocking material encountered from trauma clients. Jenkins and Baird (2002) in their validation study of VT and STS state that they chose Burnout as a comparison as it is conceptually related to VT, as both are measures of work-related stress response. They suggested that, to show construct validity, measures of VT/STS should be moderately correlated with measures of Burnout. In order to show discriminent (and potentially incremental) validity the correlations should not be so high as to suggest redundancy. They further suggest that in order to show concurrent validity supportive of construct validity, the measures need to correlate more highly than with Burnout but, again, not so high as to indicate redundancy. In other words, the unique variance of the measures should be high enough to support the notion that the measures are differentially associated with the specific criterion.
Their results from a survey of 99 volunteer sexual abuse and domestic violence counsellors showed moderate convergence, but useful discrimination between two measures of VT/STS, the Traumatic Stress Institute’s Belief Scale-Revision L and the Compassion Fatigue Self-Test for Psychotherapists and the most frequently used measure of Burnout, the Maslach Burnout Inventory. The correlation (Pearson’s r) between the Traumatic Stress Institute’s Belief Scale-Revision L and the MBI sum score was 0.44, with the MBI emotional exhaustion scale the correlation was 0.30, with the depersonalisation scale it was 0.030 and with the personal accomplishment scale it was –0.24. Between the Compassion Fatigue Self-Test for Psychotherapists sum score and the MBI scales the correlations were 0.52 for the sum, 0.53 for emotional exhaustion, 0.36 for depersonalisation and –0.10 for personal accomplishment. They concluded that VT and STS are related to, but adequately different from Burnout. Additionally they found that VT and STS were experienced both similarly and slightly differently by these participants. The authors point to the relative emphases of cognitive symptoms and social/emotional symptoms.

They also conducted a factor analysis (varimax rotation) that showed a difference between a factor primarily concerned with trauma, reflected by the VT/STS measures plus the MBI Personal Accomplishment sub-scale and another concerned with Burnout, most strongly indicated by the MBI emotional exhaustion and depersonalisation sub-scales. The results of this study suggest that a concept of work-related stress that is different to Burnout has merit.

Evidence of change to schema
In addition to studies mentioned above, some researchers have looked specifically at schema change in relation to working with trauma survivors. Studies have looked at schema change by both quantitative and qualitative methods. Van de Water (1996) surveyed 130 female and 35 male therapists with a new scale developed to assess schema change regarding the psychological needs outlined by McCann and Pearlman (1990), the Trauma Work Impact Scale (Van de Water, 1996). Participants with a high trauma caseload endorsed a higher number of items on the questionnaire reflecting anxieties about safety both for themselves and others. Those with a personal history of
trauma had higher scores on items reflecting difficulties with interpersonal relationships and intimacy.

Hollingsworth (1993) found schema change in the areas of trust of others, safety of children, intimacy, connectedness, esteem for others and independence of power among female therapists working with female incest survivors. Coping strategies were also identified as: peer support, supervision, consultation, training, personal therapy, maintaining a balance in one’s life and maintaining clear boundaries with clients.

Illiffe and Steed (2000) employed Interpretive Phenomenological Analysis (IPA) (Willig, 2001) with data from 18 semi-structured interviews (13 women 5 men). Participants were from different disciplines but all worked in counselling rather than advocacy or social support. All had a caseload that was at least 50% domestic violence cases. The average age was 45.8 and average counselling experience was 9.9 years. Changes in cognitive schema were reported with regard to feeling less secure in the world, world-view with regard to power and gender issues and trust. These seem to match with McCann and Pearlman’s (1990) basic psychological needs of dependency/trust, frame of reference and power. A strength of this study is that it looked at both survivors and perpetrators. This has a bearing on the reactions of the therapist, as Herman (1997) suggests that therapists working with survivors may identify with the sense of victimhood. Exposure to both victim and perpetrator issues may serve to reduce this phenomena and means that the results observed are not simply a reaction to the client’s distress.

Interpreting as a stressful task (non-VT stresses)
Dean and Pollard (2001), in a job analysis model, assessed the work of sign language interpreters. They found that demands made on the interpreter that go beyond linguistic demands, such as inter-personal and environmental demands, are likely to contribute to Burnout. They also point to the lack of “decision latitude” (the amount of control the interpreter has in the course of the dialogue) as contributing to the stress of the job of interpreting. These finding are important, as it may be that the inherently stressful aspects of the job of interpreting affect the outcome measures.
Granger and Baker (2003) report on an unpublished survey, conducted by the first author, of interpreter's feelings about their role and experience of their work. 300 questionnaires were distributed with 64 returned. Most of the respondents were over 36 years old and had been an interpreter for more than 5 years. Details about the questionnaires included in the research and the statistical analyses used are not given. They reported that, despite multiple-locations and irregular work patterns, most interpreters were confident about their ability to do their job well. Job satisfaction in the sample was high, although an analysis of qualitative data that accompanied the study found that most had moved to the UK from professional jobs in other counties, such as doctors, lawyers, etc. and were seeking a job in their field of expertise. Qualitative data reported showed more stressful aspects of the work. Salient among these were the stress in interpreting nuances and complex language which commonly occurs in medical or legal settings, having to build rapport with emotionally distressed clients and the difficulties in maintaining clear boundaries when clients were asking advice about what to say from an interpreter who is professionally obliged to remain neutral.

**Risk factors for VT and aims of the current study**

Psychinfo, Medline, Bids and hand searches all produced no evidence of research that has examined the levels of stress, Burnout, VT/STS or evaluated coping mechanisms within the interpreting/translating profession. Interpreters frequently work in settings similar to those of therapists (Phelan and Parkman 1995; Ravel, 1996; Tribe and Raval, 2003) as well as other settings where they might be exposed to hearing traumatic stories (Tribe, 1999). With the increase of refugees into the UK and the preponderance of PTSD (especially related to torture) and other mental health difficulties among this population, it is likely that many interpreters may have exposure to harrowing experiences of clients in therapeutic settings, as well as hospitals, legal firms and social services departments. The support structure for interpreters is not well established and there is no understanding or guidance in the literature at present of how to help interpreters who may be suffering job stress. There is also a possibility that many interpreters may have experienced similar traumas themselves if they have come from countries where torture or war are features of many people's lives. This may mean that there are serious issues regarding working practices of interpreters.
From the evidence detailed above potential risk factors exist with regard to therapists and VT. In summary, these are:

2. Personal history of trauma (Allt, 1999; Pearlman and Maclan, 1995; Kassam-Adams, 1994)
3. Working with trauma cases (Pearlman and Maclan, 1995; Arvay and Uhlemann, 1996),
4. Amount of trauma work engaged in (Arvay and Uhlemann, 1996; Shauben and Frazier, 1995)
5. Age (Pearlman and Maclan, 1995; Steed and Bicknell, 2001; Baird and Jenkins, 2003)
6. Level of education and training – as a protective factor (Baird and Jenkins, 2003)
7. Level of support - as a protective factor (Hollingsworth, 1993)

The risk factors mentioned here are all potentially present for interpreters. Additionally interpreters may frequently have concerns about their leave to remain in the UK, as many of them will be working without having had their asylum applications dealt with (Tribe and Raval, 2003). This is likely to be stressful when interpreting for others who may be facing similar difficulties.

Sabin-Farrell and Turpin (2003) argue that it is difficult to understand the nature of the amount of trauma work needed to cause distress and VT as some studies look at current workload, some at career total and others at number of hours spent directly exposed to trauma material. Number of hours per week and total trauma work experience will be examined in this study as these variables cover both current intensity of exposure and build-up of exposure over time.

The constructivist self-development theory of VT (McCann and Pearlman, 1990) offers the most useful theoretical framework for the impact of trauma work on the listener (Allt, 1999). More evidence is needed to be confident about the utility of this model and to better understand its relationship to Burnout. For this reason it is important to examine cognitions related to trauma to assess the level at which they contribute to any observed
PTSD-type symptoms. The aim of this study, therefore, is to survey interpreter's levels of trauma-related distress as it is associated with a number of variables identified in previous research and to assess the involvement of cognitions in this phenomenology, as outlined in McCann and Pearlman's (1990) model of VT. Drawing on the research conducted with therapists described above, ten research questions were developed to explore potential VT in interpreters. These are listed in table one.

Table 1: Research questions

| 1. Do women have higher scores in relation to their interpretation work? |
| 2. Is a personal history of trauma related to higher scores on the outcome measures? |
| 3. Is the weekly amount of work engaged in related to higher scores on the outcome measures? |
| 4. Are places of work or the number of places of work related to higher scores on the outcome measures? |
| 5. Is amount of experience (how long a person has been working as an interpreter) related to lower scores on outcome measures? |
| 6. Is unresolved refugee status related to higher scores on the outcome measures? |
| 7. Is younger age related to higher scores on the outcome measures? |
| 8. Is a longer time in education related to lower scores on the outcome measures? |
| 9. Is number of sources of social support related to lower scores on the outcome measures? |
| 10. Will trauma related cognitions, as measured by the PTCI, be related to higher scores on the IES-R and the STQ? |

Summary
Exposure to working with emotionally disturbed and traumatised people has long been thought of as causing negative reactions in the worker. Empirical research has grown in the past 30 years following the formal recognition of a diagnosis of PTSD. This research has focussed largely on therapists and 'front line' workers. With the increase in the numbers of refugees entering the UK who have experienced trauma in their home country, interpreters/translators are increasingly in the 'front line' as well. Attempts at empirical validation of these concepts has become confused by variation in measurement and the descriptions of the phenomenon by different authors. Despite these inconsistencies, there is some evidence that certain factors, such as personal trauma history, are related to general work related symptoms of distress. This is
hypothesised by McCann and Pearlman (1990) to be maintained by changes to core schemas. This notion is supported by some evidence from qualitative studies (Illiffe and Steed, 2000) that those who work with trauma cases experienced more negative cognitions related to feeling less secure. This theory in turn fits with other theories of anxiety and PTSD that hypothesise schemas related to fears regarding trauma underlie and maintain symptoms (Ehlers and Clark, 2000).

The research questions in table one hope to examine the phenomena among interpreters/translators to assess the degree to which this population might be affected by VT. The research also hopes to examine the theoretical link between cognitions and the development or maintenance of VT. The model of STS is useful for comparison material, but as it does not go beyond descriptions of the phenomenon to theories about causes, will not be used to explore these research questions. Similarly, Countertransference will not be used in this exploration, as it does not deal specifically with reactions to trauma or long-standing symptoms. Burnout will be measured (by the MBI) for comparison, but will not be commented upon in detail, as it is reactions to trauma material, not reactions to work-related stress in general that are under investigation.
Method

Pre-survey interviews
Two interpreters were interviewed for one hour each about their work with regard to stresses and traumatic feelings they may have experienced with regard to their work. A draft questionnaire pack was taken to two meetings of interpreter/translator agencies, one monthly meeting of 22 interpreters in an agency based in a hospital, and one the Annual General Meeting if the heads of interpretation/translation agencies in the local area, which comprised 16 people. The questionnaire pack was discussed with regard to content of the demographic variables and the face validity of the questionnaire measures. Feedback from these meetings was positive and confirmed the importance and relevance of the study. Only minor changes in item wording to make the measures specific to interpreters/translators were suggested. These were incorporated into the questionnaire.

Design
This study used a cross-sectional postal survey design. A quantitative methodology was used to assess the levels of trauma, secondary trauma, burnout and changes in beliefs among interpreters and translators using standardised and unstandardised questionnaires.

Participants
1000 questionnaires were distributed to four interpretation/translation agencies in the area. One agency took 350 questionnaire packs, one took 150, one 300 and another 200. One hundred and forty four were returned of which 34 were rejected, as only the demographic questionnaire and no the other measures had been completed. It was not possible to know whether these 34 participants felt that the questionnaires did not apply to them, or whether they wished to avoid thinking about their experiences, or whether they had some other reason for not completing these measures. This gives a response rate of 14.4%, which is lower than Granger (1996, cited in Granger and Baker, 2003) who had a return rate of 21% among interpreters in the UK. Higher rates were observed among the questionnaire surveys of mental health workers reviewed by Sabin-Farrell and Turpin (2003) the response rate has varied from 32% to 57%. The comparatively
low response rate in the present study may have been due to response rates among
interpreters generally being lower than mental health workers, who are perhaps more
socialised into the idea of traumatisation and effects of emotional work stress and there
for more motivate to respond. It is hard to be firm about this conclusion as Granger 1996
(cited in Granger and Baker, 2003) is the only study available for comparison. The third
party distribution of questionnaires as interpretation/translation agencies databases of
who was on their books may have been out of date. As such, it not clear how many
potential participants actually received the questionnaire. Of the participants who
completed only part of the questionnaire pack, some wrote comments suggesting they
did not believe the items in the standardised measures applied to them as they did not
feel distressed and did not complete them.

Twenty-two (20.2%) of the sample were men and 76 (69.1%) were women with 12
(10.9%) declining to indicate their gender. The youngest participant was 23 years old
and the eldest was 81. The mean average was 45.7. A breakdown of the number of
participants by age range is given in table one.

Table 1: Age of participants:

<table>
<thead>
<tr>
<th>Age range</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>9</td>
<td>8.2</td>
</tr>
<tr>
<td>30-39</td>
<td>27</td>
<td>25.4</td>
</tr>
<tr>
<td>40-49</td>
<td>29</td>
<td>26.4</td>
</tr>
<tr>
<td>50-59</td>
<td>33</td>
<td>30.0</td>
</tr>
<tr>
<td>60-69</td>
<td>10</td>
<td>8.2</td>
</tr>
<tr>
<td>70-79</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>80+</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>100</td>
</tr>
</tbody>
</table>

Nine (8.1%) were currently refugees and the remaining 101 (91.9%) had permanent
leave to remain in the UK. As the participants all worked through agencies, their level of
experience of interpreting/ translating in different settings varied considerably. 38 (34.5)
regularly worked in traumatic stress clinics, 58 (52.7) in legal firms, 75 (68.2) in hospitals, 32 (29.1) in refugee agencies and 76 (69.1) in social services departments.

Sixty-two (56.4) had been involved in interpreting/translating details about rape, 75 (68.2%) torture, 51 (46.8%) sexual abuse, 51 (46.4%) child abuse, 62 (56.4%) beatings/muggings, 63 (57.3) racial harassment, 36 (32.7%) accidents and 13 (11.8%) natural disasters.

Participants covered a large numbers of countries, with a large proportion also being from the UK originally. This gave a wide range of cultural experience and views to the results of the study. A breakdown of the countries of origin of participants is given in table two.

Table 2: Country of origin of participants

<table>
<thead>
<tr>
<th>Country</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Albania</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Algeria</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Argentina</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Australia</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Brazil</td>
<td>4</td>
<td>3.7</td>
</tr>
<tr>
<td>Chile</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Croatia</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Cyprus</td>
<td>5</td>
<td>4.6</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>3</td>
<td>2.7</td>
</tr>
<tr>
<td>Eritrea</td>
<td>3</td>
<td>2.7</td>
</tr>
<tr>
<td>France</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Germany</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>4</td>
<td>3.7</td>
</tr>
<tr>
<td>India</td>
<td>4</td>
<td>3.7</td>
</tr>
<tr>
<td>Iran</td>
<td>7</td>
<td>6.4</td>
</tr>
<tr>
<td>Iran/Kurdish</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Italy</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Kosovo</td>
<td>3</td>
<td>2.7</td>
</tr>
<tr>
<td>Kurdistan</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Lebanon</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Morocco</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Mozambique</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>N. Ireland</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>New Zealand</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Pakistan</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Poland</td>
<td>6</td>
<td>5.5</td>
</tr>
<tr>
<td>Portugal</td>
<td>3</td>
<td>2.7</td>
</tr>
<tr>
<td>Romania</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Russia</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Somalia</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Spain</td>
<td>7</td>
<td>6.4</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>5</td>
<td>4.6</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Turkey</td>
<td>6</td>
<td>5.5</td>
</tr>
<tr>
<td>Uganda</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>UK</td>
<td>14</td>
<td>12.6</td>
</tr>
</tbody>
</table>
Ninety-four participants responded to a question asking them to state how long they had been in Britain. The range was from one year to 59 years. A breakdown of how long participants had been in Britain is shown in Table 3.

Table 3: Length of time in Britain

<table>
<thead>
<tr>
<th>Number of years</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>2-5</td>
<td>12</td>
<td>13.2</td>
</tr>
<tr>
<td>5-10</td>
<td>20</td>
<td>22.0</td>
</tr>
<tr>
<td>10+</td>
<td>61</td>
<td>67.1</td>
</tr>
<tr>
<td>Total</td>
<td>94</td>
<td>100</td>
</tr>
</tbody>
</table>

Participant's level of experience of interpreting/translating traumatic material had a wide range. Two participants estimated that they had never done such work and one participant estimated that they had done more than 8000 hours. The mean number of total hours worked in interpreting/translating trauma was 508. Participants years of experience was biased in favour of those who had at least one years experience (see Table 4).

Table 4: Participants years of experience

<table>
<thead>
<tr>
<th>Experience</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>One month</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>2-6 months</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>7 months - 1 year</td>
<td>8</td>
<td>7.3</td>
</tr>
<tr>
<td>1-2 years</td>
<td>13</td>
<td>11.8</td>
</tr>
<tr>
<td>2-3 years</td>
<td>15</td>
<td>13.6</td>
</tr>
<tr>
<td>Over three years</td>
<td>69</td>
<td>62.7</td>
</tr>
<tr>
<td>Missing</td>
<td>3</td>
<td>2.7</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Most participants worked only a few hours per week interpreting/translating trauma material (see table five).

Table 5: Hours per week worked by participants in interpreting/translating trauma material.

<table>
<thead>
<tr>
<th>Hours per week</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>35</td>
<td>31.8</td>
</tr>
<tr>
<td>2-3</td>
<td>18</td>
<td>16.4</td>
</tr>
<tr>
<td>4-5</td>
<td>20</td>
<td>18.2</td>
</tr>
<tr>
<td>5-10</td>
<td>16</td>
<td>14.5</td>
</tr>
<tr>
<td>11-15</td>
<td>8</td>
<td>7.3</td>
</tr>
<tr>
<td>16-20</td>
<td>3</td>
<td>2.7</td>
</tr>
<tr>
<td>21-25</td>
<td>3</td>
<td>2.7</td>
</tr>
<tr>
<td>26-30</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Missing</td>
<td>6</td>
<td>5.5</td>
</tr>
<tr>
<td>Total</td>
<td>109</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Procedure
Ethics approval was obtained by the University of Surrey Ethics Committee (Appendix two).

Contact was made with a translation agency through the local trust traumatic stress department. Contact with this local translation department facilitated an invitation to present the research proposal to the Annual General Meeting of translation agencies in the local health district. Following this meeting, several agencies were keen to be involved and arrangements were made for the distribution of questionnaires with four agencies that were furthest apart geographically. This helped minimise the chance of one participant who was registered with two agencies in abutting areas receiving two questionnaires. Participants were asked to give their date of birth on the questionnaire in order to ensure, by cross-referencing with other demographic variables, that no duplication occurred in the database. In the event, no two participants reported the same date of birth.
Each participant received a cover letter from their agency, an information sheet (appendix three), a consent form (appendix four), a set of demographic and qualitative questions (appendix five) and four standardised measures (appendices six to nine). Confidentiality was assured and participants were told that they could withdraw from the research at any time without prejudicing their work with the Interpretation/Translation agency.

Viljoen and Wolpert (2002) recommend ten points to improve response rates in questionnaire survey research. Most of these were followed, including using simple language, keeping questions short, including a cover letter from the relevant translation agency head supporting the research, paying for postage and requesting that translation agencies let their members know that the research was imminent by placing flyers in their offices. Other suggestions such as paying participants and printing the questionnaires on coloured paper were not followed due to cost. Each agency was given a summary of the results following data analysis.

Measures
The questionnaire pack contained four two standardised measures, two unstandardised measures and additional questions regarding demographic details and qualitative information pertinent to the hypotheses.

1. Demographic questionnaire (appendix five)
The initial questionnaire asked participants their age, gender, refugee status, country of origin, length of time in the UK, level of education, how much trauma work they did, how long they had done such work for, the setting where they did this work, what types of traumatic interpreting/ translating they had done, their personal history of trauma, their sources of support, what aspects of their jobs they had found most difficult, why they thought this was, positive aspects of their job and recommendations they would make to improve coping with stresses in their profession.

2. Secondary Trauma Questionnaire (STQ) (Motta, Kefer, Hertz and Hafeez, 1999) (appendix six).
This measure assesses negative effects of listening to traumatic stories by self-report. Participants were asked to complete the questionnaire in relation to their work as an interpreter/translator. Items on the scale are related to the DSM-IV criteria for PTSD and also draw on the Compassion Fatigue Self-test for Psychotherapists (Figley, 1995). The authors suggest that the STQ can be used with a number of different populations, as opposed to the Compassion Fatigue Self-test for Psychotherapists, which was developed specifically for assessing STS in therapists. The STQ is the only measure specifically designed to measure secondary trauma (Sabin-Farrell and Turpin, 2003).

With a traumatic scenario from their work experience in mind, participants are asked to rate 20 items related to PTSD on a 1-5 scale (1= Rarely/never, 2= At times, 3= Not sure, 4= Often, 5= Very often) following the hypothesis that vicarious trauma and PTSD will manifest similar symptomatology. Re-experiencing of the client's distress, avoidance of stimuli that was significant to the experience that was interpreted/translated, intrusive thoughts related to clients experiences and changes in increase arousal such as irritability. It is scored on a continuous scale that reflects the frequency of these symptoms and therefore, by implication, the severity of PTSD-like symptoms. No cut-off scores have been developed for this measure at the time of writing.

Motta et al (1999) found the scale has internal consistency of 0.75 when tested on a sample of 157 students who reported on traumatic events that happened to a friend. When tested on mental health workers reporting the trauma of a client internal consistency was 0.88. Motta et al (1999) also report correlations with established measures of trauma of 0.33-0.56 (p<.01). These results suggest that the scale has good internal consistency and validity.

In a study of 114 students, Motta, Hafeez, Sciancalpepore and Diaz (2002) found good internal consistency and discriminant validity when compared with the Beck Anxiety Inventory and the Modified PTSD symptoms scale.

3. Post-traumatic Cognitions Inventory (PTCI) (Foa, Ehlers, Clark, Tolin and Orsillo, 1999) (appendix seven).
This scale has been developed to elicit the presence of trauma related thoughts and beliefs. Theoretically it follows Information Processing theories of PTSD, which focus on trauma-related threat and how trauma-related information is represented in the cognitive system (Foa and Rothbaum, 1998). Specifically it suggests that symptoms are maintained by thoughts that the self is incompetent and the world is a dangerous place following a traumatic event. It is a self-report measure with thirty-three statements regarding trauma related beliefs which participants rated on a 1-7 analogue scale (1= Totally disagree, 2= Disagree very much, 3=Disagree slightly, 4= Neutral, 5=Agree slightly, 6= Agree very much, 7= Totally agree). Following previous research using this questionnaire by Allt (1999) and Clare (2002) and the suggestion of Sabin-Farrell and Turpin (2003) in relation to research in VT, some items in the scale were dropped, as they did not make sense for a non-clinical population. Specifically the items: "The event happened to me because of the way I acted" and: "There is something about me that made the event happen" were deleted. Scoring was adapted to take account of these changes.

An overall (total) score of trauma related beliefs is comprised of three subscales: negative cognitions about the self, negative cognitions about the world, self-blame. The authors report internal consistency (Cronbach’s alpha) results of 0.97, 0.88 and 0.86 respectively for these subscales, with 0.97 for the total score. This level of alpha is considered to denote good internal consistency (Tabachnik and Fidell, 1996).

Test-retest reliability was also assessed by the authors. Results from this investigation are shown in table seven indicating Spearman’s rho reliability co-efficients of p=0.75 (negative cognitions about self), p=0.89 (negative cognitions about the world), 0.89 (self blame) and 0.74 (total score). These results indicate that the PTCI has good test-re-test reliability.
When compared with other measures of PTSD severity the PTCI demonstrated moderate to strong correlations and also showed discriminative utility in judging the presence or absence of PTSD (Foa, Ehlers, Clark, Tolin and Orsillo, 1999). The authors also cite studies suggesting the PTCI has good convergent validity with other measures of belief (the Personal Beliefs and Reactions Scale and the World Assumptions Scale).

The PTCI suffers from not having established norms related to its use within the workplace. Additionally its three factor structure does not cover all of the schemas suggested to be implicated in VT by McCann and Pearman (1990). Perhaps a better measure to approach assessment of cognitions of VT is the Traumatic Stress Institute's Belief Scale (Revision L) (Pearlman, 1996). This scale contains norms based on research that discriminated between trauma survivors versus control group. It is also designed by the author to tap the schemas related to the cognitive model of VT as described by McCann and Pearman (1990). It was not used in this study as it was not obtainable at the time that the questionnaires were distributed. The Young Schema Questionnaire (Young, ) could also have been used to give further information about the schemas of participants. Use of another questionnaire may, however, have made the pack of questionnaires supplied to participants too long.

4. Maslach Burnout Inventory (Maslach and Jackson, 1981) (appendix eight)
This 22-item scale is commonly used among staff in mental health settings and measures three aspects of “burnout” on a 0-7 scale (0= Never, 1= A few times a year or less, 2= Once a month or less, 3= A few times a month, 4= once a week, 5= a few times a week, 6= every day): emotional exhaustion, depersonalisation and lack of personal accomplishment. High scores on emotional exhaustion and depersonalisation scales along with low sense of personal accomplishment indicate burnout in the respondent. The authors provide three bands of burnout, low medium and high. They also report reliability co-efficients of 0.90, 0.79 and 0.71 for the three scales respectively. The also detail convergent and discriminent validity based on normative data established with 1384 participants across occupations.

5. Impact of Events Scale – Revised (Weiss and Marmar, 1997) (appendix nine)
Weiss and Marmar developed the established Impact of Events Scale IES (Horowitz, Wilner and Alvarez, 1979) to mirror the DSM-IV criteria for PTSD. The previous IES was designed before PTSD was recognised by DSM and only tapped two of the four criteria (intrusion and avoidance). The IES-R is similar to the IES. It is a self-report measure designed to assess current subjective stress for a specific life-event. Seven items were added, six that tap hyperarousal and one further intrusions item that taps dissociative experience. These seven items were randomly interspersed within the order of the items. Participants rate each item on a scale of 0 (not at all), 1 (rarely), 3 (sometimes), 5 (often), according to their experiences in the previous seven days.

Briere (1997) used Cronbach's alpha to measure the scale's internal consistency across four population samples and reported reliability co-efficients of 0.87-0.92 for intrusions, 0.84-0.86 for avoidance and 0.79-0.90 for hyperarousal.

Test-retest reliability was assessed with data from two samples by Weiss and Marmar (1997) using Pearson's r. In the first sample intrusions, avoidance and hyperarousal scores 0.57, 0.51 and 0.59 respectively, in the second they scored 0.94, 0.89 and 0.92 respectively. They suggest that the higher correlations for sample two are due to a shorter interval between administrations of the measure and comparative recency of the criterion A event.

With regard to predictive (criterion) validity the original IES intrusion and avoidance components have been shown to be sensitive to degree of trauma experienced and changes over time (Wiess and Marmar, 1997, Horowitz et al, 1979). The hyperarousal component has also been shown to have good predictive validity (Briere, 1997). Content validity for the hyperarousal scale has not been established, but Horowitz et al report endorsements of up to 85% for the original scale.

**Power analysis**

Gpower was employed to give a power analysis estimate for two-tailed test of means. Assuming a medium effect size ($R^2 \approx 0.5$) with an alpha value of 0.05 and a power of 0.75 a total sample size of 114 was indicated. A medium effect size was assumed as no previous research has been conducted with this population, therefore no assumptions
could be made. The final sample was slightly smaller than this. As the difference between the number suggested by Gpower and the number of participants in the sample was small, the analysis was carried out. A number of significant results were found. This suggests that the sample size was sufficient to have avoided type two error. As such, the results were thought of as robust.

Gpower was also employed to give a power analysis estimate for correlations analysis. Assuming a medium effect size ($R^2 \approx 0.3$), an alpha value of 0.05 and a power of 0.8 the total sample size suggested was 82.

**Statistical analysis**

Statistical tests appropriate for each research question were conducted as shown in table six.

Table 6: Research question and statistical analysis test

<table>
<thead>
<tr>
<th>Research question</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do women have higher scores in relation to their interpretation work?</td>
<td>Independent groups Mann-Whitney U test</td>
</tr>
<tr>
<td>2. Is a personal history of trauma related to higher scores on the outcome measures?</td>
<td>Independent groups Mann-Whitney U test</td>
</tr>
<tr>
<td>3. Is the weekly amount of work engaged in related to higher scores on the outcome measures?</td>
<td>Correlation</td>
</tr>
<tr>
<td>4. Are places of work or the number of places of work related to higher scores on the outcome measures?</td>
<td>Correlation</td>
</tr>
<tr>
<td>5. Is amount of experience related to lower scores on outcome measures?</td>
<td>Correlation, Independent groups Mann-Whitney U test</td>
</tr>
</tbody>
</table>
Results

Survey results: Standardised DV measures
All 110 participants completed all of the questionnaire items. The scoring on each measure was as follows:

Impact of Events Scale – Revised (IES-R)
Seven participants (6.4%) scored in the “severe” category of the IES total. Although there are no established norms for the IES-R (Cornille and Meyers, 1999), this score would almost certainly indicate casesness for the presence of PTSD. The figures reported here are similar to the results found by Kessler, Sonnega, Bromet, Hughes and Nelson (1995) in the national co-morbidity study in the USA who found a lifetime prevalence of PTSD of 7.8% (10.4% of women and 5% of men) in a sample of 5877 people using DSM-III criteria, which is similar to the IES-R is based. In a telephone survey of 2181 people in Detroit in the USA, Breslau, Kessler, Chilcoat, Schultz, Davis and Andreski (1998) found an overall rate of PTSD following exposure to a traumatic event of 9.2% (13.0% in women, 6.2% in men). These figures are an increase on the older prevalence research conducted by Helzer, Robbins and McEvoy (1987) who found a rate of 1.35% when using the older DSM-III classification system. It is possible that changes in classification systems and measurement tools played some part in this difference in estimated prevalence rates. A further 13 (11.8%) scored in the “moderate” range in the current study.

Maslach Burnout Inventory (MBI)
Maslach and Jackson (1981) provide means and standard deviations specifically for 730 “Mental Health Workers (psychologist, psychotherapists, counsellors, mental hospital staff and psychiatrists)”. These norms were used for comparison with this sample.

Eight participants (7.3%) scored in the “high” range on the emotional exhaustion scale. A further 11 (10%) scored in the “moderate” range. Maslach and Jackson (1981) recommend that the categories are used more for information for individual respondents and that the MBI is not a suitable tool for diagnosis of Burnout as there is insufficient
research into its use. It is also worth remembering that Burnout per se is not a medical diagnosis.

Seven participants (6.4%) scored in the “high” range on the Depersonalisation scale. Thirteen (11.8%) scored in the “moderate” range.

Twenty-three (20.7%) scored in the “low” range of the Personal Achievement scale. This suggests that these participants find no sense of well-being or fulfilment from their work and are at risk of becoming demoralised.

Research question results
Dependent variables in this analysis were the questionnaire measures described in the Method section above. Independent variables are detailed below, analysed individually by each research question.

Variables were tested for normality using the one sample Kolmogorov-Smirnov test. The following variables distributions varied significantly from a normal distribution: Personal experience of violence trauma; personal experience of accident trauma; personal experience of trauma of either type; number of places of work; gender; amount of experience; refugee status; amount of education; and social support. Non-parametric tests were used for the analysis of these variables. Age was normally distributed.

Care was taken in the interpretation of results as a large number of correlations had been conducted on the database. This can lead to results being deemed significant when they may not be so (Type 1 error) (Tabachnik and Fidell, 1996). Therefore caution was exercised in the interpretation of results that were above the 0.01 significance level. Two-tailed tests were used even though directional research questions were posed, as the analysis was exploratory in nature.

1. Do women have higher scores in relation to their interpretation work? 
This research question was analysed with a two-tailed independent samples Mann-Whitney U test. None of the dependent variables yielded significant results. This analysis may be compromised by the fact that there were only 22 men compared with 76 women (12= missing data).
2. Is a personal history of trauma related to higher scores on the outcome measures?
Three independent variables were used to analyse this question: personal experience of violence, personal experience of accidents and personal trauma of either type. Two-tailed independent samples Mann-Whitney U tests were used for statistical analysis.

Personal history of violent trauma
Participants who answered 'yes' to the question “Have you had a personal experience of violent physical trauma, such as rape, torture, beating in the past? (Yes or no is sufficient)” were significantly related to several of the dependent measures, as shown in table seven.
Table 7: Dependent variables observed to have significant relationships to participants answer to the questions “do you have a history of personal violence trauma?”

<table>
<thead>
<tr>
<th>Dependent measure</th>
<th>Personal trauma</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Mean rank</th>
<th>z- value</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>STQ total score</td>
<td>Yes</td>
<td>34</td>
<td>32.01</td>
<td>10.11</td>
<td>69.15</td>
<td>-3.150</td>
<td>0.002*</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>75</td>
<td>32.01</td>
<td>10.11</td>
<td>48.59</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTCI factor 1</td>
<td>Yes</td>
<td>30</td>
<td>32.68</td>
<td>14.09</td>
<td>66.70</td>
<td>-3.210</td>
<td>0.001*</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>73</td>
<td>32.68</td>
<td>14.09</td>
<td>45.96</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTCI Factor 3</td>
<td>Yes</td>
<td>32</td>
<td>5.08</td>
<td>2.52</td>
<td>69.44</td>
<td>-3.548</td>
<td>0.000*</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>74</td>
<td>5.08</td>
<td>2.52</td>
<td>46.61</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MBI EE</td>
<td>Yes</td>
<td>27</td>
<td>12.55</td>
<td>9.92</td>
<td>53.81</td>
<td>-</td>
<td>0.023</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>61</td>
<td>12.55</td>
<td>9.92</td>
<td>40.38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTCI total score</td>
<td>Yes</td>
<td>28</td>
<td>72.88</td>
<td>25.41</td>
<td>63.02</td>
<td>-2.692</td>
<td>0.007*</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>72</td>
<td>72.88</td>
<td>25.41</td>
<td>45.63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IES avoidance</td>
<td>Yes</td>
<td>32</td>
<td>7.93</td>
<td>7.82</td>
<td>61.16</td>
<td>-2.096</td>
<td>0.036</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>71</td>
<td>7.93</td>
<td>7.82</td>
<td>47.87</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IES intrusions</td>
<td>Yes</td>
<td>32</td>
<td>5.38</td>
<td>5.45</td>
<td>68.84</td>
<td>-3.549</td>
<td>0.000*</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>73</td>
<td>5.38</td>
<td>5.45</td>
<td>46.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IES hyperrarousa I</td>
<td>Yes</td>
<td>32</td>
<td>3.07</td>
<td>4.74</td>
<td>65.42</td>
<td>-3.052</td>
<td>0.002*</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>72</td>
<td>3.07</td>
<td>4.74</td>
<td>46.76</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IES total score</td>
<td>Yes</td>
<td>30</td>
<td>16.10</td>
<td>16.64</td>
<td>60.78</td>
<td>-2.917</td>
<td>0.004*</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>66</td>
<td>16.10</td>
<td>16.64</td>
<td>42.92</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Significant at the 0.01 level.

Personal history of accident trauma

Participants who answered ‘yes’ to the question “Have you had experience of other types of trauma, such as serious car crashes, natural disasters (e.g.: earthquakes) or being caught in a fire? (Yes or no is sufficient)” were significantly related to dependent measures as shown in table eight.
Table 8: Dependent variables observed to have significant relationships to participants answer to the questions “do you have a history of personal accident trauma?”

<table>
<thead>
<tr>
<th>Dependent measure</th>
<th>Personal trauma</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Mean rank</th>
<th>z-value</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>STQ total score</td>
<td>Yes</td>
<td>40</td>
<td>32.01</td>
<td>10.11</td>
<td>66.71</td>
<td>-2.949</td>
<td>0.003*</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>69</td>
<td></td>
<td></td>
<td>48.21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MBI EE</td>
<td>Yes</td>
<td>32</td>
<td>12.55</td>
<td>9.92</td>
<td>53.91</td>
<td>-2.614</td>
<td>0.009*</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>56</td>
<td></td>
<td></td>
<td>39.13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IES avoidance</td>
<td>Yes</td>
<td>38</td>
<td>7.93</td>
<td>7.82</td>
<td>59.16</td>
<td>-2.022</td>
<td>0.043</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>64</td>
<td></td>
<td></td>
<td>46.95</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Significant at the 0.01 level.
Personal history of trauma of either type
Participants who answered ‘yes’ to either of these questions obtained scores that were observed to be significantly related to dependent measures as shown in table nine.

Table 9: Dependent variables observed to have significant relationships to participants who had personal experience of either type of trauma.

<table>
<thead>
<tr>
<th>Dependent measure</th>
<th>Personal trauma</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Mean rank</th>
<th>z-value</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>STQ total score</td>
<td>Yes</td>
<td>58</td>
<td>32.01</td>
<td>10.11</td>
<td>63.87</td>
<td>-2.910</td>
<td>0.004*</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>52</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTCI factor 1</td>
<td>Yes</td>
<td>54</td>
<td>32.60</td>
<td>14.09</td>
<td>59.97</td>
<td>-2.851</td>
<td>0.004*</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>49</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTCI factor 3</td>
<td>Yes</td>
<td>56</td>
<td>5.08</td>
<td>2.25</td>
<td>59.80</td>
<td>-2.258</td>
<td>0.024</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MBI EE</td>
<td>Yes</td>
<td>46</td>
<td>12.55</td>
<td>9.92</td>
<td>51.11</td>
<td>-2.310</td>
<td>0.021</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>43</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTCI total score</td>
<td>Yes</td>
<td>52</td>
<td>72.88</td>
<td>25.41</td>
<td>56.64</td>
<td>-2.205</td>
<td>0.027</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>48</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IES avoidance</td>
<td>Yes</td>
<td>54</td>
<td>7.93</td>
<td>7.82</td>
<td>58.39</td>
<td>-2.287</td>
<td>0.022</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>49</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IES intrusions</td>
<td>Yes</td>
<td>54</td>
<td>5.38</td>
<td>5.45</td>
<td>60.93</td>
<td>-2.759</td>
<td>0.006*</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>51</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IES hyper-arousal</td>
<td>Yes</td>
<td>55</td>
<td>3.07</td>
<td>4.74</td>
<td>60.68</td>
<td>-3.071</td>
<td>0.002*</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>49</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IES total score</td>
<td>Yes</td>
<td>49</td>
<td>16.10</td>
<td>16.64</td>
<td>54.70</td>
<td>-2.239</td>
<td>0.025</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>47</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Significant at the 0.01 level.
3. Is the weekly amount of work engaged in related to higher scores on the outcome measures?
This research question was assessed by two independent measures, weekly amount of work and length of experience.

Weekly amount of work.
A correlation analysis was conducted (Spearman's rho) between the self-reported number of hours worked per week and the dependent measures. No significant differences were observed on any of the dependent variables except the MBI personal achievement sub-scale ($r(87)=0.335$, $p=0.002$, 2-tailed test). Given the reversed scoring of the personal achievement sub-scale, this means that, in this sample, interpreters were experiencing a lower sense of personal achievement with higher levels of work. The significance level is above 0.01 and the correlation is not very high, therefore, this result may have limited meaningfulness.

4. Are places of work or the number of places of work related to higher scores on the outcome measures?
For this analysis, two-tailed independent samples Mann-Whitney U tests were conducted for each place of work on the questionnaire with no significant findings. A correlation analysis (Spearman's rho) was conducted between the number of different places where an interpreter worked and the dependent measures. Significant correlations were observed on the IES intrusions sub-scale ($r(103)=0.209$, $p=0.034$, 2-tailed test) and the IES hyperarousal sub-scale ($r(102)=0.214$, $p=0.031$, 2-tailed test). It may be that working across a number of places does not give interpreters/translators a chance to build up a rapport with co-workers in other professions and as a result suffer greater amounts of stress. Again, the significance levels are above 0.01 and the correlations are not very high, therefore, these results should be interpreted cautiously. The correlation figures are also weak, therefore these results may have limited meaningfulness.

5. Is amount of experience (how long a person has been working as an interpreter) related to lower scores on outcome measures?
A correlation analysis was performed (Spearman’s rho). No significant results were observed. This may be because length of time presents as a U-shaped curve rather than a linear relationship.

A two-tailed independent groups Mann-Whitney U test was conducted between those with less than two years experience and those with more than two years. The figure of two years was chosen as any shorter amount of time would have left too few participants in the less experienced group to perform an analysis. No significant difference was observed between these two groups. As only 12% of the sample had worked for less than two years it was thought that there were too few participants with sufficiently little experience to make any meaningful comparisons and the analysis was not carried any further.

6. Is unresolved refugee status related to higher scores on the outcome measures?
This analysis was abandoned, as there were too few participants who identified themselves as refugees (n=9, 8.2%).

7. Is younger age related to higher scores on the outcome measures?
A correlation analysis (Pearson’s r) was conducted. Significant negative correlations were observed between STQ total (r(110)=-0.244, p=0.010, 2-tailed test) and MBI emotional exhaustion sub-scale (r(89)=-0.243, p=0.022, 2-tailed test). Despite the fact that these correlations are weak, this result concurs with earlier studies of therapists that suggest that younger age may be a risk factor for vicarious traumatisation.

8. Is a longer time in education related to lower scores on the outcome measures?
A correlation analysis (Spearman’s rho) was performed. No significant correlations were observed.

9. Is number of sources of social support related to lower scores on the outcome measures?
Participants were asked who they spoke to about stresses they felt as a results of their work. No significant differences were observed on the dependent variables when t-tests were conducted comparing those who had at least one person to talk to about their
feelings regarding their work with those who reported talking to no-one. An ordinal scale of how many sources of social support each participant had was analysed with a correlation analysis (Spearman's rho). No significant correlations were observed.

10. Will trauma related cognitions, as measured by the PTCI, be related to higher scores on the IES-R and the STQ?

Dependent variables were tested for normality using the one sample Kolmogorov-Smirnov test and were found not to differ significantly from a normal distribution. A correlation analysis (Pearson's r, two-tailed test) was performed (see table ten).

The significance of the correlations for these measures was observed to be very strong. The correlations themselves were below the 0.4 cut-off usually thought to indicate strong associations (Tabachnik and Fidell, 1996). The correlations are strong enough to indicate that there is a relationship between the measures, without this relationship being so strong so as to render the STQ redundant. As such it may be deduced that VT/STS, as measured by the STQ is different to PTSD, as measured by the IES-R (r(96)=0.634, p=0.00). Similarly, the PTCI total score is different to the STQ total score (r(100)=0.532, p=0.000) and the IES-R (r(88)=0.451, p=0.000). This may mean that cognitions, as measured by the PTCI are related to VT/STS as measured by the STQ as well as to PTSD as measured by the IES-R. Comparison with the MBI shows similar results on the emotional exhaustion scale (r(89)=0.694, p=0.000) and the depersonalisation scale (r(91)=0.555, p=0.000).

This method of construct validation is the same as that used by Jenkins and Baird (2002) in their validation study. The results observed here are consistent with the constructivist self-development theory of McCann and Pearlman (1990), which suggests that cognitive schema are fundamentally changed in those who develop severe VT/STS reactions. It seems reasonable that this should be so in the light of the fact that psychological theories of other emotional disturbance, including PTSD, postulate that cognitions and schema are the motivating factors in development and maintenance of the difficulty (Ehlers and Clark, 2000).
Table 10: Correlations matrix showing the relationship between the PTCI, the IES-R and the STQ.

<table>
<thead>
<tr>
<th></th>
<th>STQ total</th>
<th>PTCI factor1</th>
<th>PTCI factor2</th>
<th>PTCI factor3</th>
<th>IES-R avoid.</th>
<th>IES-R intru.</th>
<th>IES-R hyper.</th>
<th>IES-R total</th>
<th>MBI EE</th>
<th>MBI DP</th>
<th>MBI PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>STQ total</td>
<td>1.00</td>
<td>.512</td>
<td>.356</td>
<td>.390</td>
<td>.531</td>
<td>.574</td>
<td>.599</td>
<td>.653</td>
<td>.634</td>
<td>.694</td>
<td>.555</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>110</td>
<td>103</td>
<td>103</td>
<td>104</td>
<td>96</td>
<td>89</td>
<td>91</td>
<td>86</td>
<td>86</td>
<td>91</td>
</tr>
<tr>
<td>PTCI factor1</td>
<td>1.00</td>
<td>.512</td>
<td>.429</td>
<td>.588</td>
<td>.890</td>
<td>.304</td>
<td>.312</td>
<td>.290</td>
<td>.341</td>
<td>.423</td>
<td>.329</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.001</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>108</td>
<td>103</td>
<td>105</td>
<td>102</td>
<td>95</td>
<td>89</td>
<td>91</td>
<td>86</td>
<td>86</td>
<td>91</td>
</tr>
<tr>
<td>PTCI factor2</td>
<td>.512</td>
<td>.429</td>
<td>1.00</td>
<td>.427</td>
<td>.766</td>
<td>.394</td>
<td>.325</td>
<td>.324</td>
<td>.443</td>
<td>.272</td>
<td>.160</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.010</td>
<td>.190</td>
<td>.009</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>106</td>
<td>103</td>
<td>106</td>
<td>102</td>
<td>95</td>
<td>89</td>
<td>91</td>
<td>86</td>
<td>86</td>
<td>91</td>
</tr>
<tr>
<td>PTCI factor3</td>
<td>.512</td>
<td>.429</td>
<td>.100</td>
<td>.691</td>
<td>.262</td>
<td>.303</td>
<td>.222</td>
<td>.296</td>
<td>.347</td>
<td>.186</td>
<td>.061</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.002</td>
<td>.004</td>
<td>.001</td>
<td>.079</td>
<td>.057</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>110</td>
<td>103</td>
<td>107</td>
<td>103</td>
<td>95</td>
<td>89</td>
<td>91</td>
<td>86</td>
<td>86</td>
<td>91</td>
</tr>
<tr>
<td>IES-R avoid.</td>
<td>.574</td>
<td>.304</td>
<td>.394</td>
<td>.262</td>
<td>.419</td>
<td>.757</td>
<td>.721</td>
<td>.934</td>
<td>.413</td>
<td>.030</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td>.002</td>
<td>.008</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>103</td>
<td>95</td>
<td>103</td>
<td>96</td>
<td>88</td>
<td>87</td>
<td>86</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IES-R intru.</td>
<td>.574</td>
<td>.304</td>
<td>.394</td>
<td>.262</td>
<td>.419</td>
<td>.757</td>
<td>.721</td>
<td>.934</td>
<td>.413</td>
<td>.030</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td>.002</td>
<td>.008</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>103</td>
<td>95</td>
<td>103</td>
<td>96</td>
<td>88</td>
<td>87</td>
<td>86</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IES-R hyper.</td>
<td>.574</td>
<td>.304</td>
<td>.394</td>
<td>.262</td>
<td>.419</td>
<td>.757</td>
<td>.721</td>
<td>.934</td>
<td>.413</td>
<td>.030</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td>.002</td>
<td>.008</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>103</td>
<td>95</td>
<td>103</td>
<td>96</td>
<td>88</td>
<td>87</td>
<td>86</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IES-R total</td>
<td>.574</td>
<td>.304</td>
<td>.394</td>
<td>.262</td>
<td>.419</td>
<td>.757</td>
<td>.721</td>
<td>.934</td>
<td>.413</td>
<td>.030</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td>.002</td>
<td>.008</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>103</td>
<td>95</td>
<td>103</td>
<td>96</td>
<td>88</td>
<td>87</td>
<td>86</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MBI EE</td>
<td>.694</td>
<td>.423</td>
<td>.272</td>
<td>.347</td>
<td>.425</td>
<td>.458</td>
<td>.490</td>
<td>.515</td>
<td>.551</td>
<td>.706</td>
<td>.050</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td>.010</td>
<td>.001</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>89</td>
<td>88</td>
<td>88</td>
<td>88</td>
<td>85</td>
<td>85</td>
<td>84</td>
<td>79</td>
<td>89</td>
<td>82</td>
</tr>
<tr>
<td>MBI DP</td>
<td>.555</td>
<td>.329</td>
<td>.160</td>
<td>.186</td>
<td>.308</td>
<td>.413</td>
<td>.328</td>
<td>.488</td>
<td>.423</td>
<td>.706</td>
<td>.064</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td>.010</td>
<td>.001</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>91</td>
<td>85</td>
<td>85</td>
<td>85</td>
<td>87</td>
<td>87</td>
<td>85</td>
<td>80</td>
<td>85</td>
<td>86</td>
</tr>
<tr>
<td>MBI PA</td>
<td>-.075</td>
<td>-.192</td>
<td>-.273</td>
<td>-.611</td>
<td>-.238</td>
<td>-.030</td>
<td>.009</td>
<td>.036</td>
<td>-.048</td>
<td>.050</td>
<td>.064</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.477</td>
<td>.076</td>
<td>.009</td>
<td>.567</td>
<td>.028</td>
<td>.781</td>
<td>.934</td>
<td>.743</td>
<td>.671</td>
<td>.565</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>91</td>
<td>86</td>
<td>89</td>
<td>85</td>
<td>86</td>
<td>88</td>
<td>86</td>
<td>80</td>
<td>82</td>
<td>86</td>
</tr>
</tbody>
</table>
Discussion

The aims of this study were to survey VT among interpreters and translators with regard to demographic, personal history and work-related variables as well as assessing the presence of trauma-related cognitions in relation to VT.

Survey results

Prevalence of PTSD symptoms in the research sample

As stated in the results section, seven participants (6.4%) scored in the "severe" category of the IES total. This score would indicate casesness for the presence of PTSD and is similar to the results found in community studies by Kessler, Sonnega, Bromet, Hughes and Nelson (1995) of 7.8% and Breslau, Kessler, Chilcoat, Schultz, Davis and Andreski (1998) who found an overall rate of PTSD following exposure to a traumatic event of 9.2%. A further 13 (11.8%) scored in the "moderate" range in the current study. As such, it does not appear that there is an increased incidence of PTSD among interpreters and translators compared with general population studies.

Previous researchers have suggested that, in surveys, many of those who were experiencing PTSD symptoms may not complete questionnaires as they were avoiding thinking about their symptoms (Bennett and Brooke, 1999, Copeland, 2001). As such this figure of 6.4% may represent an underestimate of the true figure. This suggestion is further supported by the demographic information. Fewer participants came from the upper and lower age ranges (see table one in method section), the more vulnerable ages according to Kessler et al. (1995). Only 13.2% of the sample had spent less than five years in the UK and may have found that their memories of their home country were at a far enough remove so as to be less distressing, as PTSD symptoms can spontaneously remit over time (Ehlers and Clark, 2000). Only 13.6% of the sample had had less than 3 years experience of interpreting/translating and only 7.3% of the sample worked more than 10 hours a week. This may mean that those who are doing more interpreting/translating did not complete the questionnaire pack and may be experiencing greater distress. The low response rate also makes it difficult to make definitive statements related to these findings.
Prevalence of VT in the research sample

This is harder to comment on definitively, as currently the STQ does not have cut-off points or established normative data. Other studies of VT have used the IES-R as the dependent measure of VT as there was no specific VT measure available at that time (Cornille and Meyers, 1999). They suggest the IES-R can be used for analysis of VT in this way, as there is no agreement about what level of distress qualifies a respondent for a diagnosis of either PTSD or STS. Cornille and Meyers (1999) do not report the IES-R results from their study as there are no reported norms. They defined VT instead with a combination of symptoms derived from the IES-R and the Brief Symptom Index. They suggest from this method of analysing their results that 37% of child service protection workers were found to be experiencing clinical levels of distress associated with VT. This is considerably higher than the score for 'severe' VT as compared with the IES-R cut-off points, however, if taken together with what would have been the 'moderate' scores the figure for VT in this sample would be 64 people (60%). This seems like a very high figure for VT. It may be that neither method is correct for establishing a cut-off point and further research is needed in order to clarify what level of distress is sufficient to qualify as clinically significant VT.
### Research Questions

A brief summary of the results by research question is given in table eleven.

#### Table 11: Research question and statistical analysis test result

<table>
<thead>
<tr>
<th>Research question</th>
<th>Analysis result</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do women have higher scores in relation to their interpretation work?</td>
<td>No significant results observed.</td>
</tr>
<tr>
<td>2. Is a personal history of trauma related to higher scores on the outcome measures (personal history of violent trauma, personal history of accident trauma, personal history of either type)?</td>
<td>Significantly related to STQ, PTCI factors 1 and 3, MBI emotional exhaustion subscale, PTCI total score, IES intrusions, hyperarousal and avoidance subscales and MBI total score.</td>
</tr>
<tr>
<td>3. Is the weekly amount of work engaged in related to higher scores on the outcome measures?</td>
<td>Negatively correlated with MBI personal achievement sub-scale.</td>
</tr>
<tr>
<td>4. Are places of work or the number of places of work related to higher scores on the outcome measures?</td>
<td>Significantly related to higher scores on the IES intrusions and hyperarousal subscales.</td>
</tr>
<tr>
<td>5. Is amount of experience related to lower scores on outcome measures?</td>
<td>No significant results observed.</td>
</tr>
<tr>
<td>6. Is unresolved refugee status related to higher scores on the outcome measures?</td>
<td>No significant results observed, analysis abandoned as too few refugees in sample.</td>
</tr>
<tr>
<td>7. Is younger age related to higher scores on the outcome measures?</td>
<td>Significantly related to higher scores on the STQ and MBI emotional exhaustion scale.</td>
</tr>
<tr>
<td>8. Is a longer time in education related to lower scores on the outcome measures?</td>
<td>No significant results observed.</td>
</tr>
<tr>
<td>9. Is social support related to lower scores on the outcome measures?</td>
<td>No significant results observed.</td>
</tr>
<tr>
<td>10. Will trauma related cognitions, as measured by the PTCI, be related to higher scores on the IES-R and the STQ?</td>
<td>All measures significantly correlated at varying levels of correlation.</td>
</tr>
</tbody>
</table>
Among the research questions only personal history of trauma and age were significantly related to higher scores on more than one outcome measure. These results are consistent with other findings among vicarious trauma literature (Pearlman and Maclan 1995), but were inconsistent with other findings such as Schauben and Frazier (1995) who found no correlation between previous personal trauma and VT. What is most interesting about the results in the present study is the dependent measures with which the variable of personal trauma history were significantly related. The STQ, the MBI emotional exhaustion scale and the IES avoidance scale, all appear in all three analyses (personal experience of violence, personal experience of accidents and personal experience of either). With a history of personal trauma it might be reasonable to expect the IES scores to be present, although how long ago the history of trauma was for the individual or how well they had recovered from it is unknown. The finding that the STQ is related to this personal traumas may be evidence that traumatic feelings and thoughts were re-awakened by interpreting/translating for others. The finding that PTCI factor one and factor three are also significant related to personal history of trauma is consistent with McCann and Pearlman's (1995) theory on vicarious trauma, that cognitions about the self and the world maintain the presence of VT. The findings for the variable of age show that younger age is significantly related to higher STQ and MBI emotional exhaustion scales. Taken together these variables could be thought of as potential vulnerability factors for VT in this sample.

Number of places of work showed significant correlations with higher scores on the IES intrusions and hyperarousal sub-scales. Although neither of these correlations are particularly high, it is notable that it is PTSD symptoms that are associated with multi-site working, rather than burnout symptoms. It may be that the opportunity to build up a rapport with others whom one works alongside, allows people to vent feelings regarding their work. No such relationship may mean that interpreters have no opportunity to express their feelings or feel a sense of support from others and results in them experiencing higher than average symptoms of intrusive thoughts related to trauma and hyperarousal. If this were the case, it is interesting that other outcome measures were not related to work place variables. There may be something specifically about lack of support from peers that ameliorates the PTSD symptoms of hyperarousal and intrusions. Alternatively, it may be that the intensity of the reaction of the participant to their work in
a work environment that lacked support of any sort caused them to experience more severe, clinical symptoms of PTSD (hyperarousal and intrusions) and masked the presence of scores on the STQ.

**Cognitions and VT**
The theory behind the VT model suggests that schema distortion in response to repeatedly hearing traumatic material leads to chronic changes in emotion and behaviour similar to PTSD symptoms. In order to test this notion among a sample of interpreters/translators, the PTCI was used to assess the level of trauma related thoughts that occurred in this sample. As there are no norms for the PTCI, correlations with the IES-R and STQ were used as evidence that cognitive processes might be suggested to underlie manifestations of VT and PTSD-type symptoms.

The results in table ten (at the end of the results section) show that there are significant relationships between all the dependent measures. Interestingly, the correlations between the PTCI total score and the STQ are higher than between the PTCI total score and any of the scales of the IES-R. There is no way of knowing in this sample if the traumatic cognitions experienced by the individual pre-dated their work as an interpreter/translator nor how well those with personal histories of trauma have recovered from any PTSD-type symptoms they may have had. Having said that, it is likely that anyone suffering very badly from PTSD symptoms would not be able to continue with work. This idea is supported by the finding of 6.4% of the sample scoring in the "severe" range of the IES-R, a figure slightly lower than that reported by Kessler et al.'s (1995) community study. As such, this sample could largely be thought of as a non-clinically distressed population. With this in mind, an analysis of the correlation matrix in table ten shows that correlations between the PTCI total score and the IES-R scales are lower than the correlation between the PTCI total score and the STQ total score. As such, it could be concluded that there is a link between symptoms of VT, as measured by the STQ and trauma-related cognitions, as measured by the PTCI, although temporal precedence is not known. This point in illustrated in figure one.
Figure 1: Correlations between the PTCI, IES-R and STQ

![Correlation Diagram]

It can be seen in this diagram that the STQ and IES-R scores are strongly correlated. This may reflect the fact that many similar questions appear in each questionnaire, since both are assessing for similar symptoms. As mentioned above, however, what is useful to note is the higher correlation between PTCI total score and STQ total score, than between the PTCI and IES-R scales. This suggests that cognitions of a traumatic nature may play a part in higher scores on the STQ. This finding supports the VT theory of McCann and Pearlman (1990) that suggests trauma related cognitions and consequent alterations in schema contribute to development of the PTSD-type symptoms seen in those experiencing VT. This is a process that is thought to take place slowly over time. It is regrettable that there were so few participants who were new to interpreting/translating, as further analysis of interpreters/translators across a greater range of experience might have helped to clarify the presence or absence of traumatic cognitions in a group who had not had long-term exposure to traumatic material.

In comparison with other studies on VT, it is interesting that Allt (1999) in a study of British Psychologists found correlations between those with trauma histories and PTCI factor two (negative cognitions about the world), whereas the present study found positive correlations between participants with a trauma history and PTCI factor one (negative cognitions about the self). It could be hypothesised that this is due to therapists feeling a greater sense of control over the situation of therapy, as they have
skills and knowledge and an understanding of what is happening with a client in therapy, whereas interpreters/translators are not able to be see themselves as an agent of change in the same manner. Psychologists may see trauma as reflecting negative attributes about the world in general, whereas interpreters/translators may feel that they are somehow personally at fault.

**Relationship to Burnout**

Both personal history of trauma and younger age were related to the MBI emotional exhaustion scale which Maslach and Jackson suggest reflects: "being emotionally over extended by one's work (p.6)". As relationship to Burnout was not one of the initial research questions, a post-hoc correlation analysis was conducted. It showed that there was only a weak correlation between those who scored in the 'severe' category of the IES-R (suggesting they would meet caseness for PTSD and/or may have symptoms of VT) and those scoring in the 'high' category for MBI emotional exhaustion (r=0.214, p<0.025). This level of significance is also less robust as is above the 0.01 level used in the rest of the study. This suggests that whilst many common features may manifest in PTSD, VT and Burnout, many people will develop VT without Burnout. It is worth noting as well that it is only one scale on the Burnout measure that is significantly related to VT in this sample. It may be that emotional exhaustion is one part of a larger picture of reactions to work with traumatic material and that Burnout and VT work together in an additive model of work related distress. It may also be that VT and Burnout both manifest in distressed workers yet are different phenomena, presenting co-morbidly. This suggestion is borne out by other researchers who have found that VT was related to the percentage of trauma client on the workload, whereas Burnout was not (Schauben and Frazier, 1995).

**Clinical implications**

**The extent of the ‘problem’ of VT**

The literature reviewed in the introduction and the results of this study do not demonstrate strong evidence for the existence of widespread amounts of PTSD-type symptoms. ‘Severe’ levels of PTSD symptoms, as measured by the IES-R were found in 6.4% of this sample, lower than other community-based studies. There is evidence that workers who have had previous personal history of trauma have a higher number of
trauma related cognitions and higher scores on the STQ. Similarly, there is evidence that age is related to higher scores on dependent measures in this and other samples. Multiple regression results in this study suggest that, taken together, the factors of personal trauma history and age explain about 15% of the variance observed in results on the STQ and lower percentages on the other dependent measures. Variables found to be modestly correlated with a variety of measures of VT and PTSD-type symptoms in previous research on therapists (gender, education, amount of exposure) were not found to be significantly related to the dependent measures in this study. This presents an inconclusive picture of what factors might contribute to the presence of VT.

Qualitative research (Illiffe and Steed, 2000) suggests that counsellors report processes of VT in interviews. This leaves a picture of workers exposed to traumatic material describing, in interview, stress resulting from this type of work, whilst not scoring significantly higher on standardised and unstandardised measures unless they have been traumatised themselves or are vulnerable due to their age. It may be that whilst the process of working with traumatised individuals is stressful and demanding, it is damaging in only some cases where other variables, such as previous history of trauma, are also present.

Interpreters are exposed to traumatic material in several settings (trauma clinics, legal firms, refugee agencies etc.). Many interpreters may have come to the UK from countries where they were badly treated and suffered traumatic events. It may be that these people did not respond when invited to participate as it was distressing to think about their experiences and they avoided the questionnaires. Interpretation agencies as well as those who work alongside interpreters in their professional capacities should be aware of the potential for interpreters to become vicariously traumatised through the process of their work. Social support has been suggested to be a protective factor by some studies (Hollingsworth, 1993). This was not assessed in detail in the present study. The importance of social support, including peer support, is highlighted by the finding regarding research question four. This found that those who worked across multiple agencies and workplaces experienced greater PTSD-type symptoms. Interpreters who work in this way and have personal histories of trauma may be at increased risk of being damaged by their work. Therapists and others using interpreters
in their work with traumatised clients should be aware of how much support is being offered to the interpreters and take appropriate action as necessary. Sampling bias in this study may have selected mostly the interpreters with better coping strategies.

With no standardised measures providing norms or cut-offs for the presence of VT, it is difficult to suggest exactly how many people might be thought to be suffering from their work. The results seem to suggest modest changes in trauma-related cognitions and slight elevation in PTSD symptoms and emotional exhaustion in those with previous trauma histories but overall there is no elevated overall percentage of PTSD in this sample, as measured by the IES-R. Employers should be aware of the nature of an interpreter/translators past and provide support as needed.

Limitations of study and suggestions for future research

Objectivity
The results reported in this study are of self-report measures, as such no independent verification of the stress reported by participants is available. It is possible that, as many of the items represent sensitive issues, some participants may have been reluctant to disclose fully their feelings, or may have been selective in their reporting. Arvay and Uhlemann (1996) suggest these concerns should be borne in mind when interpreting the data from postal questionnaire surveys.

Generalisability
It must be remembered that the results in this study are relationships amongst data, not causal relationships. The finding presented here are an initial sounding of this population with regard to VT and cannot, in their present form, be generalised to other populations or other samples. The results reported, whilst interesting, should be treated cautiously until further research has been conducted. Having said that, the results reported here show encouraging evidence from an initial survey that interpreters/translators are not suffering large-scale levels of stress and VT.

Relationship of age to VT
Interpreters/translators who were younger appeared to be suffering the greater distress. It may be that a U shaped curve would describe this phenomenon better, with those at
the older end of the age range also experiencing distress. This has been the finding of previous research into emotional reactions to traumatic events (Kessler et al, 1995). This was not addressed in this study due to the small number of participants in the upper age range.

*Dose-response*

This study did not assess the amount of traumatic material an individual would need to be exposed to in order to develop VT, a feature that the model of VT suggests is necessary in the development of VT. Sabin-Farrell and Turpin (2003) report that previous studies have used different measurements of dose (i.e.: either cumulative or proportional) and suggest that knowledge about amount of trauma material needed to cause adverse reactions is inconclusive. It is also not known whether such reactions are short or long term. Future research could assess participants at the beginning of their career and at time series afterwards in a within-subjects cohort study in order to address these concerns.

*Cultural bias in measures*

The measures used were all developed in the UK and the USA, and most of the research in this field has been conducted in the USA and Australia (Sabin-Farrell and Turpin, 2003). Although the interpreters/translators will be fluent in English, a cultural bias may exist. Different cultures may understand or talk about physical and psychological symptoms differently.

*Low return rate*

The return rate in this survey is below what has been found by other researchers. This may have biased the results towards participants who were less distressed and therefore not adverse to completing the questionnaires.

*Quality of personal information*

A major finding of this research is the relationship between personal history of trauma and higher scores on the measures. More information, about when the trauma had occurred, what was the nature of the trauma, whether the participant had received any therapy to help deal with the trauma, whether they felt that the trauma severely affected
their functioning, whether they had experienced trauma as a child or an adult and so on would have greatly added to the understanding of how these variables interact.

**Normative data in measures**
The lack of normative data for the STQ and the PTCI makes interpretations with this measure inconclusive. The IES-R, however, has been used with both clinical and non-clinical samples and its comparison with the STQ and PTCI adds weight to their use, given the significant correlations observed between the measures.

**Homogeneity of sample**
There was some variance in the sample that was not accounted for in the research design: There was a variation in workplace, no account was taken of organisational factors in the different interpretation/translation agencies, also ethnic and cultural differences were not controlled for.

**Previous employment**
Participant's previous training may have had a bearing on their responding and would have been useful to assess. It may be that participants had previous training or employment, such as a psychologist or a medical doctor, which may have helped to protect them against VT. It would have been helpful to have requested this information in the questionnaire pack.

**Gender bias**
This study suffers from an under-representation of men. Future research could examine how different genders cope with the emotional demands of repeatedly listening to traumatic material.

**Coping**
This research was the first survey of the reactions of interpreters/translator to listening to traumatic material. It was beyond the scope of this study to examine the coping strategies of participants in any detail. Further research could examine the coping
strategies employed by interpreters/translators with regard to VT with the use of standardised measures and qualitative research methods.

**Social support**
Similarly, whilst this study discussed social support, it was only in terms of how many sources of social support a participant had. Future research could examine social support in more detail, collecting information about how much support and what quality of support was available from each source. Use of a standardised measure of social support could also offer useful information.

**Participant age and experience**
Kim (2000) suggests that the over-representation of older, more experienced therapists in research may be hiding higher levels of VT in younger and less experienced as well as less well-supported clinicians. Future research could usefully examine these factors with research dedicated to these groups.

**Cultural differences**
Future research could usefully examine differences in interpreters/translators from different cultural backgrounds. It may be that different cultures make sense of what is interpreted in different ways.

**Differences between interpreting and translating**
This research project took account of the differences between interpreting (interpreting in a 'live' setting such as a therapeutic encounter or court) and translating (translating a document from one language to another). It is possible that there is a difference in intensity in these two modes and this could usefully be examined by future research.

**Research in other countries**
Only westernised countries have been studies with regard to VT so far. Future research should study the phenomena in other cultures and health care systems.
Comparison with therapists
As mentioned previously, it could be argued that interpreters are even more vulnerable to VT than therapists, as interpreters may only repeat what is being said, as opposed to therapists who have a method of intervening to try to improve the person’s situation. This may put added pressure on the therapist to get a result or may make it easier for them to bear what the client is telling them, as they believe their intervention will be useful. The interpreter may find that they can absolve themselves from responsibility by reminding themselves that they are only there to convey what is being said and feel less pressure as a result, or they may feel worse as a result of not having the therapists training and understanding that the intervention being planned is likely to be helpful. As such it may not have been helpful to compare interpreters with therapists when deciding upon predictor variables.

Biological and other disturbance related to VT
Many people suffering from PTSD suffer from biological disturbances in addition to the psychological and behavioural symptoms. The survey questionnaire could have asked about changes participants had noticed in their sleep pattern, sex-drive, appetite, interests and hobbies, levels of irritability and quality of their interpersonal relationships.

Short-comings of the VT model
Steed and Downing (1999) suggest that the VT model is incomplete as many of the participants in their study reported positive feeling about trauma work and experienced positive changes with regard to their self-identity. This failure of the model to encompass the range of effects of trauma counselling should be addressed by future research. It may be hard for research in this field to overcome the problems of participant’s incomplete or inaccurate memories of pre-trauma feelings and thoughts (a longitudinal study is needed) and also the difficulty of distinguishing between the effects of VT and the effects of unresolved personal issues unrelated to professional trauma work.

Stressful nature of the interpreting/translating job.
This study did not account for the stressful nature of interpreting/translating as a job in its own right (in terms of cognitive load), irrespective of whether the material being
interpreted is traumatic. Future research could look at a baseline measurement of the stresses of changing complex material from one language to another.

**Relationship between VT and empathy**
Previous researchers (Claire, 2002; Sabin-Farrell and Turpin, 2003) have examined empathy in relation to VT. This was not done in this study as the emphasis was on cognitions related to VT. Future research could examine the role of level of empathic engagement with clients as a risk factor for VT among interpreters/translators.

**Imagery**
McCann and Pearlman (1990) suggest that the imagery systems of people who are experiencing severe VT reactions have been altered. Future research could examine this further.

**Measures of general distress**
The results in this study report on measures directly related to traumatic distress. Future research could examine general distress in this population for comparison with trauma-related measures.

**Qualitative research**
Formalised qualitative research was beyond the scope of this study. Qualitative research could be usefully used to explore further the experiences, reactions and coping of interpreters/translators.

**Amount/severity of trauma exposed to**
The results of this study would have been improved if there had been a measure of how much trauma the people the interpreters/translators worked with suffered, rather than the trauma the interpreter/translator suffered themselves. This could have allowed for a greater degree of certainty about how exposure to the trauma of others affected scores on the measures.
Professional issues

Professional should be aware of issues around working with interpreters and translators with regard to VT. Group de-briefing to alleviate vicarious psychological distress has been shown to be effective by Everly, Boyle and Lating (1999) in a meta-analysis of ten peer-reviewed studies. Caution should be exercised in the application of de-briefing techniques, as meta-analyses by other authors on the use of de-briefing following trauma more generally have found equivocal evidence (Raphael, Meldrum and McFarlane, 1995). Other methods of support such as supervision and peer support should be offered to interpreters/translators. Given that a certain proportion of interpreters/translators may be vulnerable to VT, such provision should be made to meet their needs. An issue that arises is the willingness of interpreters/translators to admit that they are having a difficulty, or admitting to a colleague they have worked alongside (such as a clinical psychologist) that they are having difficulties that are related to their work and perhaps are related to a previous history of abuse. Assurances of confidentiality should be given and special clinical time set aside for this type of staff support. Developing an ethos that incorporates interpreters and translators, along with other auxiliary staff such as administration staff, into clinical teams and other professional bodies may help these workers feel more supported. Additionally professionals should also be clear about what warnings they give to interpreters and translators coming to work at clinics regarding the risks of vicarious trauma, even thought the risk factors are, as yet, unclear.

Conclusions

Interpreters and translators have never been studied with regard to VT before now. This study supports the findings of research among therapists that a minority of workers may be at risk of developing a severe stress reaction, or VT. It is encouraging to find that there is no epidemic of extreme stress reactions in this population when compared with community studies of the general population. That said, there is no consensus in the VT literature about what level of distress acts as a cut off for VT, making it impossible to offer a firm conclusion about how many individuals may be suffering stress reactions due to the nature of their work. Clearly some participants in this sample experienced high levels of distress. The importance of offering support to these individuals has been discussed above.
Results in this study indicated relationships in the data between measures of trauma and VT with participants who had personal histories of trauma, were younger, and had several places of work. This tallies with previous research that has identified these variables as predictors of VT in therapists. These variables support the model described by McCann and Pearlman (1990), as previous trauma history would conceivable cause alterations to schemas and the construct of self. Similarly younger age may be a vulnerability factor, as those who are at the beginning of their working career may not have built up a solid work persona constructed of stable schema and might be vulnerable to taking on the beliefs and attitudes of traumatised clients. Having a large number of workplaces may be a vulnerability factor, as the inability to build up a rapport and working relationship with others may inhibit workers from availing of social support and a place to process their feelings with others.

Other studies have suggested relationships with variables not found to be significantly related to VT in the present study. These include gender, amount of trauma work engaged in and level of education (as a protective factor). This fact reflects the inconsistent state of the research regarding VT. Further research is needed to identify what amount of exposure may prove damaging and how protective and vulnerability factors interact. Prospective designs and the establishment of cut offs for the measures used would give a better picture of the amount and nature of VT in trauma workers and specifically what factors made individuals vulnerable. Such research may always be dogged by sampling problems, as it is possible that only those who are coping will complete questionnaires. Qualitative studies have been used to good effect to identify trauma related schemas in those working with trauma survivors. The current discrepancy between qualitative and quantitative findings in this regard may indicate a difference in degree rather than kind, such that working with trauma may be stressful, but not damaging to all but a few with predisposing vulnerability factors. A combination of quantitative and qualitative studies might be use usefully in the future to offer further insights into the degree and phenomenology of VT.

A salient finding from the current study is the relationship between the measures. Correlations between established measures of PTSD and Burnout correlated
significantly with the STQ, as a measure of VT, but not so strongly as to indicate redundancy of the STQ measure. This suggests that the STQ is measuring a construct that may be allied to, but is distinct from both PTSD and Burnout. This method of construct validation is suggested by Jenkins and Baird (2002), who found similar results in studying the relationship between VT and Burnout. This suggests that the constructs are related and may overlap, but are phenomenologically different, perhaps being co-morbid or working in an additive model of psychological distress.

Perhaps even more provocative is the finding that the correlation between the measure of trauma-related cognitions (the PTCI) and the STQ is strong enough to suggest that cognitions may be playing a part in the development and maintenance of VT in a non-clinical sample who are theoretically vulnerable to VT. This finding supports that theory of McCann and Pearlman (1990) and also matches other theories about the development and maintenance of symptoms of PTSD following exposure to trauma (Ehlers and Clark, 2000). This is an exciting finding, as understanding that cognitions may maintain symptoms of VT in a similar way to which cognitions are thought of to maintain PTSD and other emotional disorders, allows for intervention strategies to treat VT to be developed from the current body of knowledge. Unfortunately, temporal precedence is not known, so it is not possible to be certain whether the cognitions lead to symptoms or symptoms to cognitions.

Interpreters and translators who work with trauma victims may be at risk of developing VT as much as therapists and other ‘front line’ staff. Without appropriate data regarding the amount of exposure required it is impossible to say how much of this work would lead to problems for the interpreter/translator. Certain vulnerability factors, however, have been identified. It is the responsibility of employers and those who work with these staff to ensure that appropriate care is taken in supporting them. Further research examining the coping strategies of this group would be useful in ascertaining the appropriate level of support that should be on offer.
References


Steed, L. and Bicknell, J. (2001). Trauma and the therapist: The experiences of therapists working with the perpetrators of sexual abuse. *Australasian Journal of Disaster and Trauma Studies, 5, (1),* NP.


Appendix one
<table>
<thead>
<tr>
<th>PTSD Criteria (DSM-IV)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> The person has been exposed to a traumatic event on which both the following are present</td>
</tr>
<tr>
<td>1. the person witnessed, or was confronted with an event that involved actual or threatened death/serious injury, or threat to physical integrity of self or others</td>
</tr>
<tr>
<td>2. the person’s responses involved intense fear, helplessness or horror</td>
</tr>
<tr>
<td><strong>B.</strong> The traumatic event is persistently re-experienced in one (or more) of the following ways</td>
</tr>
<tr>
<td>1. recurrent and intrusive distressing recollections of event including images, thoughts or perceptions</td>
</tr>
<tr>
<td>2. recurrent dreams of event</td>
</tr>
<tr>
<td>3. acting or feeling as if the event were recurring (including dissociative flashback episodes, including those that occur on wakening or when intoxicated)</td>
</tr>
<tr>
<td>4. intense psychological distress at exposure to internal or external cues that symbolise event resemble any aspect of the traumatic event</td>
</tr>
<tr>
<td>5. physiological reactivity on exposure to internal or external</td>
</tr>
<tr>
<td><strong>C.</strong> Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before trauma as indicated by three (or more) of the following)</td>
</tr>
<tr>
<td>1. efforts to avoid thoughts, feelings or conversations associated with the trauma</td>
</tr>
<tr>
<td>2. efforts to avoid activities, places or people that arouse recollections of the trauma</td>
</tr>
<tr>
<td>3. inability to recall important aspects of the trauma</td>
</tr>
<tr>
<td>4. markedly diminished interest or participation in significant events</td>
</tr>
<tr>
<td>5. feelings of detachment or estrangement from others</td>
</tr>
<tr>
<td>6. restricted range of affect (e.g.: unable to have loving feelings)</td>
</tr>
<tr>
<td>7. sense of foreshortened future (e.g.: does not expect to have a career, marriage, children, or a normal life span)</td>
</tr>
<tr>
<td><strong>D.</strong> Persistent symptoms of increase arousal (not present before the trauma) as</td>
</tr>
</tbody>
</table>
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 disturbance is more than one month

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

<table>
<thead>
<tr>
<th>Type</th>
<th>Duration of Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>less than three months</td>
</tr>
<tr>
<td>Chronic</td>
<td>three months or more</td>
</tr>
<tr>
<td>With delayed onset</td>
<td>at least six months after the stressor</td>
</tr>
</tbody>
</table>
Appendix two
Appendix three
Vicarious Traumatisation Among Translators and Interpreters.

Why you are being asked to complete these questionnaires?
The questionnaires in this pack are part of a research project being completed at the University of Surrey assessing the psychological impact of interpreting and translating in healthcare and other settings. It has come about following concerns that interpreting/translating distressing stories might affect the interpreter/translator in a negative way. The results will help clarify how this work impacts upon your life.

How long will it take?
It will only take about ten or fifteen minutes to complete all four questionnaires pack.

Why are we conducting this research? What are the concerns?
To date no-one has examined the role of interpreting and translating to assess how stressful it is. It may be that strategies to help with the stresses of the role may need to be developed by those using the services of interpreters and translators. Once this research has been completed, recommendations can be made regarding improvements to whom it concerns.

What happens if there is a problem?
This research, it is hoped, will allow the healthcare and other similar agencies to help those who are interpreting and translating to feel like they can cope effectively with the work that they do. If there are any problems highlighted by the research, help will be on hand, offering confidential de-briefing counselling and support.

If you feel that you are in need of someone to talk to about distress that you have experienced as a result of your work, please contact:

Prof. Ian Robbins,
Traumatic Stress Service,
St. George’s Hospital,
Blackshaw Road,
London SW17 0QT.
Tel: 020 8725 0355.

All enquiries are always treated with the strictest confidence.

Who is carrying out this research?
The research is being undertaken as part of a Doctoral degree by a Trainee Clinical Psychologist working closely with the staff at the Traumatic Stress Service at St. George’s Hospital. All results will be anonymised and treated confidentially. You do not have to take part in this research. If you decide not to participate your management will not be affected. You can also drop out at any time without giving a reason.

When will the results be known?
The results will be available in the later part of 2003. This may seem like a long time but does allow for a thorough and complete analysis and recommendations for future improvements to be made.

Whom do I talk to if I want to know more?
If you have any questions about the research project, please contact:

Tim Green,
Department of Clinical Psychology,
University of Surrey,
Guildford,
GU2 7XH.

Thank you very much for your participation.
Appendix four
CONSENT FORM

Vicarious Traumatisation in Translators and Interpreters
Working with Refugees

I, having read an explanation of this research project, agree to participate in the project titled above. I understand that all information I provide will be treated confidentially. I also understand that participation in this project will not affect my working relationship with the Traumatic Stress Service. I further understand that I may pull out of the project at any time.

Singed...................................................................................................

Print Name.............................................................................................

Date......................................................................................................
Appendix five
Vicarious traumatisation among interpreters and translators

1. What is your date of birth?

2. What is your country of origin?

3. Are you a refugee?

4. When did you arrive in the UK?

5. How many years of formal education did you complete?

6. How long do you have leave to stay and work in the UK?

7. How many hours per week on average do you spend interpreting/translating traumatic stories? (Please circle your answer)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>2-3</td>
<td>4-5</td>
</tr>
<tr>
<td>5-10</td>
<td>11-15</td>
<td>16-20</td>
</tr>
<tr>
<td>21-25</td>
<td>26-30</td>
<td>over 30</td>
</tr>
</tbody>
</table>

8. Roughly how many hours in total during your interpreting and/or translating career have you spent translating traumatic stories?
9. Where do you interpret traumatic stories? (Please circle your answer)

- Traumatic stress clinic
- Hospital
- Social Services department
- Legal firm
- Refugee agency
- Other (please describe)

10. How long have you been interpreting and/or translating trauma material? (Please circle your answer)

- 1 month
- 2-6 months
- 7 months-1 year
- 1-2 years
- 2-3 years
- Over 3 years

11. What types of traumatic experiences have you been involved in interpreting and/or translating? (Please circle your answer)

- Rape
- Child abuse
- Accidents
- Torture
- Beatings/muggings
- Natural disasters
- Sexual abuse
- Racial harassment/bullying
- Other (please describe)

12. Have you had a personal experience of violent physical trauma, such as rape, torture, beating in the past? (Yes or no is sufficient)
13. Have you had experience of other types of trauma, such as serious car crashes, natural disasters (e.g.: earthquakes) or being caught in a fire? (Yes or no is sufficient)

14. Do you get a chance to talk through things that you have heard when translating at the Traumatic Stress Service? If so, who do you talk to? (Please circle your answer if answering yes)

Friends
Family
Members of religious groups
Members of community
Other (please describe)

15. What types of trauma (e.g.: torture, rape, accident) do you find it most difficult to interpret/translate? Why do you think this is so?
16. What type of traumatic event in your interpretations and/or translation work do you feel has affected you most? Why do you think this is so?

17. What type of client do you feel has affected you most in your interpretation and/or translation work (e.g.: children, clients in medical settings, clients in legal settings)? Why do you think this is so?

18. Have you ever experienced difficulty in translating for someone who is from a different social group to you in your mutual home country?

19. What helps you cope best with the work involving interpreting and/or translating traumatic stories?

20. What are the good things about working with traumatic stories?
21. What recommendations would you make to improve stress management among interpreters and translators?

If you have any other comments, please add them on the back of this sheet.

22. Would you be willing to be involved in a short interview about your experiences? If so, please put your phone number or other contact details here.

NB: This sheet will be removed from the rest of the questionnaire so that your name cannot be connected with any answers that you have given
Appendix six
SECONDARY TRAUMA QUESTIONNAIRE

Consider a negative experience or experiences that have happened to some of the patients that you have translated/interpreted for.

For the items below, write in the number that best describes how you think and feel about these events. Complete the items even if you could not think of a clear example. If you were unable to identify someone above, you may use your own experience.

1= Rarely/never 2= At times 3= Not sure 4= Often 5= Very often

(Put number in each space below)

1. ___ I force myself to avoid certain thoughts or feelings that remind me of (person above) difficulties
2. ___ I find myself avoiding certain activities or situations because they remind me of their problems
3. ___ I have difficulty falling or staying asleep
4. ___ I startle easily
5. ___ I have flashbacks (vivid unwanted images or memories) related to their problems
6. ___ I am frightened by things he or she said or did to me
7. ___ I experience troubling dreams similar to their problems
8. ___ I experience intrusive, unwanted thoughts about their problems
9. ___ I am losing sleep over thoughts of their experience
10. ___ I have thought that I might have been negatively affected by their experience
11. ___ I have felt “on edge” and distressed and this may be related to thoughts about their problem
12. ___ I have wished that I could avoid dealing with the person or persons named above
13. ___ I have difficulty recalling specific aspects and details of their difficulties
14. ___ I find myself losing interest in activities that used to bring me pleasure
15. ___ I find it increasingly difficult to have warm and positive feelings for others
16. ___ I find that I am less clear and optimistic about my future life than I once was
17. ___ I have had some difficulty in concentrating
18. ___ I would feel threatened and vulnerable if I went through what the person above went through
19. ___ I would have experienced horror or intense fear if I had their problems
20. ___ I have disturbing recollections and intruding thoughts of their experiences
Appendix seven
POST-TRAUMATIC COGNITIONS INVENTORY

We are interested in the kind of thoughts which you may have had after translating the traumatic experience of trauma clinic patients. Below are a number of statements that may or may not be representative of your thinking.

Please read each statement carefully and tell us how much you AGREE or DISAGREE with each statement.

People react to hearing trauma stories in many different ways. There are no right or wrong answers to these statements.

1= Totally disagree 2= Disagree very much 3=Disagree slightly
4= Neutral 5=Agree slightly 6= Agree very much
7= Totally agree

1. ___ I can't trust that I will do the right thing
2. ___ I am a weak person
3. ___ I will not be able to control my anger and will do something terrible
4. ___ I can't deal with even the slightest upset
5. ___ I used to be a happy person but now I am always miserable
6. ___ People can't be trusted
7. ___ I have to be on guard all the time
8. ___ I feel dead inside
9. ___ You can never know who will harm you
10. ___ I have to be especially careful because you never know what can happen next
11. ___ I am inadequate
12. ___ I will not be able to control my emotions, and something terrible will happen
13. ___ If I think about the events I have translated, I will not be able to handle it
14. ___ The event happened to me because of the sort of person I am
15. ___ My reactions since hearing about these events means that I am going crazy.
16. ____ I will never be able to feel normal emotions again
17. ____ The world is a dangerous place
18. ____ Somebody else would be able to cope better
19. ____ I have permanently changed for the worse
20. ____ I feel like an object, not like a person
21. ____ Somebody else would not have gotten into this situation
22. ____ I can't rely on other people
23. ____ I feel isolated and set apart from others
24. ____ I have no future
25. ____ I can't stop bad things from happening to me
26. ____ People are not what they seem
27. ____ My life has been destroyed by the traumatic events I translate
28. ____ There is something wrong with me as a person
29. ____ My reactions since I have been translating these events show that I am a lousy copier
30. ____ I will not be able to tolerate my thoughts about the event, and I will fall apart
31. ____ I feel like I don't know myself anymore
32. ____ You never know when something terrible will happen
33. ____ I can't rely on myself
34. ____ Nothing good can happen to me anymore
**MASLACH BURNOUT INVENTORY**

Below are some questions about your reactions to your work in general. Please read the following questions carefully and circle those numbers that most represent your opinion now. Do not spend too much time on each question, your first response is probably the best one for you.

How often: 0 = *Never*    1 = *A few times a year or less*    2 = *Once a month or less*    3 = *A few times a month*    4 = *Once a week*    5 = *A few times a week*    6 = *Every day*

<table>
<thead>
<tr>
<th>Question</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel emotionally drained by my work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel used up at the end of the work day</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel fatigued when I get up in the morning and have to face another day on the job</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can easily understand how my patients feel about things</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel I sometimes treat patients as if they were impersonal objects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working with people all day is a real strain for me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I deal effectively with translating for patients and therapists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel burned out from my work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel I am positively influencing other people's lives through my work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have become more callous towards people since I took this job</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I worry that this job is hardening me emotionally</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel very energetic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel frustrated by my job</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel I am working too hard on my job</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don't really care what happens to some patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working with people directly puts too much stress on me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can easily create a relaxed atmosphere with patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel exhilarated after working closely with patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have accomplished many worthwhile things in this job</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel like I am at the end of my tether</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In my work, I deal with emotional problems very calmly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel patients blame me for some of their problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix nine
IMPACT OF EVENTS SCALE - REVISED

Below is a list of difficulties people sometimes have after stressful life events. Please read each item and then how distressing each difficulty has been for you DURING THE PAST SEVEN DAYS with respect to you interpreting/ translating work, how much were you distressed or bothered by these difficulties?

<table>
<thead>
<tr>
<th>Item</th>
<th>Not at all</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Any reminder brought back feelings about it</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>2. I had trouble staying asleep</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>3. Other things kept making me think about it</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>4. I felt irritable and angry</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>5. I avoided letting myself get upset when I thought about it or was reminded about it</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>6. I thought about it when I didn’t mean to</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>7. I felt as if it hadn’t happened or wasn’t real</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>8. I stayed away from reminders about it</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>9. Picture about it popped into my mind</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>10. I was jumpy and easily startled</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>11. I tried not to think about it</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>12. I was aware that I still had a lot of feelings about it, but didn’t deal with them</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>13. My feelings about it were kind of numb</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>14. I found myself acting or feeling as though I was back at that time</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>15. I had trouble falling asleep</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>16. I had waves of strong feelings about it</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>17. I tried to remove it from my memory</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>18. I had trouble concentrating</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea or a pounding heart</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>20. I had dreams about it</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>21. I felt watchful or on guard</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>22. I tried not to talk about it</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>