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Of Psychology (PsychD) in Clinical Psychology

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Major Research Project:
The Investigation of Vicarious Trauma in Face to Face and Phone Counsellors
Dealing with Rape Victims: The Implications of Training,
Nature of Exposure and Empathy.

Sarah Clare

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Volume I
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Adult Mental Health
Placement Summary
ADULT MENTAL HEALTH
PLACEMENT SUMMARY

Overview of Clinical Experience

Dates of Placement

13th October 1999 to 24th March 2000

Setting

The placement was based within a psychology department in a Primary Care service, servicing a local urban community. Psychological services were made available both within the psychology department and in other General Practitioner surgeries within the local area.

Models

The placement used a cognitive-behavioural model for working with adult mental health problems.

Clinical Experience

The placement offered a wide range of experience of direct face-to-face individual work and indirect observation of the supervisor using the cognitive-behavioural model. The clients spanned a wide age range, from 19 to 73 years of age. Clinical presentations included social and performance anxiety, depression, travel phobia, posttraumatic stress disorder, anger management, generalised health anxiety, social and vomiting phobia, chronic pain, stress and crisis management and several issues from a client with borderline personality disorder. The placement was also able to offer some specialist neuropsychological supervision by a different supervisor; two clients were seen. The first client exhibited symptoms of a psychosis and a depression, although no organic problems were identified using the Wechsler Adult Intelligence Scale – Revised, the Wechsler Memory Scale or the National Reading
Scale. The same cognitive tests (in addition to the Figure 15 test) were used with the second client in order to investigate the possible cause for the presence of 'white noise' and memory loss that the client had reported.

In the placement two anxiety management groups were run based on cognitive-behaviour principles. The groups were planned and run jointly with the supervisor.

**Additional Information**

Within the placement there were opportunities to evaluate the efficacy of an opt-in procedure, with a view to potentially changing the existing referral system. This project formed the basis of my service-related research project which was conducted within the placement. In addition the placement encouraged meeting with various professionals in the area, including a meeting with the Trust Professional Lead. Once a month there was also the opportunity to attend a Research and Development Meeting.
Learning Disability
Placement Summary
LEARNING DISABILITY
PLACEMENT SUMMARY

Overview of Clinical Experience

Dates of Placement

13th April 2000 to 29th September 2000

Setting

The placement was based within a Community Mental Health Team working with a multi-disciplinary team, servicing a rural area. Individual and team input was put into a number of different Learning Disability Homes.

Models

The placement used a multi-element eco-behavioural model (LaVigna & Willis, 1995) which takes into account the individual, the environment and their competing needs, and the possible communicative message of the challenging behaviour. The eco-behavioural approach advocates the use of non-aversive intervention strategies (proactive and reactive strategies) based on information from a functional analysis. The placement also used cognitive-behavioural methods of working.

Clinical Experience

The placement offered a wide range of experience of direct face-to-face individual work and indirect interventions working with the carers of clients' with a learning disability. Clinical presentations included anxiety and low motivation, low mood, complicated bereavement over a possibly abusive father, obsessive-compulsive disorder involving ritualistic cleaning, aggression, sexual harassment of staff and a risk assessment of a vulnerable adult. There was also an opportunity to conduct neuropsychological assessments to determine possible dual diagnoses (learning disability and co-morbid mental health problems) and determining the possible onset
of dementia in an older learning disability client. A further clinical issue within this placement was the disclosure of sexual abuse by one of the clients, accusing another client who also lived in the same accommodation.

The main opportunity within this placement was to work within a multi-disciplinary team and to work directly with staff teams who care for people with learning disabilities. The work involved some teaching of behavioural principles to staff in order to manage challenging behaviour and risk issues.

**Additional Information**

During the placement I was able to be part of discussion regarding a revision of the quality care standards that the Community Learning Disability team uphold. These revised standards were then incorporated into the Periodic Service Reviews which evaluate the standard of service the department offers. I was also able to observe a meeting between the Community Learning Disability Department and Social Services, which discussed the implications of how long-term placements would be managed and evaluated when the services merge. There were also opportunities to attend a Specialist Interest Group, a lecture about issues regarding sexuality and male clients with learning disabilities, a teaching afternoon on the basic, commonly used Makaton signs within the therapeutic work with this client group and a two day course on safety procedures in the management of challenging behaviour based on psychological principles, incorporating the ideas of early intervention and prevention.
Overview of Clinical Experience

Dates of Placement

11\textsuperscript{th} October 2000 to 23\textsuperscript{rd} March 2001

Setting

The placement was based in a Childrens Centre which involved a multi-disciplinary team approach to the health care of children, both physical and psychological. The setting also incorporated a specialist nursery for the assessment of autism and developmental problems.

Models

The placement used a predominantly cognitive behavioural and systemic approaches, but also used Eye Movement and Desensitisation Reprocessing (EMDR) for trauma cases.

Clinical Experience

The placement offered a wide range of experience of family and individual work both based within schools and the home. The placement involved children from a range of ages, from the under fives who attended the Autistic Spectrum Clinic to adolescents. Clinical presentations included posttraumatic stress disorder, bullying, child sexual abuse, needle phobia, Asperger assessments, family interpersonal difficulties, behaviour problems, obsessive-compulsive disorder, attention-deficit-hyperactivity disorder and social skills deficits. There was also an opportunity to conduct neuropsychological and psychometric assessments with children from a range of all
ages. Within the placement there was also an opportunity to be part of a reflective team within family therapy in a case of a client who was truant from school.

Additional Information

During the placement I attended an international conference exploring the use of EMDR techniques with children who are suffering from PTSD and conduct disorder. I also attended a local school to observe children of all ages, to learn how children without problems behave and interact with adults and each other. I observed infants, aged 5-6, 7 year olds and 10-11 year olds within their classroom settings. I also attended the Language Unit and participated in a class teaching maths to children with learning difficulties and autism.
Older Adult
Placement Summary
OLDER ADULT PLACEMENT
SUMMARY

Overview of Clinical Experience

Dates of Placement

10\textsuperscript{th} October 2001 to 22\textsuperscript{nd} March 2002

Setting

The placement was based predominantly in a hospital setting providing access to the Day Hospital and community patients as well as acute patients across three inpatient wards. In addition, time was also spent at a day centre for Alzheimer sufferers. The placement focused predominantly on health concerns and covered areas such as stroke rehabilitation, recovery from physical problems and operations, falls and dementia assessments.

Models

Cognitive behavioural and rational emotive therapy were mainly used, alongside some behavioural management strategies for challenging behaviour on the wards.

Clinical Experience

The placement covered mainly health issues, which were often co-morbid with mental health problems, such as depression and anxiety. Clinical presentations included panic disorder, depression, fear of falling, differential diagnosis of dementia type from the possibility of having a pre-morbid learning disability, uncooperative challenging behaviour with carers and managing emotional lability after stroke.

The placement also afforded the opportunity to conduct two groups. The first group was a Falls Group which aimed to help clients manage their risk of falling. This group was co-facilitated with a Physiotherapist and an Occupational Therapist. Psychology covered issues regarding fear of falling.
The second group was a Reminiscence Group based at the Alzheimers Society. This group was lead by the author and co-facilitated by a day centre worker.

The placement offered a wide range of opportunities to work within a multi-disciplinary team.

**Additional Information**

Within the placement I established a new method of evaluating the effectiveness of the Reminiscence Group using a time sampling of spontaneous conversing as recommended in the literature. In addition, I evaluated the current scales assessing Carer-giver Burden and Stress. Whilst on placement I attended a Stroke Training Day, which incorporated a variety of presentations about stroke including neuroanatomy, speech and language problems, cognitive and behavioural difficulties, mobility issues and nursing requirements. In addition, I attended a Rehabilitation Conference which included presentations on the principles of rehabilitation and rehabilitation services for young adults, older people and for patients following a stroke. The afternoon workshop that I attended discussed the structure of the rehabilitation services within Day Hospitals. I also attended a number of Older Adults Interest Groups, which involved presentation of cases, issues or research of interest to this population.
Specialist Narrative
Placement Summary
SPECIALIST NARRATIVE
PLACEMENT SUMMARY

Overview of Clinical Experience

Dates of Placement

4th April 2001 to 21st September 2001

Setting
The placement was based in a psychology department situated within a hospital setting. Clinical rooms were also available in another hospital and in a community health centre. The placement covered a large urban community.

Models
The placement offered a specialist systemic narrative model of working with adult mental health clients from both Primary Care and Community Mental Health Teams.

Clinical Experience
The placement offered a range of clinical presentations within the field of adult mental health. Interventions were direct, face-to-face therapeutic contact for individuals, couples and families. Clinical presentations included the management of Chronic Fatigue Syndrome, depression, anxiety, the management of chronic pain, relationship problems such as jealousy issues and interdependency, anger management, eating disorder, prolonged complicated bereavement, panic attacks, sexual abuse histories and social phobia.

The placement also afforded the opportunity to conduct a social phobia group which was co-facilitated with a Counselling Psychologist. The group was a new enterprise which brought narrative and cognitive behavioural approaches together within therapy.

Whilst on the placement I was a regular part of a reflective team in the Family Therapy Clinic contributing ideas and different perspectives into the system. The
Family Therapy Clinic enabled me to observe a range of professionals conducting therapy and to be involved in discussions regarding process issues.

Additional Information

During the placement I presented a joint case with colleagues at a Psychology Away Day. The case presentation was designed to demonstrate narrative therapy in progress. In addition, I presented a talk on Narrative Theory and Practice along with another Trainee in the Family Therapy Clinic. Throughout the placement I regularly attend Departmental Meetings which provides up-to-date information from within the Trust and the preparation for Trust mergers. In addition this forum was appropriate to discuss departmental issues, such as resources, waiting list priorities and individual’s specialist interests. I was also able to observe a Clinical Psychologist working within an Assertive Outreach Service for complex difficult to engage clients.
Specialist Forensic Placement
Summary
SPECIALIST FORENSIC
PLACEMENT SUMMARY

Overview of Clinical Experience

Dates of Placement

2th April 2002 to 20th September 2002

Setting

The placement was set in a hospital which specialised in complex forensic cases. The placement was based within a centrally located psychology department; psychologists were internally referred patients from the in-patient wards.

Models

The placement offered cognitive behaviour therapy, experience of functional analysis of forensic behaviour and psychometric testing of personality.

Clinical Experience

Within the placement I was able to conduct a number of direct, face-to-face interventions with individual clients. Clinical presentations included issues surrounding shame, low self-esteem and abandonment, therapy to maximise insight into the client’s Index Offence, two psycho-sexual assessments, two risk assessments for arson and therapy for Obsessive Compulsive Disorder symptoms associated with issues of abandonment.

The placement offered experience within a specialist service and encouraged both individual and peer supervision. In addition, the placement offered opportunities to work with staff teams who worked on the in-patient wards.
Additional Information

During the placement I attended a meeting with an external visiting Clinical Psychologist who worked in a Regional Secure Unit. The meeting centred around the assessment of Arson, using functional analysis techniques. The meeting also discussed the progress of an arson group that is being facilitated by two of the psychologists within the department. I also became part of a working party which discussed how risk assessment will be conducted in the future. Throughout the placement I had the opportunity to attend regular departmental meetings which focused on the effects of recent Government initiatives and issues.
Referral

X, a twenty-seven year old man, was referred to primary care psychology services by a Community Psychiatric nurse for social anxiety and low mood. X had been referred to psychology due to his preference to address his problems by using psychological rather than pharmacological means.

Assessment

The assessment comprised of three one hourly unobserved clinical assessment interviews to elicit background personal information and current presenting symptoms. The assessment also included the administration of the Beck Depression Inventory and covered social anxiety issues. The assessment of risk of suicide and alcohol consumption was elicited through further interview and behavioural log data.

Main Presenting Problem

X described feeling very low in mood, with frequent bouts of crying and ruminating about negative events, past and present, in particular he missed his aunt who had recently died. He reported having headaches, feeling lethargic, not liking himself, a low sex drive, poor sleeping patterns, social withdrawal and anxiety. X described drinking about five to six pints of lager a night to stop himself from thinking about negative events, such as his aunt’s death and to reduce his anxiety before going out and meeting people. Alcohol appeared to have a considerable affect on his daily life, activity levels and mood and was associated with suicidal ideation.

Formulation

The formulation was based on Beck’s cognitive behavioural theory (Beck 1967, 1976). X referred to himself in negative terms, stating that there was “nothing to like about him”. The therapist hypothesised that X had the core beliefs, “I am unlovable”
(Beck, 1995). X’s concurrent experiences of his father not showing him any emotions and physical affection, may have further contributed to self-doubt and negative self-evaluation. These beliefs may have then lead to a need to please others in order to obtain the affection and reassurance that he is a valued person. The fact that people had not been supportive throughout his grief over his aunt may have also fed into this core belief that it was because he was “unlovable”. Essentially, X may have held the conditional assumption that if he did care for others then they would care for him (Beck, 1995). However, X’s experience has been that “everyone was out for themselves” despite his efforts and investment of emotion in the past. It may have seemed that life became unfair and hopeless, which may have exacerbated his symptoms of depression. It was also hypothesised that social phobia had developed as a result of X’s underlying feelings of self-doubt and negative self-evaluation.

**Intervention**

The first stage of intervention focused on positive activity scheduling to increase X’s daily positive experiences. Further therapy then focused on X’s core belief that he was “unlovable”. The focus of change was an evaluation of, and a challenge to, automatic thoughts, dysfunctional assumptions and cognitive distortions, which may have been perpetuating the depression (Beck, 1989). Once the symptoms of depression were alleviated then the focus was on reducing social phobia, through the generalising the challenging of negative beliefs about the self with regard to specific social situations and interpretations (Fennell, 1997). Continued therapy took place within an anxiety management group which focused on the eradication of safety behaviours, feedback and the testing out of beliefs through exposure to feared social situations (Clark, 1996).

**Outcome**

The Beck Depression Inventory score changed from 31 to 4, indicating a significant reduction in depression symptoms. X also scored 7 on the Beck Anxiety Inventory. X stated that he now felt more positively about himself and had changed his expectations of others and himself. X had also stopped drinking alcohol and used a variety of alternative coping strategies instead.
Learning Disability Case
Report Summary
THE ECO-BEHAVIOURAL ANALYSIS AND MANAGEMENT OF SEXUALLY THREATENING AND CHALLENGING BEHAVIOUR IN A 42-YEAR OLD CLIENT WITH A MILD LEARNING DISABILITY

Referral
X, a white, forty-two year old man with mild learning disabilities, was referred to psychology by his community Home Manager. X was referred for threatening behaviour towards a particular female member of staff, Liz, and aggression towards clients. In addition, X required an initial screening assessment to establish suitability for the service.

Assessment
A psychological assessment was completed using the Wechsler Abbreviated Scale of Intelligence (WASI-3). The assessment was conducted over two, one hourly unobserved sessions, the aim of which was to assess X’s overall level of intelligence, to gauge whether he met the CLDS’ inclusion criteria of having an IQ below 70. Further assessment was carried out using data from staff interviews, a risk assessment, a single interview with X, a functional analysis and an assessment of motivation.

Main Presenting Problem
X’s behaviour centred on Liz, whom he admitted he was attracted to. His behaviour involved mild verbal abuse and repeated calling of her name for long periods. This often escalated into the more moderate to severe forms of aggression, including grabbing and pinching, with frequent attempts and re-attempts occurring within any one episode. A more severe form of the sexual aggression was to grab her around the waist. Further incidents of abusive behaviour were directed towards one other client who spent a lot of time with Liz. X’s behaviour towards the other client involved mild verbal provocation, for example “clear off” to severe verbal aggression.
**Formulation**

X could not remember any past relationships during the clinical interview, which may indicate a poor history of positive attachments and social support throughout his life, crucial to normal development. X’s attachment difficulties may have reduced his confidence in his social skills, leading to poor self-esteem and potential difficulty with expressing his social and sexual needs. The further rejection from a female client, when he was in his late twenties, may have reinforced his anxieties regarding relationships and sexual expression, exacerbated by a possible lack of sex education and role modelling of appropriate behaviour. It was also hypothesised that X’s history indicated limited choices and opportunities leading to issues of powerlessness and lack of environmental control. To exert control and choice, X may use challenging behaviour which may have been positively reinforced by people’s reactions in the past, whether a positive reaction (social attention) or a negative reaction by Liz (“you’re an animal”). Both the positive and negative reactions from staff could have strengthened X’s need to exhibit challenging behaviour as they were essentially the only source of contact that X was gaining from staff that he had any control over.

**Intervention**

The eco-behavioural model advocated several strategies. Proactive strategies attempted to address the function of the behaviour, namely to obtain social contact, through ecological strategies and antecedent control. Staff were advised to increase his activity levels and encourage positive engagement with a wider range of staff members. Staff were also instructed to use praise and social attention whenever X interacted or behaved appropriately to positively reinforce this behaviour.

**Outcome**

There were no recordings of either form of challenging behaviour after the implementation of the immediate intervention strategies. In addition, X appeared to be spending more time engaging positively with others and appeared more confident.
Child and Adolescent Case
Report Summary
Clinical Case Report Summaries

ASSESSMENT OF A 6 YEAR-OLD CHILD WITH ATTENTION DEFICIT-HYPERACTIVITY-DISORDER. A BEHAVIOURAL FORMULATION

Referral

X, a white six year old boy was referred to Child and Family Services by a Community Paediatrician for behaviour problems. X was described as immature and reckless and had started having difficulties succeeding at school. The referral letter enclosed Conners’ questionnaires from X’s parents and teacher.

Assessment

The following information was obtained over one ninety-minute unobserved clinical interview with X and his parents, one home visit and two school visits. In addition, clinical features of attention-deficit-hyperactivity-disorder (ADHD) including attention span, distractibility, impulse control, excitability were assessed according to DSM-IV criteria and the use of current parent and teacher Connor Rating Scales. Further cognitive assessment of attention and ability were also conducted.

Main Presenting Problem

X had a history of impulsive and reckless behaviour, for example, he often ran out into busy roads. X had constant motor activity and was considered by his parents to be a mischievous, impatient and "investigative" child. Since May 2000, X had been started on a small dose of Ritalin (5 m.g.s. twice a day) by his Paediatrician for his 'attention deficit like behaviour'. In terms of a risk assessment, the difficulties presented by X were considered by his parents to be highly frequent, of considerable duration and could potentially have severe consequences due to his lack of concern for safety. The Connor’s Scales evaluated earlier in May scored 28-29 (teacher) and 35 (parents) on the DSM-IV Total score, indicated both hyperactivity-impulsive and inattentive symptoms.
Formulation

The formulation was based on an understanding of learned behaviour as a consequence of 'operant conditioning principles' (Skinner, 1953). X's activity levels were apparent since pregnancy, therefore hyperactivity and impulsivity were naturally occurring behaviours which then could have been subsequently reinforced through parental attention. In behavioural terms, successive attempts at gaining attention may have been gradually shaped by successive reinforcement through attention, therefore operant conditioning and learned behaviour would be said to have taken place. X has learned that demonstrating unsafe or ADHD-like behaviour meets a function, which may have later generalised to other settings, like school. Inconsistent management styles noted to have taken place between the parents and the difference in management between school and home, would further have exacerbated X's behaviour through intermittent reinforcement.

Intervention

The aim of behavioural interventions is to help foster more socially acceptable behaviour in children with ADHD by teaching and shaping skills to enable a child to regulate his/her own behaviour (Warner-Rogers, 1998). In order to do this, parents and teachers needed to reinforce appropriate behaviour and to withdraw all possible reinforcement from inappropriate behaviour. Therefore in this case, the proposed strategy was to alter behaviour eliciting stimuli and response-reinforcement contingencies, mainly by promoting pro-social behaviour by reinforcing incompatible but socially acceptable behaviours to enable X to re-learn behaviour.

Outcome

Behavioural strategies implemented after the extended assessment which formed the basis of the case report went well, with a significant reduction in behaviour problems even without medication.
Older Adult Case
Report Summary –
Neuropsychological Assessment
THE DIFFERENTIAL DIAGNOSIS OF A 67 YEAR-OLD WOMAN WITH SUSPECTED DEMENTIA OF THE LEWY-BODY OR A POSSIBLE LEARNING DISABILITY

**Referral**

Mrs X, a white, sixty-seven year old, woman was referred by a Consultant Geriatrician attached to a Day Hospital. The main referral question was a confirmation of a suspected diagnosis of dementia of the Lewy-Body type. Concerns had recently arisen due to Mrs X’s frequent falls and signs of cognitive impairment. Alongside the referral of the differential diagnosis, the referrer also noted the possibility of Mrs X having a learning disability.

**Presenting Problem**

Mrs X described having frequent falls, recalling an incidence of more than one a month. In addition, she reported talking and thinking more slowly, mobility difficulties and word finding problems. Mrs X denied low mood and anxiety, described no problems concentrating or conducting everyday tasks and there was no evidence of paranoia or psychosis. Staff at the day centre were concerned about her falls and apparent cognitive decline.

**Hypotheses**

The assessment needed to establish whether Mrs X was cognitively impaired. If she was impaired, then whether Mrs X had a form of dementia; if yes, then what form of dementia was it, Dementia with Lewy Bodies (DLB), Alzheimer’s Dementia (AD) or another form; if no, did she have a learning disability. If Mrs X did not have a learning disability or a dementia, was there any other likely cause, such as depression due to the death of her late husband. A further consideration was whether Mrs X had co-morbid problems, for example a learning disability and a dementia.

**Assessment**

The presenting problems as understood by the client and close informants were established within the interview structure of the Cambridge Mental Disorders of the
Clinical Case Report Summaries

Elderly Examination - Revised (Camdex-R) assessment battery (Roth, Huppert, Mountjoy, Hendrie, Verma & Goddard, 1998). The interview was used as part of a diagnostic assessment battery for diagnosing dementia and differentiating it from other possible mental health problems, such as depression.

Further cognitive assessment was conducted using the Wechsler Adult Intelligence Scale – Version 3 (WAIS-3), the National Adult Reading Test – Revised (NART-R) to assess current and pre-morbid cognitive functioning. In addition, the CAMCOG cognitive test was used as part of the Camdex-R differential diagnosis of dementia assessment. Further cognitive areas identified in the literature as being potential problems areas within at least one of the dementias (DLB or AD) were also assessed, namely memory (Rivermead Behavioural Memory Test: RBMT) and visual perception (Visual Object and Space Perception: VOSP).

**Conclusion**

Mrs X was currently under-performing according to the NART-R predictions, and she exhibited current global cognitive deficits, however her cognitive difficulties did not impact on her social and occupational daily functioning and so could not be attributed to a dementia process. Clinical opinion would suggest that it was likely that Mrs X had an undiagnosed borderline learning disability, the affects of which became more evident when her husband suddenly died and her support structure was no longer there. This theory is supported in the assessment as both Mrs X and her son reported that she had undergone a recent gradual and continuing cognitive decline since the death of her husband, who may have compensated for Mrs X’s difficulties. This conclusion is more in line with the assessment information if it is deemed possible that the NART-R predictions were not reliable. The current calculation that is used to predict current levels of functioning on the WAIS-3 from the NART-R only gives an approximation.

**Recommendations**

The recommendation is to repeat the assessment in about one year if there are further concerns. It may be that a dementia process has started but has not yet met full criteria, whether this is co-morbid with a learning disability or not.
NARRATIVE ASSESSMENT AND TREATMENT OF A 52-YEAR-OLD WOMAN WHO STORIED ‘LOSS OF INDEPENDENCE’ IN THE FACE OF CHRONIC PAIN

Referral

X, a white, fifty-two year old, English speaking woman, was referred for chronic pain and tension headaches. X suffered from chronic pain resulting from a wrist fracture two years ago. In addition she was having stress related headaches which were not responding to treatment, hence the referral to psychology for assessment. The referral letter also highlighted that X found her husband, Bob stressful.

Assessment

An assessment was conducted using an assessment questionnaire prior to a clinical interview, which both requested details about the problem and historical information about the client. The interview was conducted over one unobserved, ninety-minute session by the author with both X and her husband due to the potential relationship issue. The assessment also involved the administration of the Clinical Outcome Routine Evaluation form (CORE), a thirty-four item questionnaire, which measured the ‘global distress’ of symptoms. During the assessment the use of a pain diary over a two-week period to indicate levels of physical pain and distress was also used. Finally, the use of X’s statements about the problem and her identified therapy goals were incorporated into the assessment.

Presenting Problem

X identified her “loss of independence” in conducting daily living tasks as her main difficulty, not the chronic pain. She described problems with being able “to prepare food easily” and “some difficulty dressing” and was unable to drive. The chronic pain was therefore increasing X’s dependency on her husband and medication, her “anxiety” and “vulnerability” when handling unsafe equipment (such as boiling water in a pan) and her fear of walking outside (due to the possibility of a further fall). Overall, the increase in dependency has lead X to believe that she “can’t cope”.
Formulation

The formulation was based on social constructionist ideas in the form of a narrative approach (White & Epston, 1990). During the assessment, the main tasks were to establish the dominant problem-saturated narrative that the client was telling herself and others and to examine the client’s ‘preferred’ view of themselves and whether this fits with their current view of self and how others see them (Eron & Lund, 1996). During the assessment/treatment session, X repeatedly reported a dominant narrative of her “loss of independence”, expressed also as a loss in control, self-efficacy, her identity and role within her marriage, her job, her routine and her social network. The impact of this narrative was global and was often expressed as “I can’t cope” or “I am not in control”. In addition, X’s current view of herself as a dependent, helpless, inactive person did not fit in with her ‘preferred’ view of herself as an independent, capable woman. Both X and Bob held the above problem-saturated narratives and views about how chronic pain had affected X and subsequently their marriage.

Intervention

The main aim of therapy was to elicit examples of alternative stories of independence and control to embellish the alternative narrative of “I am independent” which would be more in line with X’s preferred view of herself and would be a positive empowering self-narrative. A further aim was to externalise the problem as a separate entity that was outside of X in order to unite and empower X and Bob against the narrative of “loss of independence”. The third aim was to embed the alternative story historically to ensure it was experienced as a genuine narrative (White & Epston, 1990). A further goal was to include Bob in the therapy. The aim was that a positive focus would emerge within sessions, which would affect their communication and allow a more positive view of X to emerge.

Outcome

After three sessions, X was able to self-generate and historicise her alternative narrative of independence and control, however Bob was still storying the problem-narrative which lead to further relationship problems and additional therapy.
BOTH BEHAVIOUR THERAPISTS AND COGNITIVE THERAPISTS MAY USE BEHAVIOURAL TECHNIQUES IN THE TREATMENT OF ANXIETY DISORDERS AND DEPRESSION. HOWEVER, THE UNDERLYING THEORETICAL RATIONALES FOR THE USE OF THESE BEHAVIOURAL TECHNIQUES DIFFERS. CRITICALLY EVALUATE THESE DIFFERENT THEORETICAL RATIONALES BY DRAWING ON THE LITERATURE FROM ANXIETY AND DEPRESSION.

The use and integration of behavioural and cognitive theory in the treatment of anxiety and depression has provoked strong debate as to the nature of the change evoked in clients and therefore the validity of both theory rationales. This essay explores the common element to both approaches, the role of behavioural techniques within therapy and looks at how the differing underlying theories seek to explain the use of these techniques in treating anxiety and depression. Both approaches are variable in their use of behavioural experiments, activity scheduling, mastery and pleasure ratings, social skills, assertiveness training, role-playing, homework assignments and relaxation techniques within their treatment methodologies. Many behavioural techniques are outlined by Kanfer and Schnett (1988; as cited in Sweet & Loizeaux, 1991). The greater use of behaviour techniques is found within behavioural therapy and so the rationales involved will be evaluated first and used as a grounding for the later discussion on their use in cognitive-behavioural therapy.

The Rationales behind Behavioural Therapy

Behavioural theorists postulate many different rationales which centre on the idea that anxiety and depression are ‘learned behaviours’ (Schwartz & Schwartz, 1993). These rationales are based on classical and operant conditioning models and modelling techniques.

Classical conditioning theory states that anxiety can develop as a response to the paired association of a neutral object or situation to a painful event (Watson & Rayner, 1920), so that the anxiety becomes ‘conditioned’. A phobia is derived from a generalisation of the anxiety response to other similar stimuli connected to the original feared object or situation (Riccio, Richardson & Ebner, 1984: cited in...
The classical conditioning of depression is associated with loss of nurturing and mothering which leads to apathy, depressive behaviour and low mood. This theory was based on animal studies where nurturing was withheld from young monkeys which elicited symptoms such as despair, which are believed to be symptoms typical of human depression, (Kinney, Suomi, & Harlow, 1971: cited in Schwartz & Schwartz, 1993).

The operant conditioning model stipulates that behaviour interacts with the external world and is affected by consequences; for example, if any behaviour is ‘rewarded’ then it will be positively reinforced and the likelihood that it would occur again increases (Skinner, 1953: cited in Sheldon, 1995). In anxiety, avoidance behaviour can be positively reinforced by the sense of relief that comes from the reduction in the physical symptoms of anxiety whenever an anxious person escapes from a fearful situation. However, according to operant conditioning model principles, depression is due to a prolonged process of extinction, as a response to loss, for example the depressed widow doesn’t want to cook dinner since her husband has died, as the lack of reinforcement of him eating has gone (Schwartz & Schwartz, 1993). Secondary gains can also maintain depression, for example the attention and sympathy gained from others, reinforces and perpetuates the continuation of depressive behaviour.

The theory of modelling or vicarious conditioning is that a phobic fear or a depression response can be adopted through the observation of those responses in others (Mineka, Davidson, Cook, & Keir, 1984).

**The Rationales behind Using Behavioural Techniques in Behavioural Therapy**

Behavioural treatment is a process of counterconditioning, a technique whereby a new appropriate response is elicited in the presence of the feared stimuli as a substitution for the previous anxiety or depressive response. The rationale is that after repeated trials of exposure, the new response becomes the new learned behaviour (Sheldon, 1995). However, there is evidence that refutes the underlying assumption that all people with phobias have had prior exposure to the feared stimulus associated with a bad experience (Ost, 1987: cited in Davison & Neale, 1996). Attempts to replicate Watson’s and Rayner’s (1920) experiment with Little Albert and other forms of
conditioning experiments have also been unsuccessful (Davison, 1968, Mineka, 1985: cited in Davison & Neale, 1996). It is also apparent that not all people who have for example, had a car accident will go on to develop anxiety about getting into a car, and not everyone who suffers multiple losses develops depression.

Another form of counterconditioning is the behavioural technique of assertiveness training, which neutralises anxiety or depression through the process of skill building. However historical accounts in clients self-reports are often adequately explained by conditioning theories alone (Ost & Hugdahl, 1981; Wolpe, 1981: cited in Wolpe, 1989). It may be erroneous to view phobia and depression as merely a consequence of learning and treatment a reversal of a conditioning process that may not have existed in the first place. Treating each patient on an individual basis is necessary to direct treatment.

Shaping is another behavioural technique, which attempts to change an overt avoidance response to a form of approach behaviour through the rewarding of successive approximation of the target desired behaviour (Sheldon, 1995). This technique is based on Skinner’s (1953) operant conditioning model and the rationale that behaviour is contingent on its consequences. It must be noted that the nature of human relations is very complex and therefore the behaviour would be influenced by many conflicting factors. This complex interplay of influences on behaviour is individualised and not often clear to interpretation, for example an anxious or depressed person may receive positive reinforcement by attention from others, but conversely their lives are ultimately restricted which is an ongoing negative experience. The crux of the issue is how these factors are weighted in value and therefore interpreted into beliefs and action. It is often difficult to ascertain what are the mediating factors in the decision-making process, which responds to one influence more than the other. Another concern of the behavioural rationale, is that different compulsive acts lessen anxiety to different degrees (often ineffectively), which combats the theory regarding the positive influence of relief (Rachman & Hodgson, 1980: cited in Davison & Neale, 1996). Performance rituals, hypothesised as a means to reducing anxiety, fail to account for the role of obsessions which increase attention and therefore in theory, exacerbate anxiety in the problem within Obsessive

Modelling is used to teach appropriate behaviour based on the rationale that behaviour could be learned from the observations of others. This basic premise, doesn’t account for all phobias based on patients self-reports and the fact that many people observe the fear response of others, without becoming phobic themselves (Davison & Neale, 1996). Not every stimulus is capable of becoming a source of acquired fear. Rhesus monkeys were shown films of a monkey showing fear to a toy snake, toy crocodile, flowers and a toy rabbit, however fear was only acquired with first two modelled stimuli (Cook & Mineka, 1989), which suggests a possible predisposition to fear certain stimuli. Depression, anxiety and general coping strategies can appear to be modelled by parents and carers, however behaviourism does not account for the possible involvement of genetic and biological factors. This finding taints its validity, as mental health problems are complex and seemingly multi-factorial (Williams, 1984: cited in Schwartz & Schwartz, 1993).

The most widely used behavioural technique is systematic desensitisation; in anxiety this incorporates the induction of deep relaxation, followed by exposure to imaginal or real elements of the feared stimuli in a gradual predetermined exposure hierarchy (Davison & Neale, 1996). The rationale is that the relaxation inhibits the anxiety response, a technique called reciprocal inhibition (Wolpe, 1989), which states that the body can not be in a relaxed and anxious state at the same time. The theory of reciprocal inhibition has been useful in the treatment of Obsessive Compulsive Disorder (OCD) when exposure is used with response prevention (Visser, Hoekstra & Emmelkamp, 1992: cited in Bergin & Garfield, 1994). Within treatment, a patient with OCD, who has cleaning rituals would have to purposely touch a dirty plate and whilst all counteracting cleaning rituals are banned. Many studies have shown that in time, the anxiety extinguishes after repeated practice (Foa, Steketee & Ozarow, 1985: cited in Davison & Neale, 1996).

Wolpe’s theory on systematic desensitisation for depression is based on the supposed anxious responses due to a lack of self-confidence, shyness and low self esteem. Easing the anxiety should therefore extinguish the conditioned link between low self-
image and anxiety felt in threatening situations (Wolpe, 1980: as cited in Schwartz & Schwartz, 1993). Therapy is centred on assertiveness training involving modelling, practising and systematic desensitisation to social situations. Wolpe’s theory has been criticised for many reasons, in general it doesn’t account for cognitive, biological and other factors and the role of secondary positive reinforcement gained from having anxiety or depression (Schwartz & Schwartz, 1993). Although Wolpe has contested this and states clearly that cognition is accounted for within behavioural theory, he states it is not objective criteria valid for direct study. Another criticism of Wolpe’s study has been the absence of control studies (Turner, DiTomasso, & Deluty, 1985: cited in Schwartz & Schwartz, 1993).

Alternatively a flooding technique can be used within behaviour therapy where full prolonged exposure is implemented whilst the patient is in a relaxed state, often useful for the treatment of Posttraumatic Stress Disorder (Keane, Gerardi, Quinn & Litz, 1989: cited in Davison & Neale, 1996). The relaxation techniques have decreased anxiety, anger and depression across many studies, however caution must applied as the findings have been based on self-reports which have dubious reliability and validity (Lehrer & Woolfolk, 1982: cited in Davison & Neale, 1996).

Techniques, such as skills acquisition, role playing, modelling and behaviour rehearsal, help patients to demonstrate and learn more adaptive ways of functioning, which may be more helpful (Turner, Beidel, & Townsley, 1992: cited in Davison & Neale, 1996). These behavioural techniques provide a new forum for learning new skills like assertiveness. Lewisohn’s social learning approach highlights the use of assertiveness training for depressed people, who often lack the social skills to increase positive interactions with others (Lewisohn & Hoberman, 1985: cited in Schwartz & Schwartz, 1993). Within this behavioural theory the role of expectations of failure is recognised, although cognitions are not directly assessed due to their lack of objectivity. The behavioural rationale applied to Becker’s Social Skills Training (Becker, 1987: cited in Schwartz & Schwartz, 1993) is that depression occurs when the person receives too little or infrequent positive reinforcement or lacks feedback or other forms of rewards, for example recognition from the external world. Becker’s Social Skills Training is aimed at teaching skills to maximise the potential of obtaining positive reinforcement from the environment. Social skills deficits are
believed to derive from developmental problems in the acquisition of social awareness, lack of feedback, the learning of inappropriate skills or attempts at using skills that haven’t been used for a while, e.g. dating. Therapy requires awareness of appropriate behaviour and involves help with self-evaluation and self-reinforcement training, teaches expressive communication skills, recognising social cues, understanding non-verbal communication, empathy and flexibility training. The behavioural techniques involve role-play, practice, generalisation and social perceptions training. Patients are encouraged to set achievable and realistic goals for behaviour and for judging themselves; ultimately they must learn to reinforce themselves for appropriate behaviour. Becker’s model has limited efficacy because it can not be used with inflexible, resistant clients with severe depression and therefore it is usually aimed at outpatients only.

Activity scheduling and ‘mastery and pleasure’ exercises have stemmed from a further rationale on anxiety and depression and are associated with a lack of control. Themes to do with feeling unable to control the unpleasant things that happen can produce a generalised anxiety disorder or bring about depression through learned helplessness. The theory stems from animal experiments where dogs were restrained so that they could not avoid electric shocks (Seligman, 1975: cited in Schwartz & Schwartz, 1993), after many attempts to escape the shocks, the dogs finally gave up and developed overt signs of depression. These overt behaviours were believed to be similar to the depressive symptoms displayed by people who have been subjected to severe trauma or deprivation. Whenever the opportunity to escape or avoid trauma is accessible or if the person is equipped with sufficient coping skills and support then depression may not occur, but a lack of these opportunities may result in depression, low self esteem and vegetative symptoms. The behaviour techniques involved in activity scheduling is to start initiating and regaining control through self-monitoring of activities. The techniques attempt to increase the likelihood of eliciting positive feedback through experience, enabling the development of coping strategies, control and an increase in ‘valuable’ experiences which will heighten feelings of pleasure. Rehm’s Self control Model (1977: cited in Bergin & Garfield, 1994) also builds from the same behavioural rationale, wherein people take on an active role in influencing the nature of their patterns of behaviour and their interactions with the environment (Schwartz & Schwartz, 1993). Fundamentally this approach is based on the idea that
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people have a choice and can control what they do and builds on Kanfer & Gaelick’s (1986: cited in Schwartz & Schwartz, 1993), three-step process of changing behaviour model using self-monitoring, self-evaluation and self reinforcement or self-punishment stages. However an initial problem could be that depressed people judge themselves too harshly and could potentially set up a self fulfilling prophecy, which makes skill building and supervision a vital component (Schwartz & Schwartz, 1993).

A fundamental problem, which has been a criticism of Rehm’s self-control model, is that it is not apparent what are the mediating factors which induce the desired changes (Beach, Sandeen, & O’Leary, 1990: cited in Schwartz & Schwartz, 1993).

Overall the use of behavioural techniques within behaviour therapy has been successful, since the aim of changing behaviour is usually achieved. Many benefits stem from the implementation of techniques based on observable outcome measures, behaviour techniques make it easier to assess whether therapy has been effective and help to focus therapy and motivate clients by monitoring progress. However more general criticisms of the behavioural theory and therefore the rationales for the use of behavioural techniques must be considered.

Overall the behavioural approach has provided clinically applicable explanations for anxiety and depression, however most of the findings and rationales have been based on animal studies which have failed to provide an insight into possible internal changes. All of the results are based on observable behaviour, however the interpretation of what constitutes a discrete behaviour, it’s causes and consequences are all subject to the interpretations of the observers. The observers have no access of other unobservable factors, e.g. internal process or a high pitched noise only audible to animals which may have an effect on the animals behaviour but is not necessary apparent, therefore conclusions may be erroneous. The theories based on experiments with animals have stipulated causal relationship, however in real life, internal and external behaviour is more complex, for example depression in people is more complex than the false depression produced in laboratories, which tends to disappear within days (Marks, 1981: cited in Wolpe, 1989).

Another criticism of behavioural rationales and therefore the treatment techniques is what is assessed as an effective outcome. The self-reports of depressed people treated
by behavioural methods, suggest that although they are doing more which indicates success in behavioural terms, they do not feel any different which impedes their quality of life. Ultimately behavioural therapy changes behaviour but does not produce any long-term personality changes (Ellis, 1997: cited in Reitman, 1997). It would appear that until this leftover problem is challenged, people would remain fundamentally untreated. Behaviourist Wolpe's (1989) contention is that mediating cognitions or interpretations are not always necessary and that some anxiety or depressed responses are merely an immediate reaction to certain triggering stimuli, which would make extensive cognitive therapy redundant.

Behavioural research and therapy has methodological short-comings and is unable to provide any conclusive evidence of a fit between theory and results of interventions (Blaney, 1981; cited by Schwartz & Schwartz, 1993). Marshall and Segal (1990) stated that within behaviourism there is no single approach and the different rationales regarding how behaviour is learned makes evaluating and comparing outcomes difficult. Research into depression is too complicated as the symptoms are specific to each individual and so comparative controlled research is difficult; the research obscures patient characteristics and outcomes measures as all individuals respond differently (Marshall & Segal, 1990: cited in Schwartz & Schwartz, 1993). Ultimately behavioural therapy has been accused of “exaggerating the generality of theories of conditioning and learning” and of “over-simplifying” the causes of complex mental disorders (Gelder, 1997: cited in Clark & Fairburn, 1997, pp 27).

The Rationale behind Cognitive-Behavioural Approaches

Cognitive-Behavioural therapy is concerned with the role of cognition, namely the process of the interpretation of physical senses, experiences and the interaction with the external world. Cognitivists state that as conscious beings, people develop a core belief system derived from past experiences which set up a system of assumptions about the self, others, the world and the future (Beck, 1976: cited in Davison & Neale, 1996). These beliefs and assumptions trigger certain expectations and will bias what information is attended to (Burgess, 1981) and therefore effects the way events are experienced. Unpredictable fears can lead to experiences of hyper-vigilance, fear and depression, which leads to a focus on anticipated future disasters. As a result many
people with anxiety or depression end up living and functioning within a “vulnerability schema” (Beck & Emery, 1985: cited in Davison & Neale, 1996) and the focus of therapy is a response to feelings of not having control and those of helplessness.

The above themes and rationales are evident in the models of anxiety and depression. If an anxious person believed he (in this case a male client is used as an illustration) would die of a heart attack if he entered a lift, then he would consciously look out for lifts all the time (bias). When he saw one the associated beliefs would be triggered, which would trigger the physical symptoms of anxiety as the body prepares itself against the threat, which escalates the fear as physical symptoms are misinterpreted as signs of imminent death. In short a vicious cycle develops between physical sensations, thoughts (interpretations) and behaviour, for example avoidance of lifts means that this belief is never challenged which perpetuates its existence (Hawton, 1989).

In depression previous experiences help mould a person’s belief system and cognitions about themselves, the world and the future, for example, if someone has experience of a lot of loss they will withdraw, may blame themselves, and expect future losses which will colour their view of the world (Beck, 1976). Depression is the consequence of these negative thoughts and beliefs being triggered, which are rigid and counterproductive. Negative thinking will in time form a negative bias, which feeds back into the system by attending primarily to negative events and loss. As a result a depressed person will remember negative experiences more vividly and will develop negative thinking errors and patterns which perpetuates the bias, for example minimising positive experiences whilst maximising the importance of negative ones. The experience of life seeming negative will maintain low mood and negative thoughts and core beliefs (Hawton, 1989). There are many other personality factors involved in the development of depression, for example perfectionistic tendencies, when people try to hold themselves to unrealistic, unobtainable standards (Horney, 1950: cited in Schwartz & Schwartz, 1993) which can lead to feelings of helplessness and therefore depression.
Rational Emotive Therapy (Ellis, 1962: cited in Schwartz & Schwartz, 1993), a form of cognitive therapy, fulfils the criticism of behavioural therapy by attempting to elicit enduring "personality change" as an outcome of therapy (Reitman, 1997). The rationale is that events that occur will elicit consequences, which are shaped by the mediating core beliefs, which can be irrational. Causal relationships and triggers such as behaviour or thoughts are identified. Therapy involves disputing the irrational beliefs and substituting with more appropriate ideas, which leads to modification to more appropriate emotional responses and desirable behaviours. Clients are encouraged to express negative or bad feelings and experience them as tolerable; to do this a change in behaviour must be sought.

The Rationale of Behavioural Techniques Implemented in Cognitive-Behavioural Therapy

Cognitive-behavioural therapy and Rational Emotive Therapy attempts to challenge the belief system and misinterpretations within anxiety, and depression treatment involves attempts to test out current beliefs and the substitution of more appropriate rational beliefs through behavioural experiments (Hermberg, Dodge & Becker, 1987: cited in Davison & Neale, 1996). Behavioural experiments are also used to help access negative automatic thoughts, to illustrate the role of thoughts and the vicious cycle, to elicit alternative experiences and beliefs and to counterbalance the deleterious effects of avoidance behaviour which maintains the emotional disorder. The primary problem with the use of behavioural experiments within anxiety is the assumptions that, for example in panic, it is assumed that a misinterpretation of physical symptoms has occurred. If a spider phobic has a core belief that they are going to be harmed by the spider, that it will bite and kill them, this would be deemed a misinterpretation of the facts and would be challenged within cognitive behavioural approaches by education, rationalisation and exposure. However this does not explain why people who are spider phobic have the same anxiety fear response to pictures of spiders, when conceivably there is no real danger (Wolpe, 1989). Wolpe argues that if there is to be a "catastrophic misinterpretations" (Clark, 1986: cited in Clark & Fairburn, 1997, pp 125) of physical symptoms of anxiety then it must follow the initial symptoms of panic which must then be an automatic "unconditioned fear response" (Wolpe, 1989). Many studies have discovered that depressed people have
more realistic appraisals than non-depressed people who tend to “overestimate the likelihood of success” (Lobitz & Post, 1979: cited in Davison & Neale, 1996, pp 232). If this were the case then their expectations within these behavioural experiments would be more not less realistic. In follow-up studies it was also found that depressives do not necessarily have greater thought distortions (Layne, 1986: cited in Davison & Neale, 1996). It is of note that in a longitudinal study it was found that negative thinking does not precede depression (Lewisohn, Steimetz, Larsen & Franklin, 1981), which suggests the symptoms of depression occur first without the mediation of thoughts.

The behavioural techniques of systematic desensitisation is used in cognitive-behavioural approaches because the experiences of imagined exposure hierarchies is useful in establishing that reactions can be brought on by fantasy alone. This is an important step in the realisation that it is the internal thoughts or interpretations that has triggered the anxiety or depression and not a real threat or negative experience (Beck, 1976). Through this graded experience, the client can also acquire the ability to discriminate between fact and fantasy which has been shown to reduce anxiety (London, 1964; as cited in Beck, 1976) and gain the conviction of the thoughts being irrational and therefore have the impetus to change them (Beck, 1976). Cognitive – behavioural therapy is criticised for not recognising that changes in the thoughts do not necessarily have a causal role in the reduction of depression but it could be that the natural mood changes and concurrent lessening of depression which changes the cognitive experience of depression. It has been argued that cognitive distortions may be the symptoms rather than causes of depression (Bellack, 1985: cited in Schwartz & Schwartz, 1993).

Activity schedules and mood, mastery and pleasure ratings (Beck, 1979: cited in Schwartz & Schwartz, 1993) are similar to behavioural logs, both identify negative automatic thoughts, thinking errors, cycles of rumination and coping, triggers for anxiety or depression and cycles of behaviour. These logs are used to set specific individualistic targets and goals for the client to reach, for example an assigned activity could be to speak to someone at lunch and help to reflect progress. The associated rationale is the replacement of “lost” mastery and pleasure, with the aim of producing an immediate shift in mood, allowing access to cognitions by immediately
challenging beliefs. Fundamentally, it can be used to disprove the thoughts that the patients have about being generally inactive and useless (Hawton, 1989) and helps them assess useful ways of behaving or thinking. Cognitive-behavioural therapy has failed to explain the exact process of how habits and cycles of behaviour can be changed and it is argued they are not as individualistic in their treatment as they pertain (Wolpe, 1989).

The teaching of skills, such as assertiveness training is a forum wherein the client can test the validity of thoughts of anxiety or depression within a safe environment, as an attempt is made to change the concept of the self (Beck, 1976). This rationale also underpins the use of modelling within a cognitive-behavioural framework and allows the rehearsal of adaptive thinking, behavioural actions and problem solving skills. Again this rationale is subject to the same criticisms as above, relating to the importance given to cognitions at the expense of genetic and biological factors, a criticism also of behavioural approaches.

Relaxation is another behavioural technique used within cognitive behavioural therapy, since it a demonstrable way of proving that the symptoms of anxiety and depression can be controlled (Hawton, 1989). Again the process by which this is proven and then changes that then take place are not clear since there is no satisfactory explanation of behaviour based on the process of cognition and its interactions within its levels and with other aspects of the self. The fundamental problem is that cognitive-behavioural theory treats “hypothetical structures and process, which do not exist in any empirical sense as if they were real” (Lee, 1987: cited in Lee, 1990, pp 145).

In general the outcome studies from the cognitive-behavioural literature has been criticised by Wolpe for using “non-psychotic depression” (Wolpe, 1989). Wolpe, also states that the interaction between therapist and client are not taken into account, and so reinforcers like attention and reassurance from the therapist are factors which are ignored. Ultimately cognitive-behavioural rationales have been criticised, since a lot of behaviour variability is not explained cognitively (e.g. Baer, Holt & Lichtenstein, 1986: cited in Davison & Neale, 1996) and observable overt behaviour still remains a more reliable predictor of treatment efficacy (Feltz & Mungo, 1983:
cited in Lee, 1983). However cognitive methods alone have never been seen as an effective treatment within its own right (Beck, Rush, Shaw et al, 1979; Ellis, 1979; as cited in Latimer & Sweet, 1984).

**Discussion**

Cognitive-behavioural and behavioural theory have many things in common; during assessment both approaches try to establish causal relationships and establish baseline measures e.g. frequency counts or depression scale score. Both approaches base their interpretation of the problems as a formulation, have an active therapeutic approach in trying to engage the client quickly, are present focused, adopt a problem-solving strategy and establish clear defined goals for treatment (Beck, 1976). It would also appear that learning and the importance of past experiences as recognised within cognitive-behavioural therapy are similar in eliciting certain disordered behaviours, however cognitive-behavioural therapy extends to the hypothetical thought processes involved in interpreting experiences.

As cognitive theorists have taken on behavioural techniques there has been a shift for behaviourism to use ideas from cognitive and other disciplines. For example, behaviourist Wolpe (1989) has identified four different types of depression, which integrates cognitive behavioural theories regarding the role of cognitions in the development of depression.

Within the theoretical background it is important to establish the differences between the two rationales as outlined above in the use of behavioural techniques. Again the issue is raised in what therapy is hoping to change within the individual, behaviour, cognition or affect? The cognitivists state that cognition, behaviour and affect interact with each other; if this is the case, then the behaviour changes brought about by behavioural therapy could potentially produce shifts in cognition and affect as well. It would seem that the new revolution that cognitivists claimed has not materialised and therefore can’t be separated distinctly from behaviourism (Sweet, 1984, as cited in Latimer & Sweet, 1984). The question remains whether the use of exposure and behaviour experiments themselves would serve the same function in behavioural therapy as they do in cognitive-behaviour therapy, as challenges to dysfunctional
beliefs? One study found cognitive change after behaviour therapy, although cognitive-behaviour therapy elicited a greater shift in cognition (Butler, Fennell, Robson & Gelder, 1991). The emphasis is clearly different in where therapy is directed within the individual, however both start with making changes to behaviour, as the more obvious and immediately effective shift. There is the possibility both therapies change similar aspects of the client, albeit behaviour or cognition but places its measure of emphasis on different characteristics for clinical evaluation. Cognitions could be viewed as a form of verbal behaviour, as “covert self statements” which are subject to the same behavioural rationale (Meichenbaum, 1977; cited in Bergin and Garfield, 1994, pp 430).

The outcome measures from both treatments have been omitted due to a large amount of research favouring either one or the other, therefore producing conflicting results, from which can be elicited little meaning. The diversity of the results makes it difficult to come to any conclusions about the merits of the theoretical rationales behind the use of behavioural techniques. Behaviour therapy is well structured and the outcome measures are based on more reliable factors, but it is closed to the phenomena of cognition and the undoubtedly vital role it plays. Cognitive-behavioural theories attempt to redress this imbalance, but essentially, the process of these hypothetical cognitions is still unclear and access through self-report is unreliable. Left with this knowledge, it may be acceptable for now, knowing that behavioural techniques are effective within therapy, without really knowing how or why.
References


Learning Disability

Essay

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WHAT IS THE IMPACT OF OTHERS’ EXPECTATIONS ON THE COMMUNICATIVE ABILITIES OF PEOPLE WITH LEARNING DISABILITIES AND HOW MIGHT A CLINICAL PSYCHOLOGIST WORK WITH THESE ISSUES?

"Communication is the most complex of all human behaviours and is fundamental to an individual’s experience of relationships, choice, assertion, control and emotional and self expression. It enables an individual to develop personal identity and self-esteem, build relationships and exert a measure of control over their life”

(Thurman, 1997)

Communication is a crucial factor affecting the quality of life of everyone, however within people with learning disabilities it is a fundamental barrier to valuable interactive experiences. People with learning difficulties have pervasive problems with communication, with an estimated prevalence rate from 50% (Enderby & Davis, 1989) to 89% found within a representative sample (Noble, 1990). The expectations of others, intrinsic in interactions with people with learning difficulties can further compound these difficulties, which has a deleterious affect on the self-image and confidence of these individuals and their long-term level of dependency, social isolation and restriction (Yoder & Warren, 1997).

The impact of others’ expectations on the communicative abilities of people with learning disabilities can take on a number of forms. Fundamentally the approach of ‘others’, (service providers, teachers, peers, police, parents, healthcare professionals and carers) can impact on the educational, behavioural and psychological welfare of an individual with learning difficulties, which can effect their cognitive and language development and future prospects. This essay attempts to assess the varied impact of ‘others’ expectations on communication success, with a view to establishing a way for clinical psychology to intervene and enhance the quality of life for those with communication difficulties. The impact of communication difficulties on people with learning difficulties will be outlined, although it is recognised that all the multiple expectations of others and their impact all overlap and interact with each other.
An Historical View of Previous Expectations of Others and their Impact on Individuals Communication Abilities

Historically, perceptions of people with learning difficulties have dramatically affected their treatment and available communication resources (see Table 1). Amongst these early perceptions, it was largely assumed that people with learning disabilities were uneducable leading to a withdrawal of education and opportunities to develop communication skills (Brechin & Swain, 1988). The impact on the learning disability population was global and ultimately disempowering, leading to marginalisation from the rest of society, leading to social demarcation through negative labelling (Wolfensberger, 1972), such as ‘mental retardation’, poverty, passivity and isolation within distorted, unstimulating environments. The environment, in depriving of opportunities to learn, fulfilled the expectations of others merely as a result of the deprivation imposed. As an example, institutionalisation had limited the generalisability of skills developed in situ to novel situations, reflecting an environmental effect on skill development. This historical perspective is important in understanding the learning disability population of today, in terms of their previous impoverished experiences, which has affected their level of communicative skills and as a lesson in how our expectations can undermine and deprive this vulnerable population.

Table 1. Social-historical deviancy role perceptions and resultant service and staffing models.

<table>
<thead>
<tr>
<th>Role Perception</th>
<th>Service Model</th>
<th>Staff Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subhuman: Animal, vegetable, insensate object</td>
<td>Neglect, custody, destruction.</td>
<td>Catcher, attendant, caretaker, keeper, gardener, exterminator</td>
</tr>
<tr>
<td>Menace, or object of dread</td>
<td>Punitive, segregation, or destruction</td>
<td>Guard, attendant, exterminator</td>
</tr>
<tr>
<td>Object of ridicule</td>
<td>Exhibition</td>
<td>Entertainer</td>
</tr>
<tr>
<td>Object of pity</td>
<td>Protection from demands</td>
<td>Members of religious bodies, charitable individual</td>
</tr>
<tr>
<td>Burden of charity</td>
<td>Industrial habilitation</td>
<td>Trainer, disciplinarian, work master</td>
</tr>
<tr>
<td>Holy innocent</td>
<td>Protection from evil</td>
<td>Member of religious bodies, charitable individual</td>
</tr>
<tr>
<td>Eternal child</td>
<td>Nurturant shelter</td>
<td>Parent</td>
</tr>
<tr>
<td>Sick person</td>
<td>Medical</td>
<td>Physician, nurse, therapist</td>
</tr>
</tbody>
</table>

(Wolfensberger, 1972)
Psychology had a role in establishing that people with learning difficulties have the capacity to learn. However, further research in life-span studies are required to ascertain the long-term effect on the communication resources of adults with learning difficulties, who have received training on lexical development. Psychology has played a major role in the de-institutionalisation process, having made recommendations in the development of community residences, changing restrictive protocols and advocating reflective practice and open, supportive communications (Landesman, 1988). The whole concept of normalisation, of creating access and opportunities to resources available to all, in order to achieve a better quality of life (Wolfensberger, 1972) is now current. Further goals for services with regard to achieving the five accomplishments of ‘community presence’, ‘community participation’, ‘supporting contribution’, ‘promoting choice’ and ‘encouraging valid social roles’ (O’Brien, 1990, cited in Emerson, Caine, Bromley & Hatton, 1999) for people with learning disabilities, has opened up the services, contact and resources enhancing social integration and communication opportunities. However, when evaluating others’ expectations and knowledge, in areas of ability, communication style and the self-perceptions of people with learning disabilities, it would appear that there is still a large discrepancy between our perceptions and the reality of life with a learning disability.

The Impact of Others Expectations on Developmental Level of Communication Ability

Communication is the foundation of knowledge, education and socialisation into a world of shared culture and meaning (Remington, 19??), access to which, determines the degree of success that is achievable (Schoenbrodt, Kumin & Sloan, 1997). However, within children with learning difficulties an important breakdown in communication and therefore access to the cultural world, starts within the early developmental stages of language acquisition, with delayed and slower language development and a lower overall level of achievement (Rosenburg & Abbeduto, cited in Yoder & Warren, 1997). Language develops as a way of symbolising and internalising reality (Yoder & Warren, 1997), affected by the level of language input, which can contribute to delays in development, especially input, which is above the pre-existing language ability of the child (Yoder & Warren, 1997). A mother's crucial
input is an example of early communication breakdown in interactions with children with learning difficulties. Mothers of learning difficulties children initially develop a structured, controlling, directive style of language (Poikkeus, Ahonen, Narhi, Lyytinen & Rasku-Puttonen, 1999) in response to few and unclear communications from the child. Although this may be initially helpful, studies have shown that this directive style is maintained, instead of adapted as in interactions with non-disabled children. Therefore important skills are never demonstrated and practised, such as turn-taking, which is important for rapid achievement within language development (Menyuk, Liebergott & Schultz, 1995; cited in Poikkeus et al 1999). The impact of mothers’ expectations impacts the child with learning difficulties in further delaying development and reducing opportunities to acquire language skills, effecting education and the norms and values governing success.

However, other research has indicated that language develops in all children, irrespective of the inadequacies of the language input (Klein & Rapin, 1988, cited in Yoder & Warren, 1997). Although, modifications in language input, as in ‘motherese’ (when mothers adapt their language by using simpler constructs, slower articulation, higher pitch and exaggerated intonation) have been influential in furthering the development of language delayed children (Hoff & Ginsburg, 1986, cited in Yoder & Warren, 1997). The impact of the expectation of abilities beyond the child’s competencies will promote and perpetuate the experience of failure without any likelihood of being able to achieve and build on existing skills.

Cognitive abilities and physical impairments, such as hearing and visual problems have a high incidence rate (van der Schrojenstein Lantman de Valk, van den Akker, Maaskant, Haverman, Urlings, Kessels & Crebolder, 1997, cited in van der Gaag, 1998) and yet are frequently underestimated (Purcell, Morris & McConkey, 1999). These disabilities may play a role in the receptive and expressive communicative abilities of learning disabled people, especially when compounded by memory and organisation difficulties (Engle & Nagle, 1979, cited in Owens, 1997) which can impede the organisation of language and representation of cognitions.

It is often hard to appreciate without knowing an individual’s capabilities, how much information is understood, when there is a discrepancy between the expressive and
receptive abilities of a person with language difficulties. When expressive language capabilities are good, receptive understanding of speech is usually overestimated, when really only a few key words and contextual cues are used to obtain information. If communication is not geared to the real receptive level of the individual with communication difficulties then communication breakdown and frustration can easily occur. Clinical examples in everyday practice often reflect the assumption that people with learning difficulties “understand everything I’m saying” and are just being awkward in not following instructions, which can widen the gap between carers and clients. Again others over-expectations of ability can overlook the impact of these deficits on communication skills, which can lead to fewer chances for successful communication, which can be reinforced.

Once the capabilities of a person is known and expectations become more realistic, communication can be enhanced through individually tailored programmes and communication aids. Speech and Language Therapists (S.A.L.T.) have used eye-gaze communication boards, developed for use with people who have concurrent physical disabilities alongside speech difficulties, enhancing the use of eye gaze to indicate intent and meaning (Sigafoos & Couzens, 1995). Psychological intervention can enhance the work of S.A.L.T. through the use of functional teaching methods, based on an ‘ecological analysis’ (Remmington, 1977). The aim is to use the natural environment to help with the use, practise and generalisation of language skills by staff trained to use individualised structured interactions. An example of environmental manipulation is using table seating arrangements to facilitate communication, promoting active and positive listening skills (Schoenbrodt, et al, 1997).

Underpinning functional treatment programmes, clinical psychology is able to adopt behavioural principles and techniques, such as reinforcement, modelling and shaping to aid teaching within these training programmes (Cheseldine & McConkey, 1979). Many behavioural interventions are based on the operant conditioning model (Skinner, 1953: cited in Sheldon, 1995), which stipulates that behaviour interacts with the external world and is affected by consequences. For example, if any behaviour is ‘rewarded’ then it will be positively reinforced and the likelihood that it would occur again increases (Skinner, 1953: cited in Sheldon, 1995). Also, modelling or vicarious
conditioning theory, stipulates that a response can be adopted through the observation of those responses in others (Mineka, Davidson, Cook, & Keir, 1984: cited in Davison & Neale, 1996). Therefore, communication skills can be demonstrated and followed by people with learning difficulties or be successfully shaped as closer and closer approximations to the desired outcome through reinforcement (Sheldon, 1995).


However, although psychological theories are applicable, an awareness of their shortcomings is also relevant for good practice; behavioural research and therapy has methodological problems and is unable to provide a conclusive fit between theory and the results of interventions (Blaney, 1981, cited in Schwartz & Schwartz, 1993). It must be also recognised that behaviour is complex, influenced by many factors, to be so easily explained by behaviourism. However, psychological theories can offer sound practical advice on how staff can reinforce appropriate communication based on theoretical principles, which has been shown to be effective within clinical outcome studies (Cullen, 1988).

The Impact of Others Expectations on the Communication Style and Behaviour of People with Learning Difficulties

The difficulties in organising and presenting information in the form of discourse, also underscores their inability to manage social interactions. The social rules of interaction are often misconstrued or missed completely, which affects communication skills, such as turn-taking ability and response to cues. The discourse of learning disabled people is therefore, characteristic in that they provide fragmentary information, which omits necessary details and includes non-relevant facts and fail to follow through their thoughts or they link unconnected thoughts together. It has been asserted that people with learning difficulties can provide and obtain information and discuss future plans, feelings and points of view (Owens & MacDonald, 1982, cited in Rondal & Edwards, 1997). However, people with learning difficulties do not employ the linguistic forms deemed appropriate by the majority

Despite these findings, difficulties in everyday speech is evident, which affects how they are perceived by other people who interact with them (Leudar, 1989, cited in Beveridge et al, 1997) communication is fraught by frustration and confusion. This leads to further difficulties with ‘benevolent conspiracy’ as others will compensate for people with learning difficulties, which limits the opportunities to learn and can lower self-esteem (Sabsay & Platt, 1985, cited in Kernan & Sabsay, 1997). The impact of the often confusing interactions with people with learning disabilities is two-fold, on the frustration of the other person, which then impacts the person with learning difficulties when they perceive that they are not being understood. This in turn can effect the style of communication used by learning disabilities in an attempt to hide their problems and/or by asserting their needs in other ways to ensure an outcome, as in the case of challenging behaviour.

Conversation can be used to attempt to protect a persons self-esteem by demonstrating ‘competence’, in order to disguise limitations, termed ‘passing’ (Goffman, 1963, cited in Leudar, 1997). This is shown in a variety of ways, through self-serving displays of knowledge (Pratt, 1985, cited in Leudar, 1997) and through making false assertions (Turner, Kernan & Gelpman, 1984, cited in Kernan & Sabsay, 1997). Overall, this can come across as being arrogant, brash, annoying and obnoxious, as anxiety and lack of confidence is compensated via being loud, showing a use of language but in inappropriate ways, (Kernan & Sabsay, 1997). The gregarious nature of this conversational style also leads to further misunderstandings of ability, with staff often overestimating individuals with learning difficulties level of understanding of verbal communications (Brown, 1998; Hodginkinson, 1998). These difficulties are further compounded by staff’s frequent difficulties in recognising non-verbal cues and by them usually placing the onus of responsibility for communication onto the person with learning disabilities (Purcell, et al, 1999). This self-involvement and often accompanied lack of sense of ‘other’ can also mean that people with learning difficulties show no interest in what other people are saying. This communication style leads to a negative labelling and social withdraw, often leading to others ignoring people with learning difficulties 92-93% of the time, even when behaviour
was appropriate (Cullen, Burton, Watts & Thomas, 1983). This treatment by staff has a further impact on individuals with learning disabilities by lowering their confidence making this conversational compensatory style more likely. The little time spent with people with learning difficulties means that contingent attention, in line with the development of new skills can have little affect when they are implemented so infrequently (Cullen, 1988). This circular relationship, has a large long-term impact on people with learning difficulties as the withdrawal of adequate role models of conversation means that their opportunities to practise communication skills (Hodgkinson, 1998) and learn social rules of conversation diminish. In addition, their isolation increases with a reduction in their opportunities to be equal partners in interaction (McConkey, Morris & Purcell, 1999), which has long-term psychological affects, which will be addressed later.

The problems with communicative disability leads to a dilemma if others are withdrawing and therefore the needs of people with learning difficulties are not being met and an appropriate way of communicating those needs are not within their capabilities (Thurman, 1997). The development of challenging behaviour as a communication medium (Hodgkinson, 1998) becomes a functional way of getting needs met, because of staffs difficulties in predicting and assessing verbal and non-verbal communication (McConkey, et al, 1999). The directive style of communication often adopted by carers may also contribute to the provocation of these aggressive and challenging responses (Hastings & Remington, 1994, cited in McConkey, et al, 1999).

Challenging behaviour has many forms including, aggression, spitting, stealing and self-injurious behaviour and is usually devalued by society, with a prevalence rate of about 30 % within the learning disability population (Qureshi & Alborz, 1992, cited in Chamberlain, Cheung Chung & Jenner, 1993). These behaviours are viewed as ‘learned behaviours’ since they are frequently reinforced by staff and carer attention (Chamberlain, et al, 1993) and therefore becomes an intentional means of communication. Staffs reaction, both positive and negative can be unintentionally reinforcing for people with learning difficulties (Cullen, Burton, Watts & Thomas, 1983), especially of it enables them to meet a need for attention or escape from something (Carr & Durand, 1985).
The importance of early intervention to provide people with learning difficulties with the ability to communicate is clear for the prevention of challenging behaviour (Bott, Farmer & Rohde, 1997). Therefore the focus must be on the carers who have an important effect on the behaviour of people with learning difficulties (Cullen, 1988; Cullen, et al, 1983; Butterfield & Arthur, 1995, cited in McConkey, et al, 1999). Communication programmes have been ascribed successfully by the SALT (McConkey, et al, 1999). However communication programmes rely on the use of specialised training schemes for staff with in-built incentives, which help staff assess their own communication skills alongside those of the people with learning difficulties (Money & Thurman, 1994, cited in van der Gaag, 1998). Staff workshops and training alone have been unsuccessful in changing staff’s actual practise (Brown, 1998; Cullen, 1988) and so specific examples of what to do and not to are required (Hodgkinson, 1998). In addition, potentially the use of self-recording systems, supervisor’s praise, monetary and work schedule incentives or a combination of above is also required in administering communication programmes (Cullen, 1988). The main aim of communication programmes is to replace the aggression with an appropriate means of requesting for help and to reinforce them (Brown, 1989). However, most forms of staff training based on teaching paradigms have been unsuccessful to date, in terms of relating skills to practice (Cullen, 1988).

In order to improve the chances of success within these communication programmes, it is important to address staff’s attitudes to its implementation, environmental issues and the problems of ascribing meaning and intent must be addressed (Grove, Bunning, Porter & Olsson, 1999). Adjusting staff’s perception of the competence of people with learning difficulties, which often underpins the conversational style and behaviour of people with learning difficulties, will help to adjust and enhance the quality of their language input to those individuals (Purcell, et al, 1999), although this has been little studied. Psychology can play a role in the management of change for individuals, for example assessing staff’s feelings and attitudes to their role (Purcell, et al 1999), attributions (Hastings, Reed & Watts, 1997, cited in McConkey, et al, 1999) and communication objectives. Also of note is that, aggression elicits very strong emotions and anger in staff and can further enhance expectations of how clients will behave. Having male cover for aggressive clients for example can provide a preparatory environment can be a trigger in terms of stimulus control, for violence.
and must be analysed if staff intervention programmes are to work (Hastings, et al, 1997, cited in McConkey et al 1999).

The communication environment, i.e. the aspects of the environment which affect an individual's ability to communicate, for example demands, opportunities and relationships (Bradshaw, 1998) are also important. The main needs of the environment are that the staff need to be trained, have a supportive management structure which ensures the training is implemented within a good care system and philosophy (Cullen, 1988). These aspects of the environment are necessarily involved in the implementation of individualised communication guidelines, which need to be implemented in a consistent and meaningful way, promoting choice, with the use of graded prompts to help understanding (Thurman, 1997). Psychology has a role in programme monitoring, team facilitation and the use of behavioural management techniques, to reinforce appropriate communication skills (Brown, 1998; Symons, Fox & Thompson, 1997), which has been used successfully in the reduction of challenging behaviour (Carr & Durand, 1985).

'Functional communication training' based on behavioural principles has also been shown to reduce the challenging behaviour, when it has a communicative function (Bird, 1989, cited in Chamberlain, et al, 1993), incorporating a consistent 'real' response to communicative acts is vital in this skill development (Carr & Durand, 1985). Essentially, challenging behaviour is reduced by changing the stimulus conditions that control the difficulties in communication, so that they serve the same communicative function as the original challenging behaviour (Carr & Durand, 1985). Therefore it is helpful as a start to treat all challenging behaviour as communicative as a basis for intervention (Carr & Durand, 1985).

**Stigma, Self-perception and the Psychological Impact of Others Expectations on People with Learning Difficulties**

An individual's sense of identity, perception of self and others are determined largely through the use of language, and therefore influences people as social beings and acts as an important source of dignity and respect (Grove, Bunning, Porter & Olsson, 1999). Social adjustment is dependent on personality and social behaviour (Cohen,
1961, cited in Reiter & Levi, 1980) and the development of a sense of others having desires and needs. Inability to communicate leads to problems with anxiety, isolation, sadness and frustration (Bott, Farmer & Rohde, 1997), low self-esteem, low ideals (Szivos-Bach, 1993) and learned compliance and helplessness (Seligman, 1980, cited in Davison & Neale, 1996) and finally dependency through disempowerment. As a result, people with learning difficulties rely on carers, which means that the control lies within others' hands and yet studies find that despite people being the main source of assistance, people with learning disabilities are unwilling to use social contact to elicit help (Beveridge, 1989). This is probably to be expected as a study showed that about 50% of initiated contact by people with learning difficulties is ignored (Beveridge, 1980). Communication can be frustrating for both parties, which leads to disengagement (Kernan & Sabsay, 1997) and guess work at the communication intent of people with learning difficulties. However any pretence that others have understood or any reinterpretations of intent can be interpreted, that what they are trying to say is not important. It is therefore not uncommon for others to start to see a person with learning difficulties as a non-person and speak about them in third person, rather than address them directly (Kernan & Sabsay, 1997). However, it has been shown that consistent positive responses to initiated communication is important as a reinforcer of successful communication (Butterfield & Arthur, 1995), which is not happening in everyday interactions between others and people with learning difficulties. Staffs control of resources and attention, instead leads to a power relationship, often characterised by authoritarianism, which clearly places the individuals with learning difficulties in an impoverished, submissive position, wherein they try to secure staff attention as a way of bolstering their low self-esteem.

Active discrimination, labelling and stigma appear to underpin the interactions between people with learning difficulties and others, due to negative perceptions and fear of the unknown (Hudson-Allez & Barrett, 1996). Social integration must not be assumed because people with learning difficulties are living within the community (Reiter & Levi, 1980). Neighbours have reported fearing that people with learning difficulties are dangerous and may pose a threat to their children (Roycroft & Hames, 1980, cited in Hudson-Allez & Barrett, 1996), however these misperceptions diminish over time. These attitudes predict behaviour, hostility is usually confined to a minority, however their impact via both verbal and physical abuse of people with
learning disabilities perpetuates the feelings of marginalisation. The psychological impact of this marginalisation from society can be devastating, compounded by their existing low self-perception and higher expectation of failure. Even their attempts at ‘passing’ (Goffman, 1963, cited in Leudar, 1997), may be a process of denial regarding their own disabilities and the recognition of those limitations may be what liberates them.

Expectations of failure and labelling from others especially teachers in the realm of education, effect motivation and produces beliefs about the potential to learn which are self-limiting (Zigler & Balla, 1982; Beveridge, 1997). Teachers also fail to adapt their language to the level of linguistic ability of a person with learning disabilities (Hodapp, Evans, & Ward, 1989, cited in McConkey, et al, 1999), which handicaps their capacity to learn and increases their likelihood of experiencing failure. People with learning difficulties tend to perceive control to external factors, such as their lack of ability, which is stable and after continuous experience of failure, start to feel helpless (Weisz, 1979) and not on control of their future (Bryan, 1986). The development of these maladaptive beliefs leads to maladaptive responses, which are not appropriate and fulfil the expectations of others and feed back into the stigma (Bryan, 1986). Teachers expectations and responses can have a large mediating effect on these maladaptive beliefs and self-perceptions and even praise in that its “fine” may imply that they did not expect success anyway and therefore be an underlying criticism (Bryan, 1986).

Feedback is very important in the development of skills, however it has been noted that when expected low achievers start to do well academically, their feedback is often muted and non-reinforcing (Jussim, 1986). In contrast, expected high achievers get more support and attention, clearer feedback and have more opportunities to learn because they are perceived to hold similar values and are therefore easier to control (Jussim, 1986). These non-reinforcing, biased practices by teachers has an impact on motivation and performance, since teachers due to their expectancies of failure, interrupt expected low achievers more, give them less time to answer questions and end up providing the answer for them (Allington, 1980, cited in Jussim, 1986). When success is ignored, or opportunities to try are reduced, motivation drops and lack of self-esteem increases, through lack of experience of mastery, as ascribed in cognitive
evaluation theory (Cooper, 1977, 1979, cited in Jussim, 1986). Learning can be associated with negative experience and withdrawal may ensue leading to further reductions in learning opportunities and skill development (Jussim, 1986). These findings, although based on non-learning disabled population, are especially relevant to people with learning difficulties because they are more at risk of being labelled as low achievers and treated accordingly.

Psychology can provide theoretical explanations as to the workings of self-fulfilling prophecies, involving the role of attributions and perceptions of control (for review see Jussim, 1986). The self-fulfilling prophecy model involves three stages, the initial expectation, which leads to differential treatment, which leads to the development of self-schemas and behavioural reactions in the recipient (Jussim, 1986). In Jussim's (1986) review he argues that the initial expectations are usually flawed (or at best the research is ambiguous) and once held are prone to expectancy-maintaining biases, which are uncomfortable to shift and may lead to negative feelings directed at someone if they go against their initial expectations. Psychology can play a role highlighting these attribution processes and how they affect teaching practice and how to pitch teaching at the appropriate level, with a complete awareness of their communicative abilities and style and how to work at increased communicative skills building, in conjunction with S.A.L.T. expertise. Teachers could implement 'scaffolding', which builds new skills on to existing repertoires, encouraging the increasingly complex development of language (Harrison, Lombardino & Stapell, 1987, cited in Butterfield & Arthur, 1995) and through promoting the idea that intelligence is not stable and with effort some goals can be obtained (Bryan, 1986). In order to accomplish this development, teachers must work with the person with learning difficulties' states of mind, i.e. facilitate learning when they are most alert and motivated (Guy, Guess & Mulligan, 1993, cited in Butterfield & Arthur, 1995). People with learning difficulties who believe control is external to themselves, respond best to highly structured programmes (Bryan, 1986), although skill building in obtaining independence is vital to the empowerment of people with learning difficulties (Bryan, 1986). Praise and positive reinforcement must be also made contingent on performance and the skills in coping with failure must be enhanced within this population to ensure adaptive attributions (Bryan, 1986).
Direct work with people with learning difficulties is also required to enhance self-motivation to overcome their high expectation of failure and low self-efficacy (Loumides & Hill, 1997), attribution training and awareness can be vital for positive re-evaluations of self-efficacy and empowerment (Bryan, 1986). Cognitive behavioural therapy could play a positive role in skill acquisition, in challenging negative automatic thoughts and dysfunctional assumptions into flexible adaptive thoughts, through the use of cognitive techniques. These techniques involve seeking evidence, exploring alternative views and cognitive restructuring (Beck, 1995), which in turn would change cognitive negative biases, which would help enhance self-esteem and confidence. Although whether cognitive-behavioural therapy can be used with people who are challenged in this respect is an ongoing debate. Also within the therapeutic work within psychology, the idea of a working alliance and personal growth (Karl Rogers, 1951, 1978, cited in Brechin & Swain, 1988) is of value in working with people with learning difficulties. This concept is very important in addressing issues of quality of care and empowerment, in promoting trust, equal relationships, self-pride, developing confidence and an identity, sharing knowledge and dealing with responsibility (Brechin & Swain, 1987, cited in Brechin & Swain, 1988).

**Working with professionals**

The focus has been on the impact on the educational, behavioural and psychological impact of everyday communication between people with learning difficulties and their immediate carers, parents, staff and teachers. However there is also a concern regarding the interactions with professional staff and the impact of their assessment and diagnostic procedures. Communication problems could lead to misdiagnoses, especially when learning disabilities are compounded by mental health problems or personality disorders. Since diagnosis and labels have a major impact on people for the rest of their lives, then this is of major importance. Acquiescence is negatively correlated with IQ, which means that people with learning difficulties are particularly susceptible to giving biased answers to please others (Seligman, Bud, Spanhel & Schoenrock, 1981, cited in Bull, 1995), or to be suggestible and compliant due to low self-esteem (Scott, 1994, cited in Clare & Gudjonsson, 1995). Acquiescence and withdrawal from communication through low self-esteem are also compounding
factors, which add to the general confusion in assessment and intervention procedures.

Also within the legal field, acquiescence, unrealistic perceptions of consequences to their statements and their isolation in general can inhibit access to legal advice and support in the decision making process that accompanies answering police questions. The lack of access to legal advice means they are particularly vulnerable, especially as they assume that what they say carries little weight, even when it is a confession to a crime (Clare & Gudjonsson, 1995). These communication disabilities make them at risk of abuse (Endicott, 1992, cited in Bull, 1995) and of being suspected of criminal activity (Clare & Gudjonsson, 1995). Allegations of sexual abuse, where the reliability and validity of statements in police interviews are especially questionable poses a very difficult problem (Seligman, et al 1981, cited in Bull, 1995). Police are often unaware of the needs and difficulties a person with learning difficulties and therefore their expectations are out of touch with the realities of the problems inherent in communication.

Clinical psychologists can promote awareness of effects of acquiescence and produce questions and interview formats, which will diminish the likelihood of acquiescing occurring. Within interviews the balance of power must be as equal as possible and questions must be non-leading, open, of an ‘either-or’ or pictorial format, put in simple language with the emphasis on key words. During the interview there must be a continual allowance for “I don’t know” answers, and awareness of non-verbal communication and possible confabulation through pressure to respond with the ‘right’ answer, especially if questions are repeated. Upgrading and reinterpretations of original responses must also not occur and the choices offered are preferably unlimited, (Bull, 1995; Clare & Gudjonsson, 1995). With regards to police interviews it may be preferable to interview people with learning difficulties in familiar surroundings due to the effects of stimulus control. Stimulus control based on behavioural principles that behaviour or statements reliably produced in one setting will not necessary occur in another due to the environment being a trigger for the behaviour (Bull, 1995). With these behavioural principles in mind, it is useful to familiarise witnesses with learning difficulties to courtrooms, court procedures and what they can expect to happen and why, found useful with children (Dent & Flin,
Essays

1992, cited in Bull, 1995) or use screens or video testimonies (Endicott, 1992, cited in Bull, 1992). Psychology is able to make these recommendations in the format of a 'cognitive interview', which leads to 32% more accurate information, although the number of confabulations also increase (Brown & Geiselman, 1990, cited in Bull, 1995).

Summary

Clinical psychology can work with communication issues by drawing on a large theoretical and research base, which provides hypotheses and certain understandings, which underpin the communication problems that challenge the interactions with people with learning difficulties. Psychology can draw on behavioural principles to ensure appropriate means of communication is shaped through reinforcement alongside an awareness of why certain behaviours occur, for example challenging behaviour as a means of communication. Psychology can provide staff training on behavioural principles, involving consistency and monitoring programmes of both staff and clients communicative abilities and deal with the thoughts, fears and feelings surrounding changes inherent in taking these principles into practise. Psychology also can draw on the principles of cognitive-behavioural therapy to explain, understand and intervene with issues of low self-esteem, anxiety, low mood and confidence, through repeated experiences of failure, stigmatisation and labelling. Self-fulfilling prophecy models can also be useful in describing the negative interactions between others’ expectations and the impact that has on an individual with learning difficulties, highlighting the need for social skills and assertiveness training.

However, despite the knowledge and skills of professionals therapy groups, many studies are showing that this knowledge is not being filtered down through to the direct care staff (Yoder & Warren, 1997; Cullen, 1988) and therefore their expectations, due to a lack of access to these findings, are often unrealistic. This ironic breakdown in communication has a detrimental effect on the development of communication within the learning disabled population, which demotes their quality of life. Psychologists, as effective communicators and facilitators of change could be leading force in the training of staff, alongside the specialised knowledge of speech and language therapists, to open up communication between others, which in turn
could open up communication with the inside world of a person with learning difficulties.
References


CRITICALLY EVALUATE PSYCHOLOGICAL THEORIES OF CHILD ABUSE AND THEIR CONTRIBUTION TO CLINICAL PRACTICE

Introduction

The true extent of child abuse was not known until 1988, when the Department of Health started to record the number of children in England on the child protection register. Since then, there has been an increasing awareness of the prevalence of child abuse, for example last year an estimated 31,900 children were deemed at risk of abuse (Department of Health, 1999; cited in Corby, 2000). However, this is believed to be an underestimation as the recording of prevalence rates is problematic, due to the secrecy and denial that surrounds child abuse, leading to under-reporting.

The abuse of children takes many forms from emotional abuse and neglect to physical assault and sexual molestation and each can have a profound effect on a survivor’s growth and development, sense of self, attachment to, and relationship with, other people throughout their lives. The focus of this essay will surround the prominent psychological theories that have contributed to an explanation of childhood sexual abuse. Therefore perspectives such as social learning theory (Hertzberger, 1983; cited in Kaufman & Zigler, 1989) and Belsky’s integrative model (Belsky, 1980), which largely focus on physical abuse will not be included. However, it is recognised that there is some overlap, with 16.9% of physically abused children having also been sexually abused (Hobbs & Wynne, 1990; cited in Ney, Fung & Wickett, 1994). Sex abuse has been chosen as it is currently the most targeted form of abuse and as a consequence the literature provides detailed and systematic explanations of the consequences of sexual abuse relevant to the application of clinical practice and treatment (Corby, 2000). The consequences of childhood sexual abuse include depression, aggression and hostility, low self-esteem, high sense of personal guilt and shame, physical symptoms, developmental and cognitive delay, inappropriate sexual behaviour and sexual disturbance, anxiety and long-term psychiatric problems (Corby, 2000). In terms of sexual abuse it has been reported that the main victims are girls (91%) and in 98% of cases the perpetrators are male and are unknown to the victim (Gillham, 1994).
Sexual abuse can be defined as:
"the involvement of dependent children and adolescents in sexual activities with an adult, or any person older or bigger, in which the child is used as a sexual objects for the gratification of the older person’s needs or desires, and to which the child is unable to give consent due to the unequal power in the relationship" (Sanderson, 1990).

Overall, there has been a lack of explanatory theories to provide an understanding as to how and why sexual abuse of children occurs (Liem & Boudewyn, 1999; Shapiro & Levendosky, 1999). Understanding why abuse happens is important as it provides practitioners with a greater sense of control, gives work a sense of direction and informs those responsible for making policies (Corby, 2000). A critical analysis of the literature is required to best inform those decisions.

**Main Psychological Theories for Childhood Sexual Abuse**

**Psychoanalytic Theory**

Freud’s ‘seduction theory’, (1896, cited in Sanderson, 1990) based on his clinical observations was the first theory linking childhood sexual abuse to later adult psychological impairment. The ‘seduction theory’ proposed that the trauma suffered within child sexual abuse was the cause of the hysteria and neurosis that Freud observed in his female clients. However Freud’s later disbelief in the frequency of his clients accounts of abuse, his condemnation by his peers, coupled with his own self analysis and exploration of his own possible abuse, led him to refute his earlier theory in favour of developing the Oedipus Complex in women (Freud, 1933). Freud’s second theory placed the female child in an actively sexual role, who desires her father to become her love object, as the result of the mixture of her love for her father and her “envy for the penis” (Freud, 1977, cited in Sanderson, 1990). In line with this view, Freud assumed that the accounts of sexual abuse derive solely from fantasy and desire rather than fact and thus victims of abuse were not only disbelieved, but also were blamed, with the child given the role of ‘seductress’. The daughter was seen as
having charming, attractive and precocious qualities, whose sole aim was to seduce her weak father.

Psychoanalytic theory also placed some of the responsibility of the abuse onto the mother, who would use their daughters as surrogates to resolve their own Oedipal desires (Rinehart, 1961, cited in Sanderson, 1990). Within this theory the mother is seen as cold and rejecting, forcing her daughter to approach their father for the affection and security she can not get from her mother. The mother is further pathologised wherein she is believed to displace her hostile emotions for her own mother, onto her daughter, in effect relinquishing responsibility in an attempt to become the ‘daughter’ again. This has been supported more recently by (Sroufe, Jacobitz, Mangelsdorf, DeAngelo & Ward, 1985; cited in Alexander, Teti & Anderson, 2000) who found increased hostility from mothers towards their daughters when the mother had been sexually abused as a child. The mothers is then hypothesised to desert the father and daughter through “giving birth to a new sibling, turning to the maternal grandmother, or developing some new interest outside the home” (Kaufman, 1954, cited in Sanderson, 1990).

Freud’s theories had been largely accepted. However with the recent acknowledgement of the existence of sexual abuse there is some resistance to the idea that child abuse is just fantasy. Such abuse is now acknowledged to have a damaging effect on the victim’s personality and emotional development. It can arrest an individual’s psychosexual development, lower their self-esteem and create feelings of ambivalence; that is, the idea that both love and hate can co-exist simultaneously because the abuser may be the only person who gives the child any attention or affection (Hall & Lloyd, 1993). It is these emotional conflicts which are the focus of therapy.

Treatment involves examining the suppressed memories, feelings, conflicts and defence mechanisms that abuse sufferers develop to make sense of the abuse. The fundamental aims are to enable the client to fulfil their unmet dependency needs by developing long-term nurturing relationships essential both in and outside of the therapy and to counteract difficulties with self-esteem by placing the self in a position of dominance and control. (Finkelhor, 1986 cited in Colby, 2000). Treatment has also
addressed the need for re-parenting skills to repair any reoccurring relationship problems with the victim's own children (Reiner & Haufman, 1959, cited in Hall & Lloyd, 1993). The role of therapy however, is not seen as acting as the child protector as there is a concern regarding the disadvantages of removing abused children from their families and the implications of legal action. However, psychoanalysts are aware that the physical safety of the individuals should be the main consideration (Hall & Lloyd, 1993).

Freud was the first to attempt to acknowledge and explain the presence of childhood sexual abuse in families and to address the later effects on a child’s emotional, social and sexual development (Hall & Lloyd, 1993). The theoretical introduction of the role of ambivalence is significant and has important clinical implications for treatment, as the inherent conflict within ambivalence can be acknowledged, expressed and explored (Sanderson, 1990). This is important for future psychological health and relationships. As an absence of this could leave the child in emotional conflict, with suppressed emotions and dependency needs which would leave them vulnerable to further abusive relationships.

Theoretically however, the psychoanalyst approach does not adequately explain why sexual abuse happens in response to ‘penis envy’ and emotional family difficulties by ignoring the role and motivations of the father (Colby, 2000). It has also undermined the full extent of sexual abuse by diminishing its effects on the family (Sanderson, 1990). In addition, the psychoanalytical approach inadequately explains extra-familial abuse and abuse which occurs between father/son, mother/daughter dyads and incest by siblings and grandparents (Sanderson, 1990). By focusing on the ‘nuclear family’ the psychoanalytical approach has ignored wider social and cultural factors, for example that sexual abuse is mainly committed by men (Gillham, 1994). Therefore, psychoanalytical theory erroneously places the responsibility for the abuse on child and mother, which exonerates the abuser and ignores the father’s possible desire for his daughter and the degree of power he holds within the relationship (Dietz & Craft, 1980; cited in Sanderson, 1990). By not acknowledging the possible role of sexual motivation in the father and by placing the daughter in the central seductress role, the psychoanalytic theory also fails to explain why abusers need to consort to coercion,

The ‘blaming’ approach has major implications in practice as the child is pathologised and could be re-traumatized and re-abused within therapy as the focus is on making changes to the victims assumed ‘dysfunctional’ inner world and not the abusers. This could make the child feel blamed or as if their experience is not real or not to be taken seriously, which could compound existing difficulties with self-esteem and depression, especially if they feel they can not trust their own experiences. Psychoanalytic therapy, in not adopting a protector role for children potentially exposes them to further incidences of abuse by leaving them in the home. This in turn acts to undermine the therapeutic effects of treatment.

**Feminist Re-interpretations of Psychoanalytic Theories**

In contrast Chodrow (1978, cited in Waldby, Clancy, Emetchi & Summerfield, 1989) acknowledged the role of the father’s sexual desires in child sexual abuse and how they use their power to re-affirm feminine heterosexuality and submission. Alice Miller (1984) concurs with the shift in responsibility to the adult perpetrator and sees the abuse as a means of satisfying the adult’s emotional needs, with no regard to the child’s welfare. Men are seen as being out of touch with what children’s needs are and can easily misinterpret child’s need for affection, both physically and emotionally as an invitation for sexual relations. The responsibility is on the male adult who acts on this misinterpretation. The child can be provocative but can not consent; it must therefore be the adult who takes it further. Miller (1984) talks about abuse being passed down through different generations which acts to sanction the abuse. This acknowledges the high incidence rate and social context of abuse advocating a generational transmission of abuse through families.

An alternative reinterpretation is that the abuse comes as a response to the discovery that males are preferable to females. As such the privileged sexual relationship with the father is a way for the daughter to elevate herself, by mingling with ‘superior company’ (Herman, 1981; cited in Waldby et al, 1989). It is therefore assumed that if the father chose to have a sexual relationship with his daughter, resistance would be
minimal, but in having the choice it is acknowledged that the responsibility is within the adult male abuser.

The feminist theory is sociological rather than psychological and therefore will not be addressed in detail, but it does make an important contribution which incorporates a number of features ignored by psychological thinking. The feminist approach focuses on issues of male power and responsibility, placed within a patriarchal social context (Waldby, et al, 1989) were the male dominates females and sees them as his property. In addition, feminist theories consider the victimisation of the mother in the family. They consider her powerlessness and ability to act being in direct proportion to her level of power (Herman, 1981; cited in Sanderson, 1990).

The reinterpretations of psychoanalytic theories of sexual abuse have acknowledged the role of power and status inherent in abuse. This would account for the high number of men who are the perpetrators of child sexual abuse and also reflects why children are vulnerable to coercion (Sanderson, 1990). In acknowledging this power there is also more of a shift of responsibility from child to adult perpetrator, which is a positive change with regard to its impact on clinical practice and for the self-esteem, empowerment and sense of guilt and fear that sufferers of abuse often feel. However these reinterpretations have been largely ignored in practice and they also fail to explain other forms of abuse outside the father/daughter dyad (Sanderson, 1990). The feminist approach as it is, is too ideological, as it places responsibility onto society, which is too abstract and therefore harder to change in practice (Hall & Lloyd, 1993).

**Family Dysfunction Theory**

The family dysfunction theory, developed from the family systems approach, differed with the psychoanalytical perspective by citing that dysfunction exists within the family unit as a whole, rather than within an individual. Sexual abuse is therefore seen as a symptom of general family maladjustment and disturbance (Maisch, 1973, cited in Sanderson, 1990) which creates fixed, repetitive behaviour and communication patterns which are typically unclear, restricted (Mayall & Norgard, 1983) and governed by the family’s emotional rules, for example “father knows best”. Sexual abuse results when there are no clear power differentials between the individuals or
when power is vested in the father at the expense of other family members (Mayall & Norgard, 1983) due to the emotional needs of the abuser and the structural dependence of the others. Stern proposed three possible interaction patterns present in families with incest. The “dependent-domineering” pattern that heralds a strong mother and an inadequate father who then turns to his children for sexual gratification. The “possessive-passive” pattern that typifies a patriarchal society wherein the males hold the power over the females. Finally there is the “incestrogenic” pattern when both parents find it hard to function as adults and can not fulfil each others needs and so look to their children as substitutes (Stern & Mayer, 1980, cited in Mayall & Norgard, 1983). It would appear that families who have a higher predisposition to abuse are families which have weak intergenerational boundaries and role differentiation and who are very secretive, where parents avoid conflict and the child is used as a mechanism to get the family members closer.

Fundamentally, incest has been viewed as a means by which the family maintain itself and its secrets which are unacceptable to the outside world. The parent’s childhood fantasies are acted out within the family, hidden by a veil of secrecy used to maintain the family structure and existence (Ben-Tovim, Elton, Hildebrand, Tranter & Vizard, 1988; cited in Corby, 2000). The abuse and secrecy creates a powerful ‘closed’ system which is socially isolated and therefore resistant to change from the outside (Dale, Morrison, Davies, Noyes & Roberts, 1983; cited in Corby, 2000). The closed system therefore helps to create and maintain incest, which in turn is used to reduce the tension in response to other common factors found amongst dysfunctional families. The common associated factors with a dysfunctional family surround the absent mother, who does not provide sex for her husband, fails to protect or nurture her children and withdraws herself both emotionally and physically, for example through hospitalisation or depression (Justice & Justice, 1979). Again the mother is seen as pivotal to the occurrence of child sexual abuse by abandoning her husband and child, leaving them to use each other as substitutes for each other’s emotional needs. However, differing from the psychoanalytic view, the dysfunctional family theory also pathologises the father, claiming that both parents seek to reverse traditional family roles and cast the child in the role of satisfying and protecting the needs of the parent (Lustig, Dresser, Spellman & Murray, 1966). In blurring generational roles, the family breaks down the barrier between the two main
subsystems, that of the parent and the children, the separation of which are essential for a healthy environment (Minuchin, 1974, cited in Corby, 2000). However, essentially it is the mother who is viewed as the main orchestrator of this breakdown (Dietz & Craft, 1980, cited in Sanderson, 1990) through collusion either consciously or unconsciously (Kempe, 1977, cited in Sanderson, 1990). This collusion has been proposed to stem from different factors, such as relief from not having to have sex with her husband (Justice & Justice, 1979) or through the mothers’ desire to satisfy her own sexual desires for her father (Henderson, 1983) or her daughter (Rist, 1979).

Within treatment the focus is on the dynamics within the family in an attempt to restore interpersonal relationships; the occurrence of sexual abuse is seen as being secondary to this process (Sanderson, 1990). The aim of therapy is to make each individual accept equal responsibility for engaging in inappropriate roles in terms of both age and sexual contact. The aim of which is to open up secrets, to disentangle relationships, to free individuals for future plans, to create change within a resistant insular system (Dale et al, 1983; cited in Corby, 2000) and to make the family’s behaviour more appropriate. Appropriate behaviour is assumed to be led by the perfect mother relinquishing any independence outside the home and being the perfect wife by satisfying the husbands needs. This approach also aims to reinstate a hierarchical family system and to promote the fathers status, placing him as the authority figure (Sanderson, 1990). Some advocators of this approach, “condemn” the implementation of legal action as it allows other members of the family to deny their part of the responsibility (Machotka et al, 1967, cited in Sanderson, 1990).

The dysfunctional family systems approach is a positive contribution to an understanding of childhood sexual abuse because it reflects and explains the power of the family. In essence this theory explains how and why individuals abused by their parents fail to report abuse and even when abuse is revealed, why the victims often protect their abuser for the apparent sake of the family. These ideas are important in clinical practice and for working with the family as a whole. The issue of resistance to change is paramount in terms of how to engage the family in therapy and in recognition of the need to produce shifts within the family system. A lack of awareness of these underlying dynamics may lead to withdrawal from therapy and
prevents access to therapeutic intervention which may increase the likelihood of further abuse.

However, the dysfunctional family theory still fails to explain extra-familial abuse and abuse which occurs between dyads other than the father/daughter incest (Sanderson, 1990). In addition the dysfunctional family approach detracts from the painful effects sexual abuse has on the child (Sanderson, 1990) by proposing the child still lives with their abuser, which may compound any existing psychological damage. This is exaggerated further by assuming all family members, including those who are not involved in the abuse have equal responsibility. In doing so the responsibility is taken away from the abuser (MacLeod & Saraga, 1988, 1991; cited in Gough, 1993) and frequently placed on the mother; yet it is not the family that is incestuous, but the male perpetrator. The father is also deemed to have a right to expect to be sexually fulfilled by the females, and is even proposed to get “confused” when he makes sexual demands on whoever does the housework as “he does not really notice who it is” (Jeffries, 1982, cited in Sanderson, 1990). The theory’s claims of collusion in the mother are also not held up by research which has found that between 60% (Berliner & Conte, 1981, cited in Sanderson, 1990) and 73% (Mrazek, 1982) of mothers act when the abuse is disclosed. In addition the theory does not take into account the possible abuse of the mother and her possible lack of power within the family. Current research states that in 78% of incest families the mother was also a victim of domestic violence (Dietz & Craft, 1980, cited in Sanderson, 1990) and fears for the safety of herself and her children, exacerbated by her financial and emotional dependency on the abuser (Dietz & Craft, 1980).

Ultimately the family dysfunctional approach fails to explain why the families are dysfunctional in the first place. The aim of therapy to re-establish a hierarchical family structure, which is patriarchal in nature, may facilitate the maintenance of abuse by placing the abuser back into power. Again therapy may enhance the victim’s sense of guilt and responsibility, increase their sense of powerlessness and may minimalise or deny their experiences, further re-abusing the victim. Ultimately the child is not protected, as therapy works to keep the family together (MacLeod & Saraga, 1988, 1991; cited in Gough, 1993).
The predominant theories of abusers are demonstrated in Finkelhor’s four theories of abuse (Finkelhor, 1984). Firstly, the abuser is a ‘moral degenerate’, who has a psychopathic personality. Secondly, the abuser had a seductive mother, which stems from early Freudian ideas. Thirdly, the adult is ‘fixated on sexuality’, which originates within childhood and continues into adulthood. Finally, the sexual abuse is a way for the adult to express a range of needs, for example, through dealing with alcohol problems, fear of adults and their sexuality, their need for closeness or to release aggression.

In support of Finkelhor, theories of sexual abusers having a psychopathic disorder (Finkelhor, 1984, cited in Gough, 1993) have been supported by Becker (1991, cited in Gough, 1993). They proposed that 10% of child abusers could be diagnosed as being mentally ill. They have ‘distorted perceptions of their family, problems with coping with aggression, they suffer from depression, are ‘self-centred’ and have experienced abuse or violence as children’. In response to these difficulties the abuser finds it difficult to appreciate the child’s needs and perspective and often treats the child as an adult, attributing hostile and persecuting emotions.

The subsequent personality of incestuous fathers has been described as ‘inadequate’, socially introverted (Panton, 1979; as cited in Sanderson, 1990), domineering and controlling, and over-invested in family life (Meiselmann, 1978; as cited in Sanderson, 1990). Incestuous fathers are men who are considered to seek sexual gratification from children as they feel ill equipped to seek it from adults. The incestuous father, despite being of varied intelligence, all have been found to have a high degree of rationalisation, primarily employed to displace responsibility onto others (Sanderson, 1990). Essentially, incest abusers predominantly (80%) do not show any other criminal behaviour (Renvoize, 1982; as cited in Sanderson, 1990) and come from all social and economic backgrounds (Sanderson, 1990). Finkelhor’s ideas have been further supported by evidence that identifies abusers’ use of alcohol, which may help them overcome their internal inhibitions (Fairtlough, 1983; Renvoize, 1982; as cited in Sanderson, 1990).
Findings have indicated that emotional deprivation, for example early sexual assault or chaotic family life may influence the development of the personality of the abuser (Gerhard et al, 1965; Groth, 1979; as cited in Sanderson, 1990). It has also been proposed that the incestuous father may be conditioned early to be attracted to or "fixated" with children (Renvoize, 1982; as cited in Sanderson, 1990). Furthermore it may be someone who only turns to children for sexual gratification as a result of acute stress, namely the "regressed abuser" (Groth, 1979; as cited in Sanderson, 1990).

In addition, Finkelhor (1984, as cited in Carr, 1999) has proposed four features of male gender socialisation which 'predispose men towards child sexual abuse' (Sanderson, 1990). These features of socialisation include a lack of nurturing behaviour, a use of sex to 'bolster ego deficiencies', attraction to the genitalia of the preferred sex and the preference of younger, smaller partners. It is suggested that males tend to express their dependency needs through sex and therefore sexualise all physical contact. In doing so they fail to develop an understanding of children and their needs. Male abusers, it is argued, view children as easier, uncritical 'normal' sexual prey with whom to satisfy their desires and egos (Finkelhor, 1984, as cited in Sanderson, 1990). Within this theory the responsibility is placed with the male perpetrator of abuse.

The aim of psychological therapy is to change the perpetrators' distorted perceptions and their sexual desire for children. This is normally achieved by using behavioural techniques including aversive conditioning, positive conditioning, fading, feedback, desensitisation, operant techniques and adjunctive techniques (Kelly, 1982; cited in Gough, 1993).

The main strength of the psychological approach to studying the perpetrators of abuse is that the focus is finally on the abuser. It aims to be predictive and may have an impact on future prevention of abuse through the use of standardised testing and scientific endeavour.

However, in order to develop personality traits of incest abusers, known offenders have been compared to 'normal' fathers, but due to the secrecy around incest and the illegality of the act, researchers could not be sure that some of the 'normal' fathers...
were not in fact child sexual abusers. In addition, abusers who get caught may be
different from those who do not and so their sample may not be totally representative.
The resulting evidence is contradictory and inconclusive and therefore a picture of a
very heterogeneous group has developed which can not be generalised from (Murphy
& Smith, 1996). The literature is further limited because there has been widespread
use of non-standardized instruments and inadequate control groups (Murphy & Smith,
1996).

There is also a tautological flaw inherent within the psychological theories of sexual
abuse in that “the abuser commits incest because he has an ‘incestuous personality’”
(Sanderson, 1990). However this is contradicted by their argument that abuse happens
when the abuser is weak and he can not exercise self-control (Waldby, 1985; as cited
in Sanderson, 1990) indicating that sexual attraction to children is natural but needs to
be restrained. Psychological theories ignore power relationships within family and
responsibility, viewing personality in isolation from social factors, despite
observations that abusers change behaviour depending on power relationships, for
example being passive to police and lawyers and domineering within the family home
(Herman, 1982; as cited in (Sanderson, 1990). A further concern is that if abusers are
labelled by psychologists as ‘psychopaths’, ‘alcoholics’ or ‘paedophiles’ then this
may infer that they are ill and therefore their behaviour is excused and full
responsibility for their action is not realised (Hall & Lloyd, 1993). There has also
been evidence that contradicts the theory that sexual abusers are mentally ill
(Lukianowicz, 1972; as cited in Sanderson, 1990), which is in direct contrast to
Finkelhors theory. In addition, if therapists feel therapy is successful the risk is that
‘cured’ abusers are released back into the community despite the danger they may
present to the community.

Theoretical Perspectives of the Victim

In addition to theories governing the characteristics of childhood sexual abusers, there
is some research on the characteristics of the victims of abuse. The ‘special victim
model’ proposes that children may possess certain characteristics which may make
them more vulnerable to abuse. These include, lack of assertiveness, less
responsiveness to their environment, physical disability and youth (Carr, 199).
The psychological theories of victims are helpful in identifying the possible risk factors associated with becoming a victim of abuse. However the danger inherent in labelling victims in clinical practice in this way is that it may act to blame the child, in that it was something about them that made someone abuse them. In addition, there are problems in making these causal associations, as the child may be slower, less responsive and less likeable as a result of the abuse rather than as a predisposing factor. Research has discovered that not all 'vulnerable' children are then automatically abused and some children who are active and likeable may also become victims of sexual abuse (Sanderson, 1990).

**Integrative Approaches**

The main psychological approaches highlighted a need for a more comprehensive theoretical approach, which encompasses all aspects of the above theories that contribute to abuse, including socio-cultural factors. It would appear that child abuse may be caused by a complex interaction of individual, social and environmental factors, not by one single influence.

**Finkelhor’s Four Preconditions Model**

Finkelhor’s four preconditions multi-factor model attempts to provide a flexible framework to explain child sexual abuse, both intra- and extra-familially (Finkelhor, 1984; as cited in Carr, 1999). Finkelhor stated that there are four pre-conditions that must be met before child sexual abuse can occur. Firstly the potential abuser must find children sexually attractive and therefore have a motivation to abuse. Secondly the abuser has to overcome any internal inhibitions. Thirdly the abuser has to overcome external obstacles, for example access to the child and social tolerance of abuse and fourthly the abuser has to overcome the child’s resistance to the abuse. (Finkelhor, 1984; as cited in Carr, 1999). The motivational aspect of the pre-conditions involves various elements. It requires emotional gratification from the abuse, sexual attraction to children and a ‘block’ to other opportunities for sexual and emotional gratification. In order to overcome both internal and external inhibitions, the abuser must be motivated to conquer a wide range of obstacles, much easier in
unsupervised one-to-one contact with a child. In terms of the child’s resistance there are some reported risk factors associated with vulnerability to sexual abuse, such as emotional insecurity, lack of physical affection, lack of social support, naivety, ignorance and age. This model acknowledges that a child has the capacity to resist and that an awareness of the risk factors may help to prevent a child being vulnerable. However the model also acknowledges that pure resistance from the child alone will not necessarily prevent sexual abuse (Finkelhor, 1984; as cited in Carr, 1999).

The benefits of Finkelhor’s model are that it is a very flexible integrative approach, which places responsibility for the abuse onto the perpetrator and includes the idea that the abuser is motivated by sexual attraction. It incorporates the role of internal inhibitors, ego strength of the child and sociological factors such as pornography, social tolerance of sexualising children and unequal levels of power (Finkelhor, 1984; as cited in Carr, 1999). In addition the mother and child’s behaviour is only of interest in response to the abuse having already occurred which detracts the blame and the responsibility away from the victims of the abuse and moreover highlights their power to resist (Sanderson, 1990). In practice, this model is beneficial by including extra-familial abuse and so it does not presume that this is any less severe than intra-familial abuse, which is positive for victims in clinical practice whose experience will not be minimalised. It also allows evaluation and intervention on many levels incorporating problem solving techniques which focus on the prevention of further abuse (Sanderson, 1990).

The weakness of Finkelhor’s model is that it is merely a descriptive framework which incorporates various theories and therefore can not yet be viewed as a theory until it has been tested empirically (Sanderson, 1990). However Finkelhor’s model has been included in this discussion as it has vital implications for future clinical practice in assessing the occurrence of sexual abuse and in taking a more positive proactive view of the child. This model is limited in terms of its recommendations for effective treatment or intervention models to date (Sanderson, 1990) and fails to acknowledge the devastating effects of abuse.
Relevant Theories to Explain Sexual and Physical Abuse

Attachment Theory

Attachment theory proposes that individuals are predisposed to seek out attachment figures to obtain physical protection, psychological security and in order to form secure attachments (Bowlby, 1951, cited in Colby, 2000). The way in which the primary care-givers respond to help the child to develop an individual internal representation of the self as being someone worthy or unworthy of care and attention. These representational models of the self then serve as blueprints for relationships with significant others and are stable into both adolescence and adulthood (Alexander, 1998, cited in Shapiro & Levendosky, 1999). They guide what individuals expect from relationships and highlight whether they value themselves and others. In turn a positive secure attachment is crucial in the development of positive attachments and relationships with offspring (Sroufe & Fleson, 1986; cited in Kaufman & Zigler, 1989).

Poor, insecure attachments are the cause and consequence of childhood abuse, developmental problems and family dysfunction (Rosenstein & Horowitz, 1996, cited in Shapiro & Levendosky, 1999). A non-responsive mother who is inconsistent and rejecting may lead to anxiety and insecurity in the children, who may lack self-esteem and who can not relate to, or trust others. The insecurity and emotional neediness then acts to the detriment of the development of significant peer relationships, a pattern they then repeat into adult relationships and with their own children. When the pattern of neglect, poor attachment and inadequate parenting skills is then relived with their own children, then intergenerational transmission of abuse is said to occur (Morton & Browne, 1998; cited in Colby, 2000). There is wide acceptance of the intergenerational transmission in the child abuse literature (Kaufman & Zigler, 1989), which ultimately proposes that being a subject of abuse makes it likely that they will be an abuser. Intergenerational transmission of parenting include other forms of ‘non-optimal’ parenting, such as inconsistency, intrusiveness, rejection and poor boundaries between parent and child (Belsky, 1993; cited in Alexander, Teti & Anderson, 2000).
There appears to be evidence of attachment problems in abusers. They are more aroused by children crying and less responsive to smiling than non-abusers (Frodi & Lamb, 1980; cited in Colby, 2000). Mothers who had been abused were also more likely to engage in ‘self-focused’ communication rather than ‘child-focused’ (Burkitt, 1991, cited in Alexander, et al, 2000), and display disorganised attachment (Liotti, 1992, cited in Alexander, et al, 2000).

The attachment theory of child abuse provides a convincing explanation, but it does have some limitations. Attachment theory does not take systemic factors and cultural variables into account. Further limitations surround the determination of attachment theory in its proposal that if someone has an insecure attachment through abuse then they may go on to abuse their own children. Not all abused children go on to abuse as adults (Colby, 2000) and abusers have not always been abused (Kaufman & Zigler, 1989). Research has shown that victims of abuse can break the intergenerational cycle. Protective factors include extensive sources of social support, having physically healthy babies, having less ambivalent feelings or anger regarding their own abuse, easy recall of abuse, abuse by only one parent and having had support by another adult during the abuse (Hunter & Kilstrom, 1979; cited in Kaufman & Zigler, 1989). These protective factors have been only more recently acknowledged by attachment theory.

**Summary and Conclusions**

Essentially there is a lot of confusion surrounding the area of childhood sexual abuse; how the initial dysfunctional characteristics of the abuser, child or family originally start or in why abuse is the ‘natural’ conclusion to emotional and relationship difficulties has still not been adequately explained by psychological theories. It would appear that we must look further into sociological explanations for answers to how and why abuse occurs in conjunction with our knowledge of attachment dysfunction, sexual and social disorders. Other approaches, which were not in the remit of this essay, would therefore have to be explored further. These include the feminist perspective, social cultural perspective and social structural perspective. As outlined in the criticism of all of the approaches, there is a danger in finding single-cause
Explanations of childhood abuse, although Finkelhor's model (Finkelhor, 1984, cited in Carr, 1999) has started to address this problem for sexual abuse, as Belsky has for physical abuse (Belsky, 1980). However, the separation of theories of sexual and physical abuse and neglect is also problematic as recent research suggests that mistreated children are usually subject to more than one form of abuse (Ney, et al., 1994). Currently, the diversity of the theories means that there is currently no uniform way of understanding or providing treatment for this client group and highlights the need to assess, in light of evidence-based practice which theoretical stances and practices are beneficial. Unfortunately to date, this is still unclear and its effects under-researched.
References


Justice, B., & Justice, R., (1979), The broken taboo: Sex in the family, New York: Human Sciences Press,


Miller, A., (1984), Thou shalt nor be aware: Society’s betrayal of the child, New York: Farrar, Strauss and Giroux,


Sanderson, C (1990), *Counselling adult survivors of child sexual abuse*, London: Jessica Kingsley Publishers,


Older Adult
Essay

Year 3

Word Count: 4997
THE AGEING PROCESS GIVES RISE TO MANY INEVITABLE PSYCHOLOGICAL AND PHYSICAL CHANGES. DISCUSS.

Introduction

With an increasing proportion of the population living longer (HMOSO, 1998; cited in Stuart-Hamilton, 2000), more interest has now been directed towards the ageing process. Ageing has been studied in terms of its associated biological, psychological and social changes and the possible impact that they can have on the individual and on society as a whole. The physical and psychological changes often noted in ageing span a large amount of research and so this essay will focus on areas of change which are relevant to the field of clinical psychology. Clinical interactions with older adults tend to centre around two main areas, namely mental health problems and the possibility of cognitive impairment.

One way of examining the inevitability of changes in ageing is to explore theories regarding the nature of the ageing progress itself. Therefore, theories of ageing will first be defined and discussed in terms of biological and psychological change. A further method is to study the physical and psychological changes in older adulthood and to explore whether these changes are universal, culture-free and therefore inevitable. The main physical changes that will be considered are believed to be relevant to mental health and cognitive functioning, namely, sensory deficits, brain activity and health status. Mental health issues and cognitive impairment in older adulthood will then be discussed in more detail. Further to this discussion, will be ventured the possible interplay between physical and psychological changes and their impact on each other, which will also be used to explore the inevitability of change in ageing. It is important that inevitable changes due to primary (normal) ageing are separated from secondary ageing changes due to pathology (Busse, 1969; cited in Birren & Shroots, 1996) in order to direct interventions appropriately to treatable targets. The discussion is inherently based on the current literature and its ability to assess the changes in ageing; methodological issues will therefore be examined.
Theories of Ageing

Within the literature, ageing has been considered in terms of theories of “decline, change and development” (Vaillant & Mukamal, 2001) and even within their definition takes an inherent stance on the issue of inevitability of age-related change. Some of the more frequently cited theories of change are outlined below.

The focus on a general physical decline is prevalent in many biological theories of ageing (Birren & Schaie, 1996), as ‘ageing is associated with a decline in physiological effectiveness’ (Briggs, 1993). Physical ageing is considered normal and universal, occurring within all cultures, resulting from the wear and tear of bodily tissues and cells thought to be genetically programmed (Stuart-Hamilton, 2000). Some evidence for programmed cell death has arisen from research into cell regeneration, which demonstrates that there are a limited number of times a cell can regenerate before dying called the Hayflick limit (Hayflick, 1997; cited in Stuart-Hamilton, 2000). If genes are pre-programmed to die then this would suggest that physical changes are inevitable. However recent research has shown that it is possible to extend the life course of cells (Johnson, Marciniak & Guarente, 1998; cited in Stuart-Hamilton, 2000), which challenges the argument for inevitable physical changes in ageing.

Some psychosocial theories of ageing also view the ageing process in terms of a decline. Disengagement or withdrawal from the community for an older adult is seen as an inevitable functional process which results from the individual’s and society’s mutual accommodation of the end of the life course (Cumming & Henry, 1961). However, individual diversity in terms of levels of social engagement in older adulthood has often been cited (Tissue, 1971; Tallmer & Kutner, 1970). In addition physiology is not believed to be that deterministic, as there are ‘gender-based differences in biological and social time clocks’ (Neugarten, 1969, cited in Achenbaum & Bengstom, 1994). These differences highlight that life-style, gender and choices do not necessarily comply with a set ageing pattern and can not therefore be seen to be inevitable.
Psychological ageing refers to the ability of the individual to adapt to change and situations throughout the life-span (Woodruff-Pak, 1988). Social ageing explores the roles and social habits of individuals in relation to society (Woodruff-Pak, 1988), which can also be subject to change. Change is therefore not necessarily associated with a decline, but can be a response to external and internal factors. For example, activity theory suggests a change can occur in response to decreased opportunities presented within society in older adulthood (Havighurst & Albrecht, 1953). Activity theory suggests that despite the inevitable biological changes, older adults have the same psychological and social needs as their younger counterparts. Well-adjusted older adults therefore seek adequate substitutions for previous roles and activities when external opportunities change, which has been positively correlated with psychological adjustment and life satisfaction (Havighurst & Albrecht, 1953). Activity theory of ageing is however value- and culture-laden; to successfully age, older adults must remain happy and satisfied (Burbank, 1986) and this has been judged to be associated with activity levels. Activity levels are one possible measure of a person's quality of life and therefore it's importance to ageing 'successfully' will naturally differ between individuals, again bringing into question ideas surrounding inevitable ageing patterns.

Within the concept of maturation and development, ageing could be considered as part of a natural process or cycle. Erikson's eight stage development model highlights that during the ageing process, crises, life tasks and goals occur which must be achieved in order to adapt and move on to the next developmental stage (Erikson, 1963). Old age is associated with the 'integrity versus despair' stage, which involves a retrospective account of life, embracing achievements and regretting lost opportunities. This stage is implicitly seen as inevitable as it is seen as a response to the inevitable weakening of bodies, the loss of autonomy and reduced physical ability, which poses a threat to levels of independence and control (Erikson, 1997). There are however criticisms of this view, the eight-stage model has never been subject to extensive empirical analysis and the relationships between the stages and the way change occurs is still unclear (Stokes, 1995). In addition the concepts behind the model are difficult to operationalise and to therefore test, although this has been contested (Kogan, 1990; cited in Stokes, 1995).
Theories of Ageing and the Question of Inevitable Change

Each of the main theories outlined above appear to assume that some physiological change is inevitable in ageing due to the universal expectation of death. In turn physiological changes are seen to affect the way people socially or psychologically adapt according to a set pattern, for example, older adults disengage from society or they reach a certain reflective stage in life. The theories outlined above therefore propose that some changes are inevitable, yet none of these theories have ever been fully supported (Burbank, 1986) and their assumptions have not been sufficiently tested empirically. One problem in dictating a theory of ageing is the difficulty in encapsulating a multidimensional concept in terms of a unidimensional variable, for example, activity levels. A single definition of ageing is problematic, but ageing must be seen in terms of biological, psychological and social functioning. The lack of a clear definition of the ‘normal’ ageing is a problem within gerontological research and therefore makes an exploration of its inherent changes difficult to consider in its entirety. The rest of the essay will therefore explore specific physical and psychological changes frequently cited within the literature on the ageing process.

Due to the possible impact of physiological changes on later cognitive performance and psychological well-being, the initial focus will be on physical and sensory changes associated with biological ageing.

Physical Ageing

Biological ageing is said to occur due to strong genetic and negative organic changes or due to unpredictable factors, such as disease (Cunningham & Brookbank, 1988; cited in Stokes, 1995); although whether the latter is due to the ageing process itself or to ‘accidental’ environmental factors is still debatable (Stokes, 1995). However it would appear that age-related physiological ageing can increase vulnerability to external stressors leading to further problems either physically or psychologically (Briggs, 1993).

Some of the main organic physical changes involved within the ageing process occur in sensory functions, such as hearing (Briggs, 1993) and vision (Quillan, 1999; cited
in Stuart-Hamilton, 2000). About one-third of people over sixty-five-year-olds report some degree of sensory impairment (Office of Population Censuses & Surveys, 1982; cited in Briggs, 1993) associated with physical and structural changes in the body. Stiffening bones, shrunken nerves and the loss of elasticity have been reliably found in older adults compared to their younger counterparts, which has been strongly associated with clinical sensory deficits (Gates & Rees, 1997; cited in Stuart-Hamilton 2000). Again with respect to the Hayflick limit and the structural physical changes, theories indicate an inevitable decline. Of interest, however is that if one-third of the population suffer from sensory impairment, then conversely two-thirds do not. In addition, there has been evidence of individual variability in sensory functioning (Bromley, 1988; cited in Stuart-Hamilton, 2000). The prevalence of non-impaired older adults begins to challenge the notion of inevitable age-related change, although some decline may be more likely during old age.

Organic physical changes have also been reported in brain development of older adults, even in the absence of disease. Gross atrophy and a reduction in overall brain weight has been found in the older adult population (Cunningham & Brookbank, 1988; cited in Stokes, 1995). Nerve cell function has also been found to deteriorate with age due to the accumulation of waste products over time (Briggs, 1993). In addition, the brains energy source is also reported to decline due to a reduction in the efficiency of the metabolic and cardiovascular systems, resulting in reduced neural transmission speed, loss of cells and increased 'neural noise' (Stuart-Hamilton, 1999). In a recent study the hippocampus, temporal cortex, limbic system (Eustache, Rioux, Desgranges, Marchal, Petit-Taboue, Dary, Lechavalier & Baron, 1995) and the prefrontal cortex areas were found to be physically changed in older adults (Madden & Hoffman, 1997). Again the physical changes in the brain are believed to be inevitable although variable in degree across different individuals (Stoke, 1995).

Studies assessing physical changes are usually conducted within stringent, controlled conditions using accurate technology and imaging techniques, which are quantifiable. However, one of the main criticisms of the research that explores physical changes in ageing is that they tend to focus on the decline of specific functions and do not look at functioning as a whole. Speed of processing may look slower in old age but older adults may sacrifice reaction time for accuracy (Coleman, 1993), which would be overlooked if the focus of the study is within a deficit decline model. Further
evidence against research on physical changes is that with suitable preparation perceived deficits such as reaction times can be speeded up (Gottsdanker, 1982, cited in Coleman, 1993). The broader research on maintained functioning and improved performances after training counteract the notion of inevitability and robustness of changes associated with the ageing process.

Environmental factors such as access to health care and hygiene can also have an important influence on health which can contribute to physical change. Health problems such as arthritis, hip fractures and dementia are viewed as common within the older adult population due to longevity of life. However illness is not considered inevitable (Valliant & Mukamal, 2001) or as part of the ageing process. Illness effects only a percentage of the older adult population. After the age of eighty-five, Alzheimer’s Disease is only present in fifty percent of this population (Perls & Silver, 1999) and ‘the average centenarian’ can live until ninety-seven without a major disability (Perls & Silver, 1999). Although, disease can be more common in the older adult population, there is striking evidence against the assumption of inevitability as so many older adults do not succumb to illness in later life. However, the research is consistent that at least vital capacity and cell-efficiency does appear to be an inevitable process of ageing, declining from twenty years of age onwards, reaching half the original capacity by the age of seventy-five (Goldberg, Dengal & Hagberg, 1996).

General Critique.

In general, the research into biological ageing is either conducted as people age (longitudinal research) or by examining different groups of people at different stages of life (cross-sectional research). Both are essentially flawed. Longitudinal research is expensive, subject to participant drop-out and the conclusions are difficult to generalise from, however, cross-sectional studies can only ‘establish age differences, not age changes’ (Stokes, 1995). Developmental differences in later life are often subject to nutrition, early life experiences, medical care and cultural expectations, which will vary across the different cohorts used in cross-sectional studies. Although longitudinal methodology goes some way to eradicate cohort effects, environmental effects of the period under study can obscure physical changes and so the findings can
not be generalised to the next cohort as environmental conditions would have changed by the end of the study. When considering the inevitability of physical changes in the literature, for example, brain changes, the research is essentially cross-sectional and so subject to cohort effects and environmental factors.

In the literature regarding physical change, it is largely considered that physiological changes are inevitable within the ageing process due to pre-programmed cell death until the death of the organism. However it has been suggested that diet, fitness and maintained levels of activity can be beneficial to health and physicality in later life (Briggs, 1993). Despite the research evidence, there is still some argument against the inevitability of the physical ageing process, as it does not effect all older adults in the same way. Therefore there may be an influence from genetic material, life-style, general health and fitness, which determine the physical changes that occur with ageing. If some control will be gained through malleable factors such as health and fitness, then the assumption of inevitability becomes debatable, especially with the growth of genetic and cellular research. The life span of a cell has already been taken beyond natural Hayflick limit, delaying cell death in recent research (Johnson, et al, 1998; cited in Stuart-Hamilton, 2000). However, the effects of physical decline in ageing are apparent not only in the laboratories but in everyday experience as well and although the decline is variable within each individual, it does appear to affect us all eventually.

**Psychological Ageing – Mental Health**

There have been many studies which have shown mental-health problems in older adults (Baltes & Mayer, 1999). However there is no more evidence of mental illness compared to younger counterparts when the incidence of dementia is excluded (Baltes & Mayer, 1999). Due to the large area that mental health covers, the focus will be on depression and its contributory factors as the most prevalent mental health disorder in the older adult population (Roberts, Kaplan, Shema & Strawbridge, 1997).

Large epidemiological studies have shown that depression does not increase in older adulthood (Baltes & Mayer, 1999; Blazer, Hughes, & George, 1987) and that life satisfaction is stable (Diener, Suh, Lucas, & Smith, 1999). In a recent study, 2,417
older adults, with a mean age of 65, were examined, 6.6% of men and 10.1% of women were found to be depressed with depression increasing with age across the sample (Roberts, et al, 1997). However, when other psychosocial factors were controlled for, no such correlation existed between ageing and depression; instead depression was related to chronic health concerns and functional impairment. This study was based on the presence of depression symptoms (such as sleeplessness and somaticism), which may be more prevalent in older adults due to other factors, although not to depression itself. In relation to the question of inevitability, according to this study, depression although present within the older adult population, does not appear to be an inevitable consequence of ageing per se. Not all older adults become depressed and depression does not increase with age.

The onset of depression in older adults has been associated with impoverished environments (Woods, 1999), low social support (Cervilla & Prince, 1997; cited in Woods, 1999), dementia and stroke (Skilbeck, 1996) and poor physical health (Pitt, 1995; cited in Woods, 1999). Depression has also been reported to result from a cumulative process of poor adjustment to significant life events and loss, (such as retirement or bereavement), in association with the degree of control, choice and the extent of the necessary adjustment (Orrell & Davies, 1994). Most of depression therefore appears to stem from poor adjustment or limited coping strategies in the face of often acute life-threatening illnesses, unpredictable difficulties such as stroke or due to chronic difficulties with pain, such as arthritis. Pain and depression have been strongly associated with each other and the success of pain-management programmes have been instrumental in reducing depression (Woods, 1999). Of interest, the key to these interventions appears to be centred around increasing control, self-efficacy and confidence in older adults which has in turn appeared to reduce the depression (Lang & Heckhausen, 2001).

One area where the association between an external factor and depression has been extensively researched is physical health and depression (Geerlings, Beekman, Deeg & Van Tilberg, 2000). In their study the relationship between physical health and depression was tested to ascertain whether physical problems predicted the onset of, or maintained depression. Their sample of 327 depressed and 325 non-depressed older adults (aged between 55 and 85) drawn from a community sample showed that
the majority (57%) of depressive episodes were brief and could not directly be predicted by physical health problems. Physical problems did however predict long-term depressive episodes and the chronicity of the problems (Geerlings et al, 2000). Within this research, depression may be an inevitable consequence of physical problems. However, the sample covered a broad age range, which may suggest a very heterogenous group; a 55-year-old and an 85-year-old may be subject to different cohort effects and possible coping styles. In addition, the older-old were often not selected due to being too ill or too cognitively impaired, which would also affect the representativeness of the sample. One further problem was that physical health status was self-reported in the study, which may have been affected by the individual’s mood; ratings of physical status were not verified and so the relationship was not objectively examined (Geerlings et al, 2000).

There appears to be some significant correlations between different life satisfaction factors (including control and exposure to negative life events) and depression which can presumably exist at any age level. However, is it possible that older adults are more likely to suffer from these more negative life factors than their younger counterparts and so inevitably are more prone to depression? In recent research, older adults have been found to have fewer negative experiences predisposing an episode of depression than younger adults (McKiernan, 1996). However, older adults are reported to experience fewer positive events as well, which may usually act to counterbalance the effects of aversive life events in younger adults. Research has also shown that older adults cope with loss with fewer grief reactions, less distress and less mental health problems (McKiernan, 1996). However, grief may be expressed differently in older adults (i.e. grief may be more somatic in nature) or certain negative life events such as death of a loved one is more expected and so its impact is less devastating (Woods, 1999). It would appear that older adults do not inevitably have more adverse life experiences or respond necessarily with more distress than their younger counterparts.

However, psychosocial factors may also affect the prevalence and therefore the inevitability of depression in older adults. Prejudice is propagated within the study of geronotology, which often focuses on the negative effects of ageing maintaining negative stereotypes (Butler, 1974). Low expectations and negative attitudes towards
older adults, inherent within different cultures and times may lead to impoverished, socially isolated environments deprived of stimulation and challenges. Other factors such as social class, personality, lifestyle and self-image may have an impact on the number and type of opportunities that are both made available, and taken up on, and so in turn effect the older adult’s self-perception and functioning (Stuart-Hamilton, 2000). One qualitative study examined what it felt like to feel old (Nilsson, Sarvimaki & Ekman, 2000). Older adults reported being able to date when it happened, had a fear of helplessness, did not recognise their former selves and felt different from other people. This appears to show the impact of ageing upon the individual and the inherent exclusion from society and feeling different, which may lead to poor mental health in older adults. Support for the influence of psychosocial factors arises in research which reports that intelligence has been seen to improve in an environment where prompting and positive reinforcement (Labouvie-Vief & Gonda, 1976) and initiation were encouraged (Langer, 1983, cited in Coleman, 1993). The remaining question may not be whether psychological changes such as mental health is an inevitable part of ageing, but are changes inevitable due to social factors and attitudes separate from the ageing process itself?

Inevitability of Mental Health Changes

There are problems with ascertaining the prevalence rates of depression in older adults, as somatic complaints are more prevalent (Woods, 1999) and most of the epidemiological studies exclude cases of dementia and samples within residential homes, where the prevalence rates of depression are higher (Snowdon, 1997; cited in Woods, 1999). Prevalence rates therefore vary depending on the selected sample and the diagnostic criteria employed. Overall, depression has not been reliably shown to be an inevitable change associated with ageing. Instead, depression within this population may be attributable to psychosocial factors such as, lack of perceived control, low social support and low self-esteem. These factors are changeable given the appropriate treatment and support, which would counteract the apparent inevitability of poor mental health, such as depression. As noted in the National Service Framework for Older Adults:
“mental health problems may be perceived by older people and families, as well as by professionals, as an inevitable consequence of ageing, and not as health problems which will respond to treatment” (Department of Health, 2001).

**Psychological Ageing – Cognitive Functioning**

Intellectual decline within old age has been frequently reported in the literature, particularly during and after the sixtieth decade (Birren & Schaie, 1996; Stuart-Hamilton, 1999). One study suggested that older adults often perform within the ‘impaired range’ on tests of cognitive ability (Panek & Stoner, 1980). Most of the intellectual decline is evident in attention, conceptual organisation, creativity and Piagetian task performances (Stuart-Hamilton, 2000). One particular area of decline has been found with respect to fluid intelligence (Salthouse, 1992). Some theories explain the decline in fluid intelligence in terms of disuse (Mike, 1956, cited in Stuart-Hamilton, 2000); however it has been found that some people still lose skills despite continuing to practice them into old age. In addition, some people explain the decline in intellect in terms of the general slowing hypothesis, but this does not fully explain why the slowing down only seems to effect specific skills. There has been some support for the idea that fluid intelligence is in decline in old age as although skills can be learned by an older adult, the new skill will not necessarily generalise to other tasks (Herrmann, Rea & Andrzejewski, 1988). However, there has been some criticism levelled at tests which assess fluid intelligence. Fluid intelligence tests often involve written responses which can be hampered by physical disabilities found in older adults. Once these are taken into account the age difference in performance reduces (Storandt, 1976). However, there are some studies which report changes in cognitive performance in old age, which are not solely mediated by physical changes (Salthouse, 1991).

Most cohort studies have reported a general decline in global cognitive functioning but unfortunately have been unable to describe specific changes in cognitive domains (Korten Henderson, Christensen, Jorm, Rodgers, Jacomb & Mackinnon, 1997; Brayne, Gill, Paykel, Huppert, & O’Connor, 1995). However, one important study explored the effects of ageing on cognition within a longitudinal framework (Cullum, Huppert, McGee, Deining, Ahmed, Paykel & Brayne, 2000), the preferred
experimental design (Coleman, 1993). This comprehensive study assessed cognitive decline in normal ageing using the Cambridge Cognitive Examination (CAMCOG) assessment battery to assess a variety of different domains of cognitive functioning. Their sample of non-dementing 135 subjects, aged over seventy-five were assessed over a four year period. The rate of decline was –1.6 points per year (P<0.001). The results suggested a statistically significant decline across all of the cognitive domains associated with older age, particularly within the perception subscale (p=0.03). In addition there was greater decline within the memory subscale (associated with less education), and a significant decline within the attention/calculation subscale (associated with ‘manual social class’).

The reported global decline was consistent with other studies (Brayne et al, 1997; Jonker, Schmand, Lindeboom, Havekes & Launer, 1998). In addition, further support in an association between perceptual decline and ageing was found as perceptual problem-solving abilities were related solely to age when sensory functioning and health had been taken into account in an earlier study (Coleman, 1993). However, in contrast to other studies, which have attributed memory decline to age (Korten et al, 1997; Rabbitt & Lowe, 2000), memory was associated with less education within this study. This again highlighted the possible influence of psychosocial factors and cohort effects. For example, decline in memory function, if related to education could be attributed to a cohort effect as today’s older adults would have left school earlier than a representative younger sample (Stuart-Hamilton, 1999). Therefore it may be erroneous to compare the two samples as other studies have done.

One of the main problems with this study, however is that the sample size was too small for an epidemiological research project. In addition, the perceptual decline may mirror concerns about the role of sensory functioning as highlighted earlier, but as physical variables were not examined their impact could not be assessed within this study. A further problem with this study is that the sample scored highly within the initial baseline measure and so due to regression to the mean in the follow-up data, a spurious decline could have been indicated when there was not one (Cullum et al, 2000). An important question within longitudinal studies is whether early dementia could have set in by the later assessments, which would have also produced a spurious decline in cognitive functioning.
The Inevitability of Cognitive Change?

In favour of inevitable cognitive change, brain cells do not regenerate and so some cognitive decline may occur with cell death (Coleman, 1993). However further consideration is that most of the mental deterioration prior to the age of 80 is secondary to pathology rather than due to the normal primary ageing process (Schaie, 1990). Contrary to the assumption of inevitable age-related change, research has shown that some skills improve or are maintained well into old age, for example, wisdom, experience (Coleman, 1993), visuo-spatial working memory (Vecchi, Phillips & Cornoldi, 2001), remembering meaningful information (Cohen & Faulkner, 1984) and crystallised intelligence (Stuart-Hamilton, 1999). However some criticism of the studies which assess crystallised skills is that they do not employ a time limit and age deficits have been found when the restrictions have been imposed (Botwick & Storandt, 1974, cited in Stuart-Hamilton, 1999). There are marked individual differences between performances after seventy years of age and therefore the cognitive ageing process is different in us all (Rabbit, Diggle, Smith, Holland & Innes, 2001). Due to the contamination of the impact of physical changes within these studies and the high incidence of poor physical and mental health within older adults it is hard to come to any firm conclusions. So it is still unclear as to whether cognitive changes in fact do occur and that are not just an artefact of poor methodological design.

The Mutual Influence of Physical and Psychological Changes in relation to the Question of Inevitability.

If biological ageing was proven to be inevitable and it has an influence on psychological functioning, then are the ‘apparent’ psychological changes inevitable too? In turn do ‘inevitable’ psychological changes impact on physical functioning? A seemingly robust relationship has been explored between physiological functioning and cognitive changes associated with ageing (Anstey, 1999; Lindenberger & Baltes, 1994; Anstey & Smith, 1999; Rabbitt & Lowe, 2000). Physical changes may also have an impact on mental health. Hearing deficits have been associated with ‘a lowered feeling of well-being’ (Scherer & Frisina, 1998), lowered empowerment.
(Ryan, 1996) and a decline in cognitive functioning (Naramura, Nakanishi, Tatara, Ishiyama, Shiraishi & Yamamoto, 1999). Physical decline and depression have been often cited as lifestyle choices and access to social opportunities and activities may be limited due to physical mobility problems (Woods, 1999).

Psychological status can also affect physical functioning, as low mood and apathy can affect physical rehabilitation following illness or disability (Philpott, 1990). In addition, depression has been linked with undermining the physical health of older adults by further impairing the ageing immune system (Applegate, Kiecolt-Glaser, & Glaser, 2000).

It would appear that the ageing process is complicated and the apparent changes are inter-linked and diverse across different individuals. However, an inevitable pattern has yet to be adequately determined.

**Conclusion**

Although physical health appears to decline in old age due to biological degeneration, individual variation suggests that specific changes are not inevitable. The inevitability of poor mental health is also not clear due to the interplay of other psychosocial factors and due to the methodological considerations, neuropsychological changes in cognition effected by ageing is as yet unclear. The question of inevitability is ethically pertinent to the care that older adults receive and so further research is required in order to ascertain what changes are clearly inevitable and universal and which are the result of secondary pathology or psychosocial influences. As yet no change can be seen as being truly inevitable, change may occur ‘although their relative contribution may vary over time, environment and culture’ (Stokes, 1995).
References


Anstey, K.J. (1999). Sensorimotor variables and forced expiratory volume as correlates of speed, accuracy and variability in reaction time performance in late adulthood. *Aging, Neuropsychology and Cognition, 6, 84-95*


Essays


DISCUSS THE THEORETICAL BASIS OF NARRATIVE THERAPY AND THE EVIDENCE FOR ITS EFFECTIVENESS

“If postmodern theories teach us anything, it is that our theories about therapy and the stories we tell about them, like history, do not proceed according to some grand narrative or master plan. Like our conversations with clients, they are messy processes, each one with its own unique rhythms and patterns.”

(Diamond, 1998, cited in McQuaide, 1999)

The postmodernist era has led to the development of several approaches, which have been founded on a constructivist philosophy. Constructivism is a “metatheory that emphasizes the self-organizing and proactive features of human knowing and their implications for human change” (Mahoney, 1988, cited in Neimeyer, 1993) and focuses on the meaning people make of their experiences. Within a postmodern discipline there are many competing theories regarding the break from modern realist approaches; namely, personal construct theory, structural-developmental cognitive therapy, constructivist family therapy and narrative therapy.

Fundamental to all constructivist approaches, is the notion of antirealism. An antirealist approach stipulates that knowledge of a true reality is unobtainable and that instead, individuals construct their own subjective view of what they experience as reality (Held, 1995). The focus of this essay is the theoretical foundations and effectiveness of one of the main postmodern antirealist approaches - narrative therapy. Narrative therapy is founded on the postmodern belief in constructed realities within language and was originally developed within systemic family therapy work. However due to the breadth of literature on systemic family therapy it will not be the focus here.

Within postmodernism, narrative therapy draws upon a ‘deconstructivist theory of literary criticism’, by analysing meaning within narratives and ‘social constructionism’, which stipulates that reality is constructed within social systems and is not a ‘given’ truth (Kelley, 1998). The originators of narrative therapy, Michael
White and David Epston (1990) have also drawn on the ideas of French philosopher, Michel Foucault (1979), concerning the interplay between knowledge, power and language (Monk, 1997). This discussion will focus on the theoretical underpinnings of narrative therapy and its effectiveness in practice. It is also appropriate alongside a discussion about the recent research into effectiveness, that the implications of the paradigm shift from modern to postmodern ideas should be discussed as the issue of how effectiveness is assessed needs to be addressed. Effectiveness will be discussed in terms of the service implications for using an approach which has had limited controlled research conducted on its efficacy. The issue of effectiveness of narrative therapy is therefore important considering that treatment choice is currently founded on evidence based practice. Further concerns are whether narrative therapy can be employed within the current National Health Service (NHS) framework.

The Theoretical Basis of Narrative Therapy

The Theory behind Narrative Therapy

Narrative theory suggests that people structure their experience of life in a narrative form in order to derive meaning from their existence (Bruner, 1986). Narrative theory suggests that people tend to hold a dominant story about themselves, which is coherent and provides some security in providing this sense of meaning. However the dominant story is only one possible story of an individual who would naturally have alternative experiences and stories which counteract the plot of the dominant story. The existence of alternative stories is assumed because no one story can depict the variety of experiences that people can derive meaning from (White & Denborough, 1998). In maintaining a coherent story, people have to select particular experiences, which fit in with their dominant plot and ignore experiences, which do not support it (White & Epston, 1990). Therefore the dominant plot becomes a filter of experience which restricts other stories from developing. The dominant story is then performed to audiences within the social domain (Drewery & Winslade, 1997). The performance of the dominant plot in the social domain influences how people view the narrator and how the narrator then views themselves and the ‘positions’ or roles that they take in life (Drewery & Winslade, 1997). People both structure stories about themselves and are structured by the stories they tell (Mair, 1988, cited in Neimeyer, 1993). The
perceived ‘reality’ of experience is therefore experienced within human interactions and is therefore socially constructed within the discourse that takes place (White & Epston, 1990). This idea is fundamental, since therapy is also conducted within a discourse; therapy could therefore help construct the development of an alternative, more helpful narrative through the use of language.

Language and its use within discourse is therefore seen as a powerful vehicle for influencing people’s construction of themselves and their identity. Identity, in relation to the different roles and personas people adopt in their social worlds, is therefore not stable, which is a view in contrast to the theories about identity formation adopted by modern personality theories (Drewery & Winslade, 1997). Within postmodern narrative therapy, the individual or self, as it described in spoken language can be seen as a verbalised ‘text’. The self is therefore viewed as a series of changing stories constructed in language (de Shazer & Berg, 1992). This ‘text analogy’ is based on the deconstructivist theory of literary criticism, which defines the self as a narrative text which can be deconstructed and redefined as within literary theory.

There is some evidence for the narrative view that the self is dependent on the text that an individual performs to an audience. Human beings do not portray the same view of themselves to everyone. Instead an individual often changes his/her persona dependent on their audience. Postmodern narrative theory suggests that identity is a changeable phenomenon and people’s views are socially bound and constructed within the cultures and norms they live in; their sense of self is socially defined.

The construction of the self and identity within texts is conducted within the undertaking of the various social roles by an individual, for example, as a mother, wife, daughter, feminist, and self-employed businesswoman (Drewery & Winslade, 1997). Within these multiple, socially constructed positions, different power relationships and discourses are possible, which have an impact on the individual’s social persona. Within these different roles and constructions of self, power, language and knowledge are seen as key elements of the discourses that result, which are in turn influenced by the culture and political climate that the discourse is played out in. Therefore, in order to develop a more culture-based psychology, it would be necessary to examine the language and discourse people engage in. Examination of
discourse enables an exploration of how people construct their own identity and their lives based on the culture, politics and social circumstances that they find themselves in (Bruner, 1990 cited in Neimeyer, 1993).

The idea that narratives are changeable is useful in terms of viewing individuals as fluid with the ability to change and re-story their lives. This in turn focuses the individual on the effects of their dominant stories on their perceptions of reality (Zimmerman & Dickerson, 1994). Within this exploration of how different cultural norms, power structures and knowledge affect the stories people then tell about themselves, comes an increasing awareness of self. Narrative theory acknowledges and privileges the awareness and breadth of experience of the client, who is necessarily placed in the role of ‘expert’. The reliance on the client’s personal skills and knowledge means that their experience of self-efficacy and independence throughout therapy is both validating and empowering. In turn, the therapist develops a new role, one of a co-worker rather than an expert (White & Epston, 1990).

The Theoretical Foundations of Narrative Theory

Evolution of narrative theory - Contribution of Postmodern Constructivist Ideas

Narrative therapy has risen as an alternative way of working with clients that stems from a disenchantment with western psychology’s use of language within therapy. Western psychology focuses on personal deficits, problems and failures. It maintains social hierarchies and ideas surrounding expertise, which could be experienced as disempowering, deskilling, negative and pathologising by a client (Drewery & Winslade, 1997). Postmodern ideas and approaches like narrative therapy arose as a critique to modern theories of psychotherapy (Neimeyer, 1993). One of the main criticisms was an attack on the modern theory’s quest for logical empiricism (Radnitzky, 1973, cited in Neimeyer, 1993) and ‘truth’, which were considered timeless and culture free. These approaches were based on the premise that rationality, objectivity and logical inferences from observable outcomes were obtainable within a scientific process. With the rise in cognitive therapy (Beck, 1976), rationality became synonymous with mental health (Anderson, 1990, cited in Neimeyer, 1993). Treatment was therefore aimed at providing a client with the means
with which to dispute their irrational beliefs through a process of "reality testing," which would highlight the rational, accurate truths (Beck, 1976). This traditional 'realist' science therefore associated mental health with an ability to perceive what is actually there. However, these approaches assumed that there were indisputable 'facts' or truths in the world with which to validate your beliefs against. Postmodern constructivist theories criticised these claims of rational, objective knowledge and suggested that beliefs and 'realities' were socially constructed within ever changing time periods, cultures and circumstances, despite their apparent realism (Berger & Luckman, 1976, cited in Neimeyer, 1993).

The use of a postmodern narrative metaphor within therapy arose from the work of Michael White and David Epston (1990), who developed their ideas from the work conducted within anthropology and philosophy. The initial inspiration for narrative theory came from the work conducted by Gregory Bateson (1972, cited in White & Epston, 1990), an anthropologist and psychologist, who developed ideas against an objective reality. Gregory Bateson argued that objective reality was not possible to perceive, as the meaning we ascribe to it is restrained by the presuppositions that constitute our current understanding of the world. The new information would therefore be compared to our personal existing frameworks of meaning and it's fit would determine whether it would be incorporated or not (Bateson, 1972, cited in White & Epston, 1990). For modern basic sciences such as neuropsychology and cognitive science which depict people in "mechanistic terms" (Mahoney, 1991, cited in Neimeyer, 1993), a constructivist approach challenged the fundamental principles that categorised people in diagnostic terms. Instead, people were seen as meaning-makers, who may hold many varied beliefs within themselves or between each other and that this pluralism of beliefs was acceptable and valid. This pluralism fits in to the ethos of the twentieth century which encourages choice, democracy, religious freedom, consumerism and variety (O'Hara & Anderson, 1991, cited in Neimeyer, 1993) and so is now challenging the dominant story of modernism. The challenge to the idea that there is one rational truth or reality to be perceived in turn starts to undermine the whole diagnostic system within mental health.

Postmodern ideas contribute to narrative therapy by making its practice less prescriptive and value-laden and instead promotes individual and expert knowledge
within the client. Treatment is therefore “creative rather than corrective” (Neimeyer, 1993). The focus is on broadening and exploring the client’s constructions and emotions rather than changing them, which is more validating of the client’s experiences as there is no one true story. Evidence for postmodern ideas comes from studies which eradicate the basic premise of modern theories. Inaccurate and illusionary beliefs have been found to be widespread within the general population and have been deemed to be functional (Taylor & Brown, 1988, cited in Neimeyer, 1993).

**Evolution of narrative theory - Contribution of Social Constructionism**

The meaning-making that takes place within a social context is crucial to the self-organising development within both groups and individuals. The social context acts as a framework for the development of a coherent internal story (Maturana & Varela, 1987; cited in Neimeyer, 1993). Social constructionism within therapy explores the contributions made by gender roles, culture, race, pathology and family norms (White & Epston, 1990). Culturally based stories are not neutral (Bruner, 1986) as they define and reflect normative viewpoints which are mediated by the dominant culture, which people define themselves within and compare themselves to (Zimmerman & Dickerson, 1994). If this is broadened further, then it could be argued that social constructions are also politically laden. White and Epston therefore found these ideas useful in terms of aiding clients in mapping the effects of the problem. Problems were examined through different levels of meaning (for example, culture, family systems and politics) to assess the effects of these levels of meaning on their lives. This enables new knowledge and insights to be gained (Monk, 1997).

**Contributions of Philosophical Theories of Power, Language and Knowledge**

Finally, White and Epston (1990) incorporated the ideas regarding the interplay between power, knowledge and language, suggested by French philosopher, Michel Foucault (1979, cited in White & Epston, 1990). Foucault argues that power can have a positive ‘shaping’ effect on the experience of individuals through a process of ‘normalising truths’ or knowledge. These normalised “truths” stipulate how individuals should be; it specifies a form of “individuality” which produces “docile
bodies” who conform to dominant scripts of power. Individuals are conscripted into ideas and action, which then feed back into the power structures and ideas of ‘unitary’ and ‘global’, normalised knowledge, such as ‘objective reality’ and ‘empirical empiricism’. Power and knowledge are deemed inseparable in Foucault’s theories. The knowledge of social norms, expectations and labelling leads to social control, which is created through registration and classification, practices, exclusion, identity ascription and surveillance. Social control influences people to police their own behaviour in conjunction with the dominant social story through a process of internal institutionalisation of social norms; power is propagated through ideology rather than through force.

Foucault’s ideas inform the basis of narrative theory by expanding the assumptions, beliefs and discourses of clients and therapists. This is achieved by acknowledging that all claims of ‘global knowledge’ are mediated through the language of power and are socially and politically based. Self understanding is enhanced through the explanation of the effects of global knowledge on the stories people tell about themselves.

**Theoretical Critique**

Antirealism is a fundamental component in narrative theory which states that “the knower must always create, in language, the (non) reality – or the linguistically altered reality she experiences” (Held, 1995); reality can not ever be truly ‘known’.

The main issue is that due to its anti-realist foundations, narrative therapy does not adhere to a predetermined strategy within which to categorise problems, clients or therapy. In addition, narrative theory attempts to understand each individual’s experience or story on a personal level rather than treating clients as categories and pathologised labels. Inherent within this individuality is that the individual client’s story is one version of a perceived subjective reality. However, this theoretical story has been criticised for not being consistent (Held, 1995) in terms of whether therapy is predetermined, individualised or truly antirealist in nature.

As the narrative therapist has a framework which dictates that the client has a problem-saturated story and that it is possible to re-author it into a more helpful story,
Essays

therapy is necessarily predetermined in order for a systematic practice to occur? In response narrative theorists argue that the individualistic component is the particular story of the client and the alternative plots, which can not be predetermined. Realistically, “the narrative theoretical system allows a practice that is fully individualised with regard to therapeutic content, but not with regard to therapeutic process” (Held, 1995). Therefore, inherent within this reframe of narrative theory is a criticism based on narrative theory's foundations on antirealism.

When postmodern narrative theorists talk of ‘reality’ (Held, 1995) it is unclear as to whether they believe that the constructed reality is unique to an individual or whether ‘realities’ are constructed within a cultural context which gives rise to commonalities that groups of individuals may share. The confusion has arisen because the terms constructivism and social constructionism have been used interchangeably within the literature. However, it appears that essentially constructivism believes in the uniqueness of subjective reality to each individual and social constructionism holds the view that realities can be socially constructed within a culture. Therefore within social constructionism, if individuals have access to the same cultures, norms and discourses they may share common subjective realities. As narrative theory incorporates both of these ideas there is an inherent problem in doing so. In adhering to a social constructionist perspective, the individualised nature within narrative therapy is somewhat lost, as social constructionism suggests that some culturally based knowledge can be shared (Held, 1995). Narrative theory’s answer is a compromise; an individual’s unique experience is altered by the filtering system of social context, which is a shared phenomenon because language and culture is shared. However the language and culture is still antirealist in nature because they are still conceptual representations rather than a known objective reality (Held, 1995).

However, there is still one remaining problem, the concept of antirealism. Narrative theory suggests that people construct in language, their experiences of their lives. However in order to create stories about events it must be possible to be able to ‘know’ the extralinguistic (real) events directly, in order to be able to create a narrative around it, even if they are not accurate (Held, 1995). If the existence of real events is ignored, as antirealistic ideas suggest they should be, then ‘real’ experiences of poverty, experience of abuse or mental illness may be devalued. As Glass (1993)
states, “human beings suffer, letters do not”. In order to ensure that clients are safe and that their experiences are validated the only way to uphold narrative theory is to oscillate between what antirealist narratives are occurring about and real events that actually happen; realism (Held, 1995). This intuitively does appear to mirror what happens when narrative theory is put into practice; no narrative therapists would ignore a real abuse situation that a client was in and believe it to be one possible story about the events that are happening, the client’s safety would still be paramount. However, one further concern over the client’s safety is that the deconstructing of identity that can occur within narrative therapy could mirror what happens in the development of psychosis (Glass, 1993).

**Conclusions of Critique**

Overall, narrative therapy appears to be criticised mainly for its antirealist premise, which makes it difficult, by its very nature, to put therapy into practice. The abstract nature of narrative theory means it is difficult to conceptualise clients and their problems, but if simplified it would lose its meaning (Neimeyer, 1993), which gives modern approaches more of an aesthetic appeal (Steenberger, 1991, cited in Neimeyer, 1993).

**Evidence for Effectiveness**

Research has been conducted in order to assess the effectiveness of narrative therapy, but first a summary of how theory translates into therapy will be outlined.

**Translation of Narrative Theory into Therapy**

The stories people tell about themselves are not always helpful and sometimes need re-authoring (Howard, 1990, cited in Neimeyer, 1993). The main example of an unhelpful story is one in which the dominant story that is told is problem-saturated and the person telling it has identified with the problem; they and the problem are one. These problem dominant narratives can be very restrictive to an individual’s image of themselves, the image they project to others and their resulting behaviour (White & Epston, 1990).
Due to the restricting nature of problem stories, therapists first attempt to deconstruct the dominant story by examining “news of difference” (Bateson, 1972, cited in White & Epston, 1990); examining times when there were exceptions to the problem narrative, when an alternative ending or discourse occurred. The therapist then externalises the problem and examines the wider social system that interacts with the problem. Therapy then attempts to reconstruct the history and development of an alternative story and dominant plot, which will provide the clients with some agency.

The aim in therapy is to attempt to assist the client in performing alternative stories, which are naturally occurring within an individual’s life, but are usually ignored or suppressed by the dominant story. Alternative stories are therefore explored and embellished; discussed within a historical context and the potential meaningfulness of these experiences are examined. If an alternative story is released, examined and historicised then a more helpful self-image of being proactive, skilful and successful can emerge which can open opportunities for independence, resourcefulness and agency (White & Epston, 1990). Within this form of therapy the client’s knowledge and experience is taken as the ‘expert’ view and in doing so privileges the clients roles and participation within the therapy (Zimmerman & Dickerson, 1994).

Research

Despite its increasing use clinically (Cowley & Springen, 1995) research into the effectiveness of narrative therapy is limited. In a recent paper by Etchison and Kleist (2000) they reviewed four experimental studies, which claimed to examine the effectiveness of certain elements of narrative therapy.

Study 1

The first research study (Besa, 1994) directly assessed the effectiveness of narrative therapy in reducing the frequency of conflicts between parents and their children, as it was being increasingly used within family therapy (Hourigan-Johnston & Robinson, 1989). Six families participated who presented with a clinical parent-child conflict problem. The design of his study was a single-case research design. The frequency of
incidents was used as an outcome and three multiple baseline designs were used to evaluate the results. Five out of the six families improved by decreasing the frequency of their conflicts by 88-98% after narrative therapy; in comparison, no improvements were found in the control group.

One criticism of this study is that the findings can not be generalised to the entire population as the sample size is too small and the problems are too specific. It was also difficult to attribute all of the therapeutic changes to narrative therapy due to the influence of external factors, which also had an impact. For example in one family a mother's work shift pattern changed which had an immediate effect on her daughter's problematic behaviour. In addition, parents monitored the changes in their children's behaviour which has been proved to be unreliable in previous studies (Kazdin, 1982) and no extra checks were conducted to ensure the validity of the parents accounts. However in accordance with narrative thinking, if there is no objective truth then it is the client's perceptions of the problems that is the outcome measure and their frequency recordings were possibly a valid measure of their perceptions of the problem (Besa et al, 1994).

**Study 2**

The second study (St. James O'Connor, Meakes, Pickering & Schuman, (1997) examined the client's experience of narrative therapy. Again, the problem story focused around families who were having difficulties with their children, whose ages ranged from six to thirteen. Eight families participated who were selected from the ongoing caseload of a narrative family therapy team. The study employed an ethnographic research design and a semi-standardised interview, which was transcribed and coded using latent and manifest content analysis. Themes were identified which supported narrative theory. Therapy was experienced as empowering and that the longer the families were in therapy the better the perceived clinical outcome. The method was deemed appropriate to assess the effectiveness of narrative therapy, however success was attributed to a "number of cognitive shifts" within therapy which showed the effectiveness of changes to people's view and behaviour.
This study does have its limitations in that it used opportunistic sampling which means that the clients were selected in terms of clients who had the desired information and who were available (Sells, Smith, Coes, Yoshioka & Robbins, 1994). This method of selection may have led to an unrepresentative sample, who due to their ongoing work with the therapists/researchers may have been influenced by loyalty to their therapists. Although the interviews were conducted by students who were not part of the therapy team, there is no way of knowing whether the participants were still wary about their feedback and the implications it may have had on their ongoing therapy if their comments were negative. The researchers may have unwittingly selected clients that were happy with therapy and this work does not include clients that have dropped out of therapy.

Study 3

The third research study (Weston, Boxer & Heatherington, 1998) focused on conflicts within families. This exploratory descriptive study examined children’s attributions about why different family members argued. Ninety-two children participated. An audio-taped family argument and a structured interview about the contents and meaning of the recorded argument were conducted using a pictorial scale to identify each child’s perceptions. The resulting data was evaluated quantitively and a repeated-measures ANOVA was used for analysis. Results suggested that narrative therapy is effective in eliciting meaning and perceptions of events.

Criticisms of this study focused on the ability of the children to understand what they had to do and the length of their responses varied, which may have affected the quality of the accounts. The families recruited in this study were non-clinical and so may not represent the effectiveness of narrative therapy with severe clinical problems. A further criticism is that due to the small sample size within each age group the design could not allow reliable hypothesis testing about the developmental differences between the children. All of the children were white, from a middle-class background which may not be representative of the general population.
**Study 4**

The latest study (Coulehan, Friedlander & Heatherington, 1998) was based on Sluzki’s (1992) narrative approach, which looks at the client’s progress from an “individual intrapersonal perspective to an interpersonal systemic or relational perspective”. Interviews and questionnaires were implemented with eight families with a clinical presentation. The family’s view of the problem story was elicited during the initial interview and an observational coding system was used to evaluate any subsequent change in the original perspective after therapy. Successful and unsuccessful narrative groups were then compared, success was established if the families initial intrapersonal problem story had been changed for an alternative interpersonal, more helpful story. Successful change involved three components, a ‘marker’ (a signal of readiness to change), a ‘task environment’ (the therapy) and ‘a resolution’ (desirable change occurs).

There has been a lot of criticism levied at this study as the results are confounded by the fact that the successful group also had the input of reflexive teams. It therefore remains unclear as to whether success was down to a change from intrapersonal to interpersonal accounts or to the presence of the reflective teams. This is important considering the reflecting team has been considered one of the most powerful elements of the experience of narrative therapy (St. James O’Connor et al, 1997). A further criticism is that single parent families were over-represented in the unsuccessful groups making comparison difficult, as the samples were not matched. As in the study above, success was determined by self-report which has been shown to be unreliable and the researchers were at risk of a confirmatory bias (Rice & Saperia, 1984, cited in Coulehan et al, 1998)). Replication of this study would also be difficult due to the random nature of whether reflecting teams were used or not, when and who with.

**Conclusions of Research**

Overall, these studies show the start of an exploration into the effectiveness of narrative therapy and show some early positive signs. However, it is clear that not enough controlled research or randomised controlled trails have been employed. The
Methods employed were chosen in order to elicit qualitative data, which allows analysis of more complex answers in the form of narratives.

The lack of studies has been attributed to a paradigm shift into constructivism, which is at odds with traditional quantitative methodology (Neimeyer, 1993). Constructivists argue that there can never be an objective reality. In other words, there can be no objective criteria that can be taken as an outcome measure (Kelley, 1998, cited in Etchison & Kleist, 2000), which undermines quantitative methods. Constructivist approaches instead appear to prefer a qualitative methodology due to a shared importance given to participants' meanings, which includes their experience of therapy and the researchers' position within the process (Merchant, 1997). However, despite the complementary relationship between qualitative research methods and narrative therapy, many researchers know little about how to conduct qualitative research (Etchison & Kleist, 2000) and journals are somewhat reluctant to accept them (Ambert, Adler, Adler & Detzner, 1995).

Due to the rise in clinical governance and choice of treatment relying on evidence, it is difficult at the moment to argue for the use of narrative therapy in clinical practice, despite good initial results from studies. Etchison and Kleist (2000) and Neimeyer (1993) recommend being open to using narrative approaches but to also modify therapy accordingly, essentially incorporating narrative ideas into other models.

**Clinical Practice**

The postmodern "backlash about the 'truth'" was considered an inevitable part of the evolutionary process towards the development of current thinking in psychology (Zimmerman & Dickerson, 1994). However, there have been difficulties with incorporating narrative theory into clinical practice, as it is abstract and non-manualised. The main question now is that with all the issues surrounding effectiveness and evidence-based practice, is it possible to conduct narrative therapy in today's NHS?

In America, narrative therapy has recently been successfully integrated within the Managed Care System (Kelley, 1998), which provides some clues as to how it may be
incorporated into the NHS. White and Epston (1990) have started to specify stages of treatment and techniques, which are general and not too prescriptive. These suggested stages could be translated into treatment care plans and goals, which would be in line with current treatment practices. Narrative therapy also fits in with other approaches in that it is solution-focused without ignoring the importance of the problem story and are time-limited approaches (Kelley, 1998).

Within the NHS, time-limited approaches, such as cognitive behavioural therapy have been valued due to restrictions on resources. Narrative therapy can be usually conducted over relatively few sessions and the use of therapeutic letters within narrative therapy have further reduced the required number of sessions (White, 1992). Narrative therapy has been described as an empowering process (St. James O’Connor et al, 1997) which helps the client see pathologising diagnosis labels as being only a part of their life rather than their entire being and enables clients to attend to their strengths. In helping clients have more agency, they will need to rely on services and NHS resources less, which is again an important consideration for future services.

Narrative therapy within a postmodern framework has made us more humble therapists. We are no longer the expert. Instead the privilege of knowledge and experience is given to the clients. That in itself may be an important lesson. To be therapeutic the client should feel understood, feel their experiences have been validated and to be enabled to find a sense of empowerment. Narrative therapy adheres to these ideals in practice, but due to its abstract nature and the difficulty in reshaping these new ways of thinking of our clients, it is difficult to put into practice and therefore to assess its effectiveness. However, ever-developing methodologies are enabling new ways of studying effectiveness that are more in line with narrative philosophy. The development of narrative theory is a story of theory development in itself, it may be that it is just one of the paths that can be taken through the ‘landscape of meaning-making’ that therapists undergo. The question remains whether narrative therapy is the right path and at the moment the ending of this story is as yet unknown.
References


RESEARCH STUDIES
Service Related Research

Project

Year 1

Word Count: 2999
THE EFFECT OF AN OPT-IN REFERRAL SYSTEM
ON THE CLINICAL OUTCOMES OF AN ANXIETY MANAGEMENT
GROUP IN A PRIMARY CARE SETTING.

Introduction

Resource pressures within primary care.

Within the primary care services there is an increasing demand to manage the
growing numbers of clients presenting with mental health difficulties, despite the
limited resources available. The arrival of primary care groups, clinical governance
and the prevailing issue of clinical effectiveness has further pressured services to
address the availability of resources and it’s impact on the quality of care. In addition,
within psychological services there is growing concern about the rising level of client
non-attendance (Munro & Blakey, 1988), which in turn has an impact on service
delivery and resource availability (Fox & Skinner, 1997).

The few studies that have examined non-attendance tended to focus on the reasons
clients gave for failing to attend appointments. The reasons for non-attendance to date
include inappropriate referrals (Farid & Alapont, 1993), negative expectations
(Sheehan, Oppenheimer & Taylor, 1986); poor communication and administration
errors (Grover, Gagnan, Flegel & Hoey, 1983); distance and the nature of the health
problem (Lister and Scott, 1988); and long waiting lists (McGlade, Bradley, Murphy
& Lundy, 1988). A review of services supports the difficulty with waiting lists
(Anderson & White, 1994), despite knowledge that non-attendance is positively
related to the length of waiting time (McGlade et al, 1988). In response to this early
literature, services have attempted to address these issues, which had a positive effect
on attendance (Webster, 1992; Grover et al,1983; Skaife & Spall, 1995; Munro & Blakey, 1988).

A further way in which attendance rates have been improved is by incorporating an
opt-in referral system (Busch, 1996), when the clients send in an opt-in form
confirming their decision to attend an appointment. It has been hypothesised that the
process of opting into treatment shifts “the onus of responsibility for making and
cancelling appointments on to patients” (Mason, 1992) and allows them to make more active choices (James & Milne, 1997). Making proactive, informed decisions about attendance may foster self-help (Anderson & White, 1994) and therefore “strengthens the commitment” to attend (James & Milne, 1997).

Recent studies have shown that an opt-in referral procedure is successful at reducing drop-out rates (Green & Giblin, 1985; James & Milne, 1997) and first appointment attendance from 75% to 97% (Anderson & White, 1994). Another study based on a community addiction team, found that opt-in procedures and prioritising reduced the numbers of failed appointments from 42.9% to 18.5% compared to a baseline waiting list period (James & Milne, 1997). Opting into treatment also halved non-attendance rates in an outpatient cognitive-behavioural back pain rehabilitation clinic from 24.2% to 12.4% compared to a control group who had received the same treatment the previous year (Waring, Rose & Murphy, 1999). However, not all studies have found these results. One recent study of non-attendance rates of clients visiting a psychology department found that non-attendance rates were not improved by an opt-in referral system (Conaghan, Traynor, Davidson & Ralston, 2000). There appears to be no clear reason why this study elicited contradictory findings, although one explanation may be the length of each service's waiting list, which were not reported in most cases.

The process of opting into treatment may act as a motivating factor, as it has been shown to improve clinical outcome in an anxiety management group, maintained after a year’s follow-up (Busch, 1996). The impact of motivation on treatment recovery has been highlighted in the treatment of substance abuse (DiClemente, 1999) and found to be an important contributor to attendance rates and successful outcome in clinical therapy (DiClemente & Prochaska, 1998). The current investigation will therefore examine the effects of motivation on non-attendance rates and clinical outcome of an anxiety management group.

Summary of Objectives for this Study

The service within which this investigation took place, was interested in offering a cognitive-behavioural therapy group and in evaluating the impact of an opt-in referral procedure on its attendance rates and clinical outcomes. This pilot investigation was also interested in whether initial motivation levels will have an effect on subsequent
attendance and clinical outcomes. This study will provide demographic and statistical data based on non-parametric repeated measures analysis.

It is hoped that the results from this study will be of value to this particular service and other primary care services.

**Hypotheses:**

**Opt-in versus standard referral procedures:**

1. Participants who have opted-in to treatment will exhibit higher attendance rates for the initial appointment.

2. Participants who have opted-in to treatment will exhibit higher attendance rates for subsequent sessions,

3. Participants who have opted-in to treatment will make greater positive changes on clinical outcome measures.

**Motivation**

4. Participants who have opted into treatment will have higher motivation scores at the start of treatment.

5. Participants who have higher motivation scores at the start of treatment will have higher attendance rates for subsequent sessions.

6. Participants who have higher motivation scores at the start of treatment will make greater positive changes on clinical outcome measures.
Method

Design
This study incorporates a between-subjects design comparing the opt-in group to the standard referral group for initial and overall attendance, clinical outcome and initial motivation scores. This study also employs a within-subjects design using repeated clinical outcome measures for all participants pre-treatment, post-treatment and at three months follow-up.

Participants
Participants were selected from referrals for an anxiety management group from General Practitioners (GP’s) working within primary care services, who were then screened for suitability through a semi-structured assessment interview (Appendix 1). The Clinical Psychologist and Trainee Clinical Psychologist who facilitated the group completed the screening interviews according to the following inclusion criteria:

1. Any existing anxiety problem apart from Obsessive Compulsive Disorder
2. Aged between 18-65
3. No evidence of co-morbid severe mental illness
4. Able to work within a group setting, (for example exhibited turn-taking skills in assessment)
5. Able to attend the group session for an eight week consecutive period

Anxiety Group Non-Participants
Twenty-four people were referred for treatment for anxiety. All were sent an assessment appointment, twenty-one of these attended this appointment\(^1\). Of these twenty-one, seven did not meet the above criteria, and were excluded from the study. For further details of this sample, see Appendix 2.

\(^1\) One person for the standard group did not attend the assessment and one person for the opt-in group did not opt-into treatment
Measures

Demographic and diagnostic details were obtained from the clients’ referral letters and assessment interview. Attendance was recorded weekly for both groups. The standardised self-report measures used were chosen for brevity, ease of completion and all had good reliability and validity. The BAI (Beck, Brown, Epstein & Steer, 1988) measured physiological and cognitive symptoms of anxiety, the HADS (Zigmond & Snaith, 1983) elicited both anxiety and depression, the GHQ (Goldberg, 1978) measured general health and the ELI (Powell, 1992) measured the impact of anxiety on their quality of life. (for further details see Appendix 5). A visual analogue scale was specifically developed for this study to measure motivation (MCS), adapted from the ‘Dependence Questionnaire’ designed for smokers who want to stop smoking (Jackson, Stapleton, Russel & Merriman, 1986). Six items were adapted from the original scale, please see Appendix 5 for the full scale used in this study.

Treatment

All participants received the same treatment package, which incorporated aspects of Clark’s (1989) cognitive-behavioural treatment model for anxiety. Please see Appendix 6 for full details.

Statistical Analyses

In this study, the independent variable was group (opt-in or standard). Dependent variables were attendance rates, motivation and clinical outcome measures, taken at three intervals. The motivation measure was also used as a predictor variable for attendance rates and clinical outcome. A comparison of demographic measures was also undertaken.

Primarily, this was a pilot study to ascertain some descriptive details from the data, incorporating a repeated measures and correlation analysis. Non-parametric statistics were used as the sample size was too small to have a normal distribution. The study assessed a priori, had a power of 0.3, which meant that all results were to be interpreted with caution.
**Results**

The opt-in group was significantly younger than the standard procedure group (see Table 1).

**Table 1: Summary of comparison statistics for demographic details - age.**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Standard group (N=9)</th>
<th>Opt-in group (N=6)</th>
<th>Test Statistic</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Mean 50.89 SD 11.16 Median 53</td>
<td>Mean 35.33 SD 10.82 Median 32.50</td>
<td>Mann-Whitney = 0.03</td>
<td></td>
</tr>
</tbody>
</table>

The two groups did not significantly differ with respects to gender, type or duration of illness (please see Table 2, Figures 1 and 2), or in whether they had been seen previously by other professionals. However, there was a clear reversal in the ratios of males and females in each group and some differences in the types of anxiety exhibited (Table 2). A higher percentage of the opt-in group had suffered anxiety for longer prior to entering the group.

**Figure 1 : The Type of Anxiety Experienced by Participants**

![The Type of Anxiety Experienced by the Participants](image_url)
Figure 2: The Duration of Anxiety Experienced by Participants

![The Duration of Anxiety Experienced by Participants](image)

Table 2: Summary of comparison statistics for demographic details.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Standard group</th>
<th>Opt-in group</th>
<th>Test Statistic</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2 (22%)</td>
<td>4 (67%)</td>
<td>Fishers</td>
<td>=</td>
</tr>
<tr>
<td>Female</td>
<td>7 (78%)</td>
<td>2 (33%)</td>
<td>Exact</td>
<td>0.136</td>
</tr>
<tr>
<td>Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GAD</td>
<td>4 (45%)</td>
<td>2 (33%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td>2 (22%)</td>
<td>3 (50%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driving</td>
<td>2 (22%)</td>
<td>0 (0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>1 (11%)</td>
<td>0 (0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance</td>
<td>0 (0%)</td>
<td>1 (17%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Help</td>
<td></td>
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</tr>
<tr>
<td>Yes</td>
<td>3 (33%)</td>
<td>3 (50%)</td>
<td>Fishers</td>
<td>=</td>
</tr>
<tr>
<td>No</td>
<td>6 (67%)</td>
<td>3 (50%)</td>
<td>Exact</td>
<td>0.622</td>
</tr>
<tr>
<td>Duration of Illness *</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short (&lt;1 year)</td>
<td>4 (44.4%)</td>
<td>1 (17%)</td>
<td></td>
<td>--*</td>
</tr>
<tr>
<td>Medium (&gt;1 year &lt;10 years)</td>
<td>3 (33.3%)</td>
<td>2 (33%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long (&gt;10 years)</td>
<td>2 (22.2%)</td>
<td>3 (50%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Baseline comparison between the two groups at pre-intervention

* Cut-offs were decided based on the distribution of the data, participants clustered around having had anxiety for 1-4 years (labelled short), 12-15 years (labelled medium) or lifelong (labelled long).
* A Chi square contingency test was not performed on this data as the expected cell frequency is less than 5.
Figure 2: The Duration of Anxiety Experienced by Participants

The Duration of Anxiety Experienced by Participants

Table 2: Summary of comparison statistics for demographic details.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Standard group</th>
<th>Opt-in group</th>
<th>Test Statistic</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2 (22%)</td>
<td>4 (67%)</td>
<td>Fishers Exact</td>
<td>0.136</td>
</tr>
<tr>
<td>Female</td>
<td>7 (78%)</td>
<td>2 (33%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GAD</td>
<td>4 (45%)</td>
<td>2 (33%)</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Social</td>
<td>2 (22%)</td>
<td>3 (50%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driving</td>
<td>2 (22%)</td>
<td>0 (0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>1 (11%)</td>
<td>0 (0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance</td>
<td>0 (0%)</td>
<td>1 (17%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Help</td>
<td></td>
<td></td>
<td>Fishers Exact</td>
<td>0.622</td>
</tr>
<tr>
<td>Yes</td>
<td>3 (33%)</td>
<td>3 (50%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>6 (67%)</td>
<td>3 (50%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of Illness *</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short (&lt;1 year)</td>
<td>4 (44.4%)</td>
<td>1 (17%)</td>
<td>--*</td>
<td>--</td>
</tr>
<tr>
<td>Medium (&gt;1 year &lt;10 years)</td>
<td>3 (33.3%)</td>
<td>2 (33%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long (&gt;10 years)</td>
<td>2 (22.2%)</td>
<td>3 (50%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Cut-offs were decided based on the distribution of the data, participants clustered around having had anxiety for 1-4 years (labelled short), 12-15 years (labelled medium) or lifelong (labelled long). Please see Appendices 3 and 4 for details.

* A Chi square contingency test was not performed on this data as the expected cell frequency is less than 5.
**Baseline comparison between the two groups at pre-intervention**

The groups were compared on their initial scores using Mann-Whitney tests for each outcome measure (please refer to Table 3). There was a significant difference between the groups on the anxiety sub-scale of the HADS, \(p=0.04\), indicating that the standard group were significantly more anxious than the opt-in group.

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Standard Group (N=9)</th>
<th>Opt-in Group (N=6)</th>
<th>Statistic</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAI</td>
<td>Mean 34.00 SD 12.89 Median 33.00</td>
<td>Mean 20.83 SD 6.40 Median 23.50</td>
<td>Mann-Whitney</td>
<td>0.08</td>
</tr>
<tr>
<td>HADS-A</td>
<td>Mean 16.11 SD 1.76 Median 17.00</td>
<td>Mean 13.67 SD 1.97 Median 14.50</td>
<td>Mann-Whitney</td>
<td>0.04</td>
</tr>
<tr>
<td>HADS-D</td>
<td>Mean 11.11 SD 2.09 Median 11.00</td>
<td>Mean 7.67 SD 3.61 Median 7.50</td>
<td>Mann-Whitney</td>
<td>0.08</td>
</tr>
<tr>
<td>ELI</td>
<td>Mean 27.67 SD 9.64 Median 28.00</td>
<td>Mean 20.17 SD 5.04 Median 22</td>
<td>Mann-Whitney</td>
<td>0.12</td>
</tr>
<tr>
<td>GHQ-60</td>
<td>Mean 113.22 SD 30.29 Median 112.00</td>
<td>Mean 90.00 SD 25.91 Median 85.50</td>
<td>Mann-Whitney</td>
<td>0.13</td>
</tr>
</tbody>
</table>

**Opt-In Versus Standard Referral Procedures**

_Hypothesis 1: Participants who have opted-in to treatment will exhibit higher attendance rates for the initial appointment._

Two female participants (22%) from the standard procedure group did not attend the first group session whilst no-one failed to attend the first session of the opt-in group. There was no significant difference between the groups in initial attendance rates (please refer to Table 4).
Table 4: Summary of Statistical Findings on Attendance Rates

<table>
<thead>
<tr>
<th>Variable</th>
<th>Standard Group (N=9)</th>
<th>Opt-in Group (N=6)</th>
<th>Test Statistic</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance at initial session</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attended</td>
<td>7 (78%)</td>
<td>6 (100%)</td>
<td>Chi – square = 1.538, df=1,</td>
<td>p=0.21</td>
</tr>
<tr>
<td>Non-attended</td>
<td>2 (22%)</td>
<td>0 (0%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hypothesis 2: Participants who have opted-in to treatment will exhibit higher attendance rates for subsequent sessions.

Two female participants (22%) dropped out of the standard procedure group after the first session whilst no-one dropped out from the opt-in group (see Figure 3). There was no significant difference between the groups in attendance rates after the first session (please see Table 5).

Table 5: Summary of Statistical Findings on Attendance Rates

<table>
<thead>
<tr>
<th>Variable</th>
<th>Standard Group (N=9)</th>
<th>Opt-in Group (N=6)</th>
<th>Test Statistic</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Sessions Attended*</td>
<td>Mean 5.89 SD 2.85 Median 7</td>
<td>Mean 7.50 SD 0.55 Median 7</td>
<td>Mann-Whitney</td>
<td>= 0.256</td>
</tr>
</tbody>
</table>

There were 8 sessions in total.

Figure 3: Number of Sessions Attended by Both Groups
**Hypothesis 3: Participants who have opted-in to treatment will make greater positive changes on clinical outcome measures.**

Friedman tests were conducted for each measure for each group separately to determine if there were changes across time. For both groups improvements were seen post-intervention on all measures. Significant changes over the three time points were seen in the standard procedure group for the HADS-anxiety and for BAI, ELI and GHQ scores for the opt-in group (see Table 6 and 7).

**Table 6: Statistical findings of clinical outcomes of the anxiety group on outcome measures for the Standard Group**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre-</th>
<th>Post-</th>
<th>Follow-Up</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAI</td>
<td>Mean 33.71</td>
<td>SD 14.7</td>
<td>Median 33</td>
<td>Mean 26.43</td>
</tr>
<tr>
<td></td>
<td>Chi Sq. = 1.143; df = 2; p=0.56</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HADS-A</td>
<td>Mean 15.72</td>
<td>SD 1.80</td>
<td>Median 16</td>
<td>Mean 11.29</td>
</tr>
<tr>
<td></td>
<td>Chi Sq. = 8.720; df = 2; p=0.01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HADS-D</td>
<td>Mean 11.71</td>
<td>SD 1.98</td>
<td>Median 12</td>
<td>Mean 8.29</td>
</tr>
<tr>
<td></td>
<td>Chi Sq. = 2.769; df = 2; p=0.25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ELI</td>
<td>Mean 28.14</td>
<td>SD 8.15</td>
<td>Median 28</td>
<td>Mean 19.86</td>
</tr>
<tr>
<td></td>
<td>Chi Sq. = 4.519; df = 2; p=0.10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GHQ</td>
<td>Mean 117.4 3</td>
<td>SD 28.3</td>
<td>Median 112</td>
<td>Mean 74.14</td>
</tr>
<tr>
<td></td>
<td>Chi Sq. = 2.571; df = 2; p=0.27</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please note:

a) the shaded area denotes significant results
b) data was not provided for the post-treatment and follow-up time periods from the two participants who dropped out of the standard group and so their data has not been included in the pre-treatment measures.
Table 7: Statistical findings of clinical outcomes of the anxiety group on outcome measures for the Opt-in Group

<table>
<thead>
<tr>
<th>Measure</th>
<th>Opt-in Group (N=6)</th>
<th>Pre-</th>
<th>Post-</th>
<th>Follow-Up</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Median</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>BAI</td>
<td>20.83</td>
<td>6.40</td>
<td>23.5</td>
<td>12.17</td>
<td>6.68</td>
</tr>
<tr>
<td>HADS-A</td>
<td>13.67</td>
<td>1.97</td>
<td>14.5</td>
<td>8.83</td>
<td>4.17</td>
</tr>
<tr>
<td>HADS-D</td>
<td>7.67</td>
<td>3.61</td>
<td>7.50</td>
<td>2.33</td>
<td>1.37</td>
</tr>
<tr>
<td>ELI</td>
<td>20.17</td>
<td>5.04</td>
<td>22</td>
<td>11.77</td>
<td>4.45</td>
</tr>
<tr>
<td>GHQ</td>
<td>90</td>
<td>25.9</td>
<td>85.5</td>
<td>33.17</td>
<td>14.47</td>
</tr>
</tbody>
</table>

Please note: the shaded area denotes significant results

To assess the direction or stage of improvement for the significant scores from the Friedman analysis (see Tables 6 and 7), post hoc Wilcoxon Pairs Rank tests were conducted for each group. The results suggest significant results for the standard group between pre-intervention and post-intervention measures on the anxiety subscale of the HADS. At follow-up there was still an overall trend showing improvement compared to pre-intervention measures. However, between post-intervention and follow-up there was no significant change.

The results also showed significant changes for the opt-in group between pre-intervention and post-intervention scores on the BAI, ELI and the GHQ-60, with further significant changes between follow-up and pre-intervention scores on the BAI. Scores at follow-up compared to pre-intervention measures on the ELI and GHQ measures also reflected trends showing overall improvement (see Table 8). No significant improvement was found between post-intervention and follow-up.
Further Mann Whitney tests on the overall change scores, which assess the changes on the clinical outcome measures by taking away the post-intervention score from the pre-intervention score (see Figure 4) were conducted. The results showed that the only significant difference in improvement between the standard and the opt-in group was for the depression axis of the HADS (see Table 9) with the standard group showing greater improvement.

**Table 9: Mann-Whitney results from Change Scores**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Test</th>
<th>Z score</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAI</td>
<td>Mann-Whitney</td>
<td>-0.858</td>
<td>0.391</td>
</tr>
<tr>
<td>HADS – (anxiety)</td>
<td>Mann-Whitney</td>
<td>-0.430</td>
<td>0.667</td>
</tr>
<tr>
<td>HADS – (depression)</td>
<td>Mann-Whitney</td>
<td>-3.004</td>
<td>0.003</td>
</tr>
<tr>
<td>ELI</td>
<td>Mann-Whitney</td>
<td>-0.143</td>
<td>0.866</td>
</tr>
<tr>
<td>GHQ-60</td>
<td>Mann-Whitney</td>
<td>-0.143</td>
<td>0.866</td>
</tr>
</tbody>
</table>

**Figure 4**

Mean Change Score for all Clinical Scales used for both Groups
Measures of Motivation

Hypothesis 4: Participants who have opted into treatment will have higher initial motivation scores at the start of treatment

There was no significant difference between the groups in motivation (please refer to Table 10).

Table 10: Summary of Statistical Findings on Motivation

<table>
<thead>
<tr>
<th>Variable</th>
<th>Standard Group (N=9)</th>
<th>Opt-in Group (N=6)</th>
<th>Test Statistic</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivation</td>
<td>Mean 13.44</td>
<td>SD 2.19</td>
<td>Median 13</td>
<td>Mean 15.17</td>
</tr>
</tbody>
</table>

Hypothesis 5: Participants who have higher motivation scores at the start of treatment will have higher attendance rates for subsequent sessions

Correlation’s were performed on individual participants scores (see Figure 5). Motivation was not significantly correlated with session attendance ($r = -0.047$, $p = 0.864$).

Figure 5

Scatter Plot of Individual’s Motivation scores and subsequent Session Attendance
Hypothesis 6: Participants who have higher motivation scores at the start of treatment will make greater positive changes on clinical outcome measures.

Correlations were performed on individual participant’s scores (Table 11). Motivation was not significantly correlated with the mean change scores from any of the clinical outcome measures.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Correlation with Motivation</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAI</td>
<td>0.076</td>
<td>0.797</td>
</tr>
<tr>
<td>ELI</td>
<td>0.160</td>
<td>0.586</td>
</tr>
<tr>
<td>GHQ-60</td>
<td>0.07</td>
<td>0.811</td>
</tr>
<tr>
<td>HADS – anxiety</td>
<td>0.057</td>
<td>0.846</td>
</tr>
<tr>
<td>HADS – depression</td>
<td>-0.459</td>
<td>0.098</td>
</tr>
</tbody>
</table>
Discussion

There were no significant differences between the two groups for both initial and subsequent attendance, therefore the findings do not statistically support the hypotheses that opting into treatment improves first and subsequent attendance rates (Anderson & White, 1994). However it was of interest that two female participants in the standard referral group did not attend the first session, whereas all of the opt-in group did attend. In addition, by the second session two different female participants from the standard group withdrew from treatment, with no reason given. Overall, these findings do not support the literature that opting into treatment improves attendance rates (Green & Giblin, 1985; James & Milne, 1997; Waring, Rose & Murphy, 1999), although this may have been due to the small sample size used in this study.

Both groups improved on the clinical measures, however significant positive changes were found for the opt-in group on more outcome measures. The improvements for the opt-in group were between pre- and post-intervention on the BAI, the ELI and the GHQ-60 scales, compared to the standard group who only significantly improved on the HADS-anxiety sub-scale between pre- and post-intervention. There was also a significant change on the BAI between pre-treatment and follow-up measures, which suggests that the opt-in group continued to improve even after the group finished, in contrast to the standard group who did not. It would appear that opting into treatment may have had a positive effect on clinical outcome, which supports the hypothesis of this study and of current findings in the literature (Busch, 1996). However it must be noted that the opt-in group were significantly less severe on the anxiety sub-scale on the HADS, than the standard group. As the opt-in group was less anxious, it may be that they had either fewer symptoms to cope with or had greater resilience and sources of support. Overall the standard group significantly improved in depression in contrast to the opt-in group, which may be due to social support as this group remained in contact with each other after treatment, a fundamental coping skill for depression (Lepore, 1992).
There were no significant differences between the groups regarding their method of referral and motivation. It was expected that the opt-in group would be more motivated at the start of treatment, by virtue of the fact that they had made the choice to participate. However, this assumes that the standard group did not have the choice to “opt-out”. In fact, one participant assigned to each group did not wish to enter treatment and withdrew at the referral stage. Given that participants in both groups had the option not to enter treatment, differences in motivation between the groups may not be expected. However, the results may be due to small sample size or a lack of a standardised measure of motivation.

There was no significant relationship between motivation on either attendance or clinical outcome, which suggests that the scale may not have accurately measured motivation, the sample was too small or there was no effect. This can not be compared to current literature which used standardised scales to measure motivation (DiClemente & Prochaska, 1998).

**Disadvantages/Weaknesses of the study**

The main weakness of the study was the sample size, which was restricted due to timing and lack of referrals and that the study did not use randomised allocation for group assignment. As a result the groups were not directly comparable on several demographic details, including age and gender and severity on clinical pre-treatment measures. Therefore there may have several confounding variables which would have affected the results and the conclusions that can be drawn from them.

Due to the time shortage, it was impossible to obtain standardised measures of motivation for treatment, for example A Readiness to Change Scale (Carbonari, DiClemente, & Zweben, 1994) or the Circumstance, Motivation, Readiness and Suitability scales, (DeLeon, Melnick, Kressel, & Jainchill, 1994). In addition, the design could have been improved by obtaining a pre-referral measure of motivation to directly assess the possibility that opting into treatment may increase motivation for therapy.
Advantages/Strengths of the study

The strengths were that the measures were that the facilitators of the groups were blind to participant’s level of severity and rates of progress throughout the treatment to ensure consistency as much as possible. However, the facilitators of the group were not blind to the opt-in status of the groups.

A further strength is that although the treatment was group focused, both groups had the same amount of time allocated to developing individualised formulations and hierarchies.

Overall, people provided positive feedback about the group, stating it was “very useful”, an “excellent course” and could each pick out specific skills or experiences which helped them. However, both groups stated they wished it had continued for longer due to a reduction in motivation and social support after the group had finished.

Service Development and Research

There is some tentative evidence from this study to suggest that adopting an opt-in referral is beneficial for clinical effectiveness. However, problems remain in whether an opt-in referral procedure will eliminate people with more severe problems who may lack the motivation to respond to the opportunity to opt-in.

Further research using a larger and more comparable sample is required which employs standardised measures of motivation, random allocation to groups and therapists facilitating the group who were blind to the group’s referral status. It would also be interesting to investigate a pre-referral level of motivation in comparison to post-referral, to directly assess the effects of opting-in on motivation. There is evidently a need to further investigate the psychological impact of the opt-in referral procedure on clients and its particular value in service efficacy.
References


Goldberg, D (1978) *General Health Questionnaire (GHQ-60).* Windsor: NFER-NELSON


Appendix 1

The semi-structured assessment interview
Presenting problem

How often do you get anxious
Situation specific?
Behavioural analysis surrounding period of anxiety?
Recent example?
When did this problem start?
What else was happening around the time the problems started?
If a situation is identified – what difficulties have come from it?

Any physiological symptoms occurred when X occurred?

What were thinking when X occurred?

What were you feeling when X occurred

How has it affected your life?

Is there anything you can’t do because of the anxiety? Check for avoidance
Check sleeping patterns and appetite?
Mood - How do they feel?
Suicidal intentions?

What have you done that has helped? Coping Strategies?

Check if used drugs and alcohol
Social Support – family, friends

Recent stressors

Previous treatment history

Medication history

Check compliance.

Feel about sessions, their expectations and goals

Ask if they have any questions?
Appendix 2

Demographic Details of Anxiety Group Non-Participants

* Excluded at Assessment Interview
**Demographic Details of Anxiety Group Non-Participants**

* Excluded at Assessment Interview

<table>
<thead>
<tr>
<th>Subject</th>
<th>Age</th>
<th>Gender</th>
<th>Specific Anxiety</th>
<th>Duration of Anxiety</th>
<th>Previous Treatment</th>
<th>Reason not Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>1#</td>
<td>40</td>
<td>Female</td>
<td>G.A.D.</td>
<td>3 years</td>
<td>Counselling</td>
<td>Could not attend</td>
</tr>
<tr>
<td>2#</td>
<td>31</td>
<td>Female</td>
<td>G.A.D.</td>
<td>Lifelong</td>
<td>Counselling</td>
<td>Comorbid</td>
</tr>
<tr>
<td>3#</td>
<td>33</td>
<td>Male</td>
<td>Social</td>
<td>Lifelong</td>
<td>Counselling</td>
<td>Could not attend</td>
</tr>
<tr>
<td>4#</td>
<td>35</td>
<td>Female</td>
<td>G.A.D.</td>
<td>3 ½ years</td>
<td>None</td>
<td>Could not attend</td>
</tr>
<tr>
<td>5#</td>
<td>36</td>
<td>Male</td>
<td>G.A.D.</td>
<td>6 months</td>
<td>None</td>
<td>Could not attend</td>
</tr>
<tr>
<td>1*</td>
<td>22</td>
<td>Female</td>
<td>G.A.D.</td>
<td>?</td>
<td>?</td>
<td>DNA</td>
</tr>
<tr>
<td>2*</td>
<td>61</td>
<td>Female</td>
<td>Social</td>
<td>1 year</td>
<td>None</td>
<td>Comorbid</td>
</tr>
<tr>
<td>3*</td>
<td>50</td>
<td>Male</td>
<td>Health</td>
<td>1 year</td>
<td>None</td>
<td>Not suitable</td>
</tr>
</tbody>
</table>

• # = referred to group 1,
• * = referred to group 2
Appendix 3

Demographic Details of Anxiety Group Participants
* Client had the same follow up monitoring that those in the group had
### Demographic Details of Anxiety Group Participants – Non Opt-in Group

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Specific Anxiety</th>
<th>Duration of Anxiety</th>
<th>Previous Treatment</th>
<th>Previous Work with LM</th>
<th>Number of Sessions Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject 1</td>
<td>52</td>
<td>Male</td>
<td>GAD</td>
<td>1 year</td>
<td>Various psychotherapy &amp; groups</td>
<td>✓</td>
<td>8</td>
</tr>
<tr>
<td>Subject 2</td>
<td>50</td>
<td>Female</td>
<td>GAD</td>
<td>4 years</td>
<td>Counselling</td>
<td>✓</td>
<td>7</td>
</tr>
<tr>
<td>Subject 3</td>
<td>62</td>
<td>Male</td>
<td>Social/telephone</td>
<td>1 year</td>
<td>Individual CBT</td>
<td>✓</td>
<td>5</td>
</tr>
<tr>
<td>Subject 4</td>
<td>55</td>
<td>Female</td>
<td>Social</td>
<td>Lifelong</td>
<td>Individual CBT</td>
<td>✓</td>
<td>7</td>
</tr>
<tr>
<td>Subject 5</td>
<td>50</td>
<td>Female</td>
<td>GAD</td>
<td>1 year</td>
<td>Individual CBT</td>
<td>✓</td>
<td>1</td>
</tr>
<tr>
<td>Subject 6</td>
<td>62</td>
<td>Female</td>
<td>Driving</td>
<td>1 year</td>
<td>None</td>
<td>✓</td>
<td>8</td>
</tr>
<tr>
<td>Subject 7</td>
<td>27</td>
<td>Female</td>
<td>Agoraphobia</td>
<td>6 months</td>
<td>Individual CBT</td>
<td>✓</td>
<td>1</td>
</tr>
<tr>
<td>Subject 8</td>
<td>40</td>
<td>Female</td>
<td>GAD</td>
<td>2-3 Years</td>
<td>Seen with her son by 2 counsellors</td>
<td>✓</td>
<td>8</td>
</tr>
<tr>
<td>Subject 9</td>
<td>57</td>
<td>Female</td>
<td>Driving</td>
<td>3 years</td>
<td>Bereavement Counselling</td>
<td>✓</td>
<td>6</td>
</tr>
</tbody>
</table>

Note: Both subjects 8 & 9 received the autogenic training from the first session in a subsequent catch-up session. Shaded subjects dropped out. Whenever anyone missed a session they were given the relevant handouts and at the beginning of every session the previous session was reviewed.

* Client had the same follow up monitoring that those in the group had
### Demographic Details of Anxiety Group Participants – Opt-in Group

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Specific Anxiety</th>
<th>Duration of Anxiety</th>
<th>Previous Treatment</th>
<th>Previous Work</th>
<th>Number of Sessions Attended</th>
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<tr>
<td>Subject 10</td>
<td>27</td>
<td>Male</td>
<td>Social</td>
<td>1 ½ years</td>
<td>Individual CBT</td>
<td>✓</td>
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</tr>
<tr>
<td>Subject 11</td>
<td>50</td>
<td>Female</td>
<td>G.A.D.</td>
<td>1 year</td>
<td>Individual CBT</td>
<td>✓</td>
<td>8</td>
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<tr>
<td>Subject 12</td>
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<td>Male</td>
<td>Social</td>
<td>Lifelong</td>
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<td>X</td>
<td>7</td>
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<tr>
<td>Subject 13</td>
<td>21</td>
<td>Female</td>
<td>Performance</td>
<td>1 year</td>
<td>None</td>
<td>X</td>
<td>7</td>
</tr>
<tr>
<td>Subject 14</td>
<td>43</td>
<td>Male</td>
<td>Social</td>
<td>Lifelong</td>
<td>None</td>
<td>X</td>
<td>7</td>
</tr>
<tr>
<td>Subject 15</td>
<td>30</td>
<td>Male</td>
<td>G.A.D.</td>
<td>12-15 years</td>
<td>None</td>
<td>✓</td>
<td>8</td>
</tr>
</tbody>
</table>
Appendix 4

All correspondence
Dear

Re: ANXIETY/STRESS MANAGEMENT COURSE

Our next anxiety/stress management course will be starting soon, designed for a small group for adults, who suffer from specific anxiety disorders, but who do not satisfy the criteria for Community Mental Health Teams. The service is aimed at people who do not suffer from severe mental illness, learning disabilities, Obsessive Compulsive Disorder or recurrent depression and are otherwise reasonably well-functioning.

The course will be based on Cognitive Behaviour Therapy. This is a well-evaluated psychological treatment that has been found to be as effective as anti-depressant medication and more effective in preventing relapse. The course will consist of:
♦ learning about bodily responses to anxiety and how to control them
♦ cognitive therapy to break negative thought patterns which perpetuate fear and avoidance
♦ individually designed, graded behavioural programmes for getting back to a normal life.

The sessions will be held weekly on Friday's at 10 a.m. at the from 11\textsuperscript{th} February 2000 onwards.

If you have a client who might benefit from attending the course, could you please complete the referral form enclosed and fax it as soon as possible.

I look forward to hearing from you.

Yours sincerely,

Trainee Clinical Psychologist
Chartered Clinical Psychologist
Dear

I understand that you have recently seen Dr. .................. who has referred you for an assessment for our next anxiety-management group has arisen, which will be starting shortly at. This is an eight week course, designed to help you manage the physical symptoms of anxiety and to break negative thought patterns in order to help you get back to a normal life. The sessions will be held weekly on Friday's at 10 a.m. at the from 11th February 2000 onwards.

Please complete the attached slip and return these to me in the envelope provided as soon as possible.

Yours sincerely,

Chartered Clinical Psychologist

Trainee Clinical Psychologist
ANXIETY MANAGEMENT COURSE

Referring GP: __________________________

Patient's Name: ________________________

Date of Birth: _________________________

Address: __________________________________________

Telephone: ________________________________

Reasons for Referral:

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Date of Referral: ________________________
Dear

1. I would/would not like an appointment for an assessment of my anxiety problems;

Name: ______________________________________

Address: ______________________________________

____________________________________

Tel. No.: ______________

Signed: ______________________________________
Appendix 5

Measures

Beck’s Anxiety Inventory (BAI; Beck, Brown, Epstein & Steer, 1988) – 21 item self-report questionnaire, which ascertains the severity of physiological and cognitive symptoms of anxiety

Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) – 60 item self-report scale, assessing severity of anxiety and depression without contamination from physical symptomology

General Health Questionnaire (GHQ; Goldberg, 1978) – 60 item questionnaire, which detects non-psychotic psychiatric disorders and their severity

Effect on Life Inventory (Powell, 1992) – 6 item scale which assesses the degree of impact participants complaints have on different areas of life, including work, home, social leisure and relationships

The Dependence Questionnaire (Jackson, Stapleton, Russel & Merriman, 1986). – a 12 item visual analogue scale which examined motivation to stop smoking.

The Motivation Questionnaire (for this study) which incorporates 6 items from the dependence questionnaire.
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Appendix 6

Anxiety management course
Anxiety Management Course.

The first two sessions included introductory information about anxiety and the role of the physical arousal system, with additional relaxation techniques demonstrated. The relaxation techniques used were progressive muscle (Berstein, D.A.; Borkovec, T.D.; Hazlett-Stevens, H. (2000) and autogenic relaxation (Fryling, 1978) which incorporates hypnosis, used to manage physiological symptoms.

During the next sessions, (sessions 3 to 5) the focus was on education into the cognitive-behavioural model. Sessions concentrated on eliciting and challenging negative automatic thoughts, through the consideration of evidence and alternative explanations to misperceived non-threatening situations. Sessions also involved the identification of thinking errors and more helpful ways of thinking and also practised the use of cognitive techniques, such as positive self-talk and thought stopping.

During the last few sessions graded situational hierarchies were developed and participants were monitored during exposure work, completed as homework employing all the behavioural and cognitive techniques practised earlier.
Session 1

- Introduction to course
- What is anxiety? — Brainstorm on Flipchart
  
  Handout — What starts and maintains anxiety?

  *When anxiety is a problem*

- Introduction to the three system of anxiety —
  - physical
  - cognitive
  - Behaviour

- Physical symptoms and how to deal with them —
  
  Handout — *The Body’s Arousal Reaction*

- Relaxation method 1 — Autogenic Relaxation
  
  Handout — *Autogenic Relaxation*

- Set homework - Autogenic Relaxation
Session 2

- Review homework – autogenic relaxation
- More information on physical aspects – review last week's session
- Hyperventilation and how to deal with it
  
  *Handout – Information about Hyperventilation*
  *Acute Hyperventilation*
  *Procedures for Controlling Hyperventilation*

- Relaxation
  
  *Handout – Relaxation*

- Relaxation Method 2 – Progressive Muscle Relaxation
  
  *Handout – Progressive Muscle Relaxation Exercise*

- Set homework - Progressive Muscle Relaxation
  
  *Handout – Relaxation Training Record*
Session 3

- Review homework — progressive muscle relaxation, use of hyperventilation knowledge?
- Review last week's session
- Introduce idea of Cued Relaxation
  
  Handout – Cued Relaxation
- Cognitive Aspects of Anxiety -
  
  Handout – How Thoughts can Increase Anxiety
- Identifying negative automatic thoughts and introduce idea of levels of thoughts, conscious to subconscious
- Identifying Thinking Distortions
  
  Handout – Common Thinking Distortions
  
  Coping with Anxiety: A guide to cognitive therapy
- Summary sheets of concepts to date
  
  Handout – Anxiety and How to Deal with it
  
  Understanding Panic Attacks 1
- Set homework – Diary work identifying automatic thoughts
  
  Handout – Diary sheet
Session 4

- Review homework – cued relaxation, diary work
- Review last weeks session
- Challenges to identified automatic thoughts
  
  *Handout – Challenges to Upsetting Thoughts*
  
  *Double Column Technique*

- Other Coping Strategies
  
  *Handout – Positive Self-Talk*

  *Positive Self-statements for Coping with*

  *Anxiety*

  *Thought Stopping*

  *Distraction*

- Set homework – Diary work identifying and challenging automatic thoughts
  
  *Handout – Diary sheet*
Session 5

• Review homework – diary work
• Review last weeks session
• Behavioural Aspects of Anxiety – issues of Avoidance
  
  *Handout – How Avoidance Increases Anxiety*

  *Dealing with Avoidance and Facing Fear*

• Discuss – Graded exposure
  
  *Handout – Graded Practice Target Sheet*

• Preparing for Setbacks
• Individual work to develop own hierarchies of graded practice
• Set homework – Attempt first graded task
Session 6

- Review homework – graded task assignment
- Review last weeks session
- Review of concepts to date

*Handout – Ten Rules for Coping with Panic*

*Understanding Panic Attacks 2*

- Individual work to discussing individual progress with hierarchies of graded practice
- Set homework – Graded task assignment
Session 7

• Review homework – graded task assignment
• Review last weeks session
• Review of concepts to date

  *Handout – Common Questions about Anxiety*

• Discuss role of stress

  *Handout – Stress Control*

• Review Setback discussion
• Individual work to discussing individual progress with hierarchies of graded practice
• Set homework – Graded task assignment
Session 8

- Review homework – graded task assignment
- Review last weeks session
- Group review of ideas, coping strategies and future goal setting
Evidence of a Presentation of
the Service Related Research Project to
the Service
Re: PSYCHOLOGY RESEARCH GROUP

The next Psychology Research Group meeting has been arranged for Wednesday 20th September from 1.00 to 2.30 in MEETING ROOM 1 AT GUILDFORD CMHS in Farnham Road Hospital, Guildford. Please see the attached map for details.

There will be two presentations as follows:

- Sarah Clare, Trainee Clinical Psychologist will be presenting her project on “The Effect of an Opt-in Referral System on the Clinical Outcomes of an Anxiety Management Group in a Primary Care Setting”.

- Claire Wilson, Trainee Clinical Psychologist will be presenting her research into “The Importance of Beliefs in the Persistence of Post Traumatic Stress Disorder”.

We will follow the usual format and there will, of course, be time for people to raise any issues relating to research, for discussion. If there are any important topics which you would like to raise perhaps you could contact June or Michelle to ensure that sufficient time is allowed for open discussion.

Please put the time and date in your diary and we very much look forward to seeing you there.

We always appreciate apologies from people who are unable to come to the group.
Major Research Project
Literature Review

Year 2

Word Count: 4981
WHAT ARE THE RISK FACTORS ASSOCIATED WITH THE DEVELOPMENT OF VICARIOUS TRAUMA IN THERAPISTS?

Introduction

Despite the influx of literature on the development of Post Traumatic Stress Disorder (PTSD) as a result of direct traumatisation, little is known about the risk factors associated with indirect traumatisation. Indirect or 'vicarious traumatisation' (McCann & Pearlman, 1990a) refers to the development of symptoms of PTSD and changes in core beliefs that occur from empathic engagement with a victim's experience of a traumatic event. The reasons why indirect exposure can lead to the development of vicarious trauma in some individuals and not others is little understood, despite its importance to mental health professionals and carers who work with victims of trauma. In understanding the risk factors associated with developing vicarious trauma symptoms it would become possible to establish a theoretical framework, within which to help identify individuals and situations at risk, with the aim to support carers guard against its affects. In turn, by supporting clinicians, it would ensure best clinical practice and reduce the possible risk to trauma victims with whom professionals engage.

This review of the literature will focus on the risk associated with developing vicarious trauma in therapists. Vicarious trauma has been reported to occur within emergency workers (Mitchell, 1985, cited in McCann & Pearlman, 1990a), police (Martin, McKean & Veltkamp, 1986), hospital staff (Lyon, 1993; Hartman, 1995) and ambulance workers (Grevin, 1996; Clohessy & Ehlers, 1999). However, the exclusion of emergency professionals is due to the indeterminable cause of their PTSD symptoms, as they could stem from either direct exposure to trauma inherent within these professions or to the indirect exposure to trauma through contact with the victims.

In addition, this review excludes earlier conceptualisations of negative consequences to working with trauma victims, such as burnout and secondary traumatic stress disorder (STSD: Figley, 1995a). Burnout is characterised by emotional exhaustion, depersonalisation of clients and reduced feelings of personal accomplishment.
Burnout is now considered distinct from vicarious traumatisation, as only the latter is particular to working with victims of trauma (Haley, 1974; McCann & Pearlman, 1990a, Chrestman, 1995). STSD is the development of PTSD symptoms via indirect exposure to trauma experiences (Figley, 1995a; Chrestman, 1995), recently renamed 'compassion fatigue' because of the difficulties with sustaining empathy. In contrast to STSD, the symptoms of vicarious trauma are not necessarily checked against PTSD criteria (Pearlman & Mac Ian, 1995) and STSD has a faster recovery (Sexton, 1999). Although the burnout and STSD literature can provide a useful background to understanding vicarious traumatisation they will not be considered within this review.

What is Vicarious Trauma

Vicarious trauma is defined within a constructivist self-development theory (McCann & Pearlman, 1990a). The basis of this model is that human beings develop complex cognitive structures with which to interpret and extract meaning from the world around them. An interchange and refinement of meaning develops over time in response to differing experiences, which come to represent an individual’s sense of reality. An individual’s reality is anchored within a belief system, involving certain assumptions about the self, others and the external world. When a traumatic event occurs there is an impact on the belief system, leading to the consolidation of the beliefs or a change in their content. Within the belief system there are believed to be seven basic psychological needs in response to trauma: safety, dependency/trust, power, esteem, intimacy (McCann, Sakheim & Abrahamson, 1988), independence and frame of reference (McCann & Pearlman, 1990b), which can be affected by exposure to trauma. Vicarious trauma is therefore said to occur when indirect exposure to the details of trauma leads to the development of PTSD-type symptoms and changes in the core schemas concerning these basic psychological needs. The resulting change in core beliefs is believed to be pervasive, permanent and cumulative (McCann & Pearlman, 1990a). The symptoms associated with PTSD (DSM-IV, APA, 1994) involve re-experiencing the trauma, avoidance of stimuli associated with the trauma and increased arousal, such as hypervigilance (please see Appendix 1). When vicarious traumatisation occurs it can have a detrimental affect on the individual, generalising to their personal lives and relationship with others.
Main Issues

One of the main issues now challenging the National Health Service is the high numbers of service users, who need help for PTSD (Kessler, 2000). This naturally leads to increased exposure to trauma victims within therapist’s general caseload. With the growing recognition of vicarious trauma within therapists through increased exposure, it can be predicted that unless therapists are able to access the support required to combat its affects, a crisis in service provision may occur. The second issue is that of the identification of risk factors for the development of vicarious trauma. Areas of risk for vicarious trauma development have been debated within the literature, although the findings have been often inconsistent, leading to problems in affecting service provision and evidence based practice. Risk factors have included, therapeutic variables (countertransference and empathy), work variables (type of trauma, caseload and experience) and personal variables (personal history of abuse, gender, negative coping style, level of personal stress and negative clinical response to clients). Evidence for the negative affects of listening to trauma and then the current literature on the risk factors for vicarious traumatisation will be reviewed.

Evidence for the Negative Effects of Listening to Trauma.

The following studies will present evidence for the negative consequences for working with trauma victims, which include PTSD symptoms and stress reactions. However due to their restricted use of measures they do not completely provide evidence for vicarious traumatisation as they exclude measures of cognitive beliefs, vulnerable to traumatic material. They do however contribute to our review in eliciting risk factors for PTSD and stress in therapists and have been regularly cited within the vicarious traumatisation literature (Pearlman & Mac Ian, 1995).

Physical Affects

It has long been established that social support and confiding in others about problems have positive health benefits for the individual who discloses, by reducing levels of stress (Pennebaker, 1989; Silver & Wortman, 1980). However, the effects of listening to trauma have now been shown to be detrimental (Shortt & Pennebaker, 1992).
Shortt and Pennebaker (1992) showed sixty-six subjects (forty-two females, twenty-four males) one-to-two hour videotaped interviews of the testimony of Holocaust survivors. During the telling and listening phases of the experiment, physiological measurements were taken of the survivors and participants. The results highlighted that 70% of the listeners had skin conductance level that fluctuated in an inverse pattern to the 'disclosers'; as the stress levels decreased in the disclosers, it increased in the listeners. These 70% also had higher scores on the Epstein Feelings Inventory and reported feeling similar emotions to the disclosers.

This study provided strong physical evidence of the negative effects of listening to trauma, however there were several methodological flaws. Essentially, the dialogue involved within this study was a passive and did not involve any real interaction between the discloser and the listener, which precludes it from comparison to other studies (Levenson & Gottman, 1985). In addition, the passive dialogue was unnatural and may have prevented the listeners from engaging empathetically with the discloser or it may have heightened listeners distress as they could not offer support or influence the content of the disclosure (Barbee, 1989; cited in Scortt & Pennebaker, 1992). Further problems were that female participants were over-represented in the sample, females have been reported to be more empathic than males (Sinclair & Bourne, 1998) which would affect the overall results and may not be representative of males experiences. Further concerns were that the authors developed the Holocaust Empathy Scales for use in this study. Although it had good internal consistency (α = .89), its validity is questionable as it did not correlate the other standardised empathy scales.

**Psychological Affect**

One study evaluated the nature of the affects of working with sexually traumatised victims (Kassam-Adams, 1994). One hundred psychotherapists were surveyed. The participants were asked to complete self-report measures, that included demographic, work details, personal trauma history, the Personal Strain Questionnaire (Osipow & Spokane, 1981) and the Impact of Event Scale (IES: Horowitz, Wilner & Alvarez, 1979). Of the participants, 75% were female and the majority were Caucasian. Nearly
half of the respondents scored high in PTSD symptomology, that would suggest clinical significance and was associated with exposure to sexually victimised clients \( (r=3.6, \ p<.001) \). However general stress was not associated with exposure to sexual trauma issues or any other type of trauma.

This study presents evidence for negative psychological consequences to working with trauma victims and raises a key risk factor of trauma type, as symptoms of PTSD was only associated with contact with sexually victimised clients. However, there are some limitations, the use of the IES to determine symptoms of PTSD is incomplete as it only addressed symptoms of avoidance and intrusion and no further details of participants PTSD symptoms were provided. In addition, there is an over-representation of white females in study, which means that this study can not be generalised to how males or therapists from different cultures react to sexually traumatised victims.

A further study assessed for PTSD and stress reactions and burnout in one hundred and sixty-one randomly selected trauma counsellors in British Columbia, Canada, constituting social workers, psychologists, psychiatrists and child care workers (Arvay & Uhlemann, 1996). This study used standardised questionnaires to measure burnout, perceived stress and PTSD and a separate questionnaire to elicit demographic information. The results highlighted the presence of high general life stress and burnout. However, fourteen percent were experiencing high levels of stress similar to PTSD and ninety percent of the respondents commented that they had been affected by client’s material. Thirty-two percent stated that this happened ‘often’ and sixty-four percent felt that it affected their therapeutic interaction. Within this study certain factors were associated with increased measures of stress: lack of experience, number of years in practice, being male and perceived percentage of trauma cases.

This study employed three mail shots to get a sixty-four percent response rate, which was a significant strength of this study and clearly identifies stress reactions in counsellors. However there were some limitations. The use of self-report studies is unreliable (Arvay & Uhlemann, 1996). This study is also specific to therapists working in British Columbia and so this methodology would need to be replicated with a different sample in order to generalise its findings. The diversity of
professionals in the sample and their lack of separation in analysis for comparison means that it is not possible to ascertain whether this is a naturally homogeneous group or whether trauma affects them differently. This study also did not assess PTSD symptoms in systematic way.

**Risk Factors**

Risk factors for developing vicarious trauma will now be reviewed, including therapeutic, working and personal variables.

**Therapeutic variables**

**Empathy and Countertransference**

The vulnerability to changes in core beliefs and PTSD symptoms is believed to occur through empathic engagement with trauma victims, which is inherent in therapeutic work (Pearlman & Saakvitne, 1995). However, countertransference reactions if unnoticed and unresolved can disrupt empathic enquiry (Arvay & Uhlemann, 1996; Sexton, 1999). Countertransference reactions within trauma therapy refers to therapist’s inner experience or unresolved conflicts rather than reactions to the trauma material details themselves (Allt, 1999). Such reactions include anger, depression, intolerance, sadness, irritability (Kinzie & Boehnlein, 1993), detachment, anger and antagonism (van Wagoner, Gelso, Hayes & Diemer, 1991). Symptoms often mirror those of their clients, often labelled ‘traumatic countertransference’ (Herman, 1992) or ‘destructive countertransference’ (Corey, Corey & Callanan, 1993). Traumatic countertransference reactions “can heighten therapist’s vulnerability to vicarious traumatisation because of his affect, identifications, loss of perspective, or unconscious re-enactments” (Pearlman & Saakvitne, 1995). In turn, vicarious traumatisation inhibits the therapist recognising their inner emotional processing, which leads to ineffective therapy, miscommunication and “mutual projection” (Pearlman & Saakvitne, 1995).
The main contributors to the understanding of countertransference and empathy within trauma therapy have been Wilson and Lindy (1994). Wilson and Lindy (1994) distinguished between two different types of defensive countertransference responses: avoidance and over-identification reactions; which defend against empathic strain. Avoidance reactions (such as denial, disengagement) and over-identification reactions (enmeshment and idealisation of client) are believed to reduce clinical efficacy and can be symptomatic of vicarious traumatisation.

Pearlman and Saatvitne (1995) also examined the complex interaction between countertransference and vicarious traumatisation. Vicarious traumatisation was said to occur when a therapist's self-awareness was diminished and they were unable to process the strong affect associated with trauma. Vicarious traumatisation also arose when the therapist's psychological defences were low, they were fatigued or when experiencing a parental or negative countertransference, which lead to negative emotional projections from the therapist onto the client.

Despite the extensive writings by the two sets of authors named above there has been little systematic research conducted into theories of countertransference and empathic strain and how they contribute as risk factors to the development of vicarious traumatisation. However, there have been some attempts to show that negative countertransference reactions can occur within trauma therapists (Danielli, 1988; Kinzie & Boehnlein, 1993). Studies in countertransference tends to be conducted within a qualitative framework, this would seem to reflect the theoretical framework of psychodynamic approaches.

Evidence of Negative Countertransference Reactions in Trauma Therapy

Sixty-one trauma therapists were interviewed regarding their emotional experiences of working with trauma clients who were Nazi Holocaust survivors (Danielli, 1988). Qualitative transcript analysis highlighted that therapists reported that they experienced defensive and negative emotions (anger, horror) and uncovered themes of shame, bystander guilt, grief/mourning, murder versus death and sense of bond, often casting the client as a victim or hero. This was one of the main studies to directly examine negative consequences to working with trauma victims and therefore a
qualitative exploratory study was appropriate for this initial research. However it was unclear as to whether these countertransference reactions were specific to treating Nazi Holocaust survivors and therefore the generalisability of this study was in question.

However, further support was provided by a more general study which explored the countertransference reaction of psychotherapists working with victims of trauma, (Kinzie & Boehnlein, 1993). Each of their two case vignettes exhibited chronic PTSD symptoms according to DSM-IIIR criteria (APA, 1993). Again, negative emotional reactions were evident, including depression and anger, changes were also noted to the counsellor’s sense of safety, intolerance of violence and a sense of identification with the victim. This study therefore contributes evidence of negative countertransference reactions and changes to beliefs, characteristic of vicarious traumatisation. The authors illustrated their findings with an examination of two individual case studies and so as more descriptive study with different trauma type had been illustrated, however, it had little generalisability as it was based on two clinical case examples and does not significantly contribute as empirical evidence.

Further research needs to focus on different aspects of the theory suggested by Wilson and Lindy (1994) and to assess the contributing risk factors that give rise to the different types of defensive countertransference reactions and types of empathic strain. There has been no systematic research into Wilson and Lindy’s concept of empathic strain.

*Work Variables*

*Trauma Type*

One of the more salient risk factors associated with developing vicarious trauma is the nature of the trauma that is being addressed. Type of trauma has been highlighted as an issue by many authors (Kassam-Adams, 1994; Schauben & Frazier, 1995; Astin, 1997; Blanchard & Jones, 1997; Johnson & Hunter, 1997; Cunningham, 1999; Allt, 1999). Kassam-Adams’ (1994) study noted above highlighted that symptoms of PTSD was only associated with contact with sexually victimised clients. In addition,
Johnson and Hunter (1997) found that sexual assault counsellors exhibited more emotional exhaustion and escape/avoidance coping strategies than counselling in other areas. In Allt’s (1999) study participants tended to protect themselves by reducing their contact with sexual abuse victims, highlighting difficulties when working with these cases.

However only one of the key studies which explored vicarious trauma in therapists who worked with sexual trauma will be explored here. One hundred and eighteen female psychologists from a women psychologist organisation and thirty female rape crisis counsellors were assessed for vicarious traumatisation (Schauben & Frazier, 1995). A survey design was employed in this research to assess burnout, traumatic stress beliefs, PTSD, vicarious trauma using a scale developed for the study, co-morbidity, personal victimisation history and general demographic details. In addition, therapists were asked qualitative questions about difficult and enjoyable aspects of working with trauma clients and were asked to identify their coping strategies. Evidence of vicarious trauma as a result of working with victims of sexual trauma survivors was significantly correlated to PTSD symptoms ($r = .61$, $p<.001$), negative affect ($r = .45$, $p<.001$) and belief disruptions ($r = .33$, $p<.001$). In addition, disruption to schemas (with respect to the goodness of others) was positively related to the percentage of trauma victims within the therapist’s caseload.

One strength of this study was that it also asked about the enjoyable aspects of working with sexual trauma survivors, which made their views more valid and balanced as the focus was not solely on the negative aspects of trauma work. However there were some limitations, the measure developed to assess for vicarious trauma was not a standardised measure and the PTSD symptoms were not described in sufficient detail. Although this study has highlighted the risk associated with working with sexually traumatised victims it was limited by looking at one type of trauma. Rape crisis work may have a particular impact on therapists or this study may have simply highlighted that working with one type of trauma has a cumulative affect. Other problems with the study were that there were only female participants; gender differences have been found previously in their responses to rape victims, for example, females tend to be more empathic (Ching & Burke, 1999; Schult & Schneider, 1991; Krulewitz, 1982). Male therapists and therapists from different
cultures (ninety-eight percent were Caucasian) were again not represented.

Statistically, one in five women will be raped within her lifetime (Koss, 1993; cited in Schauben & Frazier, 1995) this signifies a high percentage of the victims in a therapist’s caseload will have been sexually traumatised. It also increases the chances that the therapist may also have experienced sexual victimisation. But the question remains why is sexual trauma more difficult for trauma therapists? Hartman and Jackson (1994) argue that:

"The sociocultural values, myths, and biases about gender and gender role are fundamental to countertransference phenomena with rape and sexual assault victims. Despite recent efforts to alter these prejudices, they remain pervasive in our society. Inevitably, they contribute to the therapist’s avoidance and/or over-identification reactions to the rape victim."

Further studies therefore need to explore the role of attributions, prejudices and beliefs about gender roles and behaviour in therapists and how this interacts with therapeutic interventions with survivors of rape and abuse.

**Caseload and Experience**

The percentage of trauma clients within a caseload and experience has never been specifically addressed singularly within a single research study, but tends to have been a part of the general analysis in quantitative studies. The most popular research method within studies of vicarious trauma has been quantitative, employing a survey design. This methodology is appropriate as it enables access to a high number of therapists, from whom empirical evidence can be derived and generalised.

In Schauben and Frazier’s (1995) study noted earlier the percentage of trauma victims within the therapists overall caseload was positively related to disruption to beliefs about the goodness in others. Caseload was also a factor in the Arvay and Uhleman (1996) study also noted earlier. The intensity of a trauma caseload was also found to be a risk factor in an earlier study which examined one hundred and thirty-eight therapists in a Veterans Administration facility (Munroe, 1991). The therapists were
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assessed for the presence of vicarious traumatisation compared to the hours worked per week and years of experience of doing trauma work, both were found to be correlated with the presence of PTSD symptomology. However in a further study, the intensity of a high trauma-based caseload was not found to lead to PTSD symptoms, even when working with sexual abuse survivors (Follette, Polusny & Milbeck, 1994). This area is well debated in the literature and conflicting findings are evident. This is in contrast to the literature on the role of experience which is consistent in its findings that lack of experience is a contributing risk factor (Chrestman, 1995; Pearlman & Mac Ian, 1995; Arvay & Uhleman, 1996). However, some studies have found that the number of years in practice has been correlated PTSD symptomology (Arvay & Uhleman, 1996). Due to the reduced scope of this essay, only the main studies will be explored here in more detail.

Support for the percentage of the caseload of trauma clients relating to increased symptoms of PTSD was found within a survey study (Chrestman, 1995). Questionnaires were sent to therapists who were members of a number of different psychological societies. The questionnaires asked about personal history, PTSD symptoms, cognitive schema, coping style, assumptions about the world and behaviour changes. This study found that qualitative changes occurred in an increase in awareness of danger within their 'safety-schema', alongside other PTSD symptoms. This study concluded that new therapists and therapists with a higher caseload of trauma cases suffered greatest stress. In addition, this study reported decreased reporting of symptoms with increased experience, increased income, training, time spent doing other work such as research, peer support and gaining a sense of community with other trauma professionals and a quality of life.

This study does however have some methodological concerns. Unusually, the study does not mention how many participants were involved within it's discussion in a chapter (it is also unpublished elsewhere). In addition, the mean scores of the symptoms identified in the study were not within the clinical range and so were synonymous with the general population. Therefore the safety core beliefs could be seen as realistic precautions rather than phobic avoidance. There is therefore some debate over whether standardised PTSD measures are sensitive enough to detect vicarious trauma in health professionals. The therapists may differ in symptoms or
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may have a more acute presentation, so the questions asked are too general (Chrestman, 1995). In addition, in sampling therapists who work within general practice, it is difficult to isolate the affect of working with trauma victims to that of working with other difficult populations.

However further support that caseload is a risk factor appears in a recent study which examined the presence of vicarious traumatisation in one hundred and forty-one clinical and counselling psychologists (Allt, 1999). Participants received questionnaires on measures of PTSD symptomology, compassion fatigue, burnout and beliefs that were related to working with trauma victims. The author also asked qualitative questions regarding the experience and meaning of vicarious trauma. Nine percent of the participants met DSM-IV criteria for PTSD, compassion fatigue and burnout was experienced by twelve percent of the participants, however vicarious trauma and burnout where not found to be synonymous. Precipitating factors for vicarious trauma included high exposure to trauma clients and a personal history of child abuse. Participants tended to attempt to protect themselves when experiencing intrusive thoughts by reducing their contact with trauma clients, especially with sexual abuse victims.

Strengths of this study were the inclusion of a pilot study by interviewing 6 clinical psychologists to gain their experiences of vicarious traumatisation and beliefs and using a wide range of assessment tools to assess vicarious traumatisation. In addition, this study employed a large sample size however due to twenty-eight percent return rate, many therapists views were not represented. There were additional limitations. By using DSM-IV criteria to check for a PTSD diagnosis, the study may have missed other co-morbid diagnoses, such as depression or anxiety which would likewise contribute to their symptom development (McFarlane & Papay, 1992). Again therapists who work in general practice were selected as participants making it difficult to isolate the affects of trauma cases alone.

A recent study, which purposely explored therapists who had a high number of domestic violence clients in their caseload (fifty-one percent), also supported the traumatic affects of such a high caseload (Iliffe & Steed, 2000). Eighteen participants (thirteen females and five males) who were trained in counselling from social work,
psychology and health science backgrounds were interviewed. Each semi-structured interview provided qualitative data about trauma counsellor's experience. Interpretative phenomenological analysis was used to elicit the data. The participants reported classical PTSD symptoms and changes in beliefs with regard to safety, world-view and issues regarding power and gender. Difficulties in this field of work included confidentiality, fear for the safety of the clients, feeling isolated, loss of confidence and powerlessness. The majority of the participants reported burnout symptoms.

The strength of the study was the use of qualitative data to explore the specific impact of working with victims of domestic violence. However, again the use of such a specific field can not be generalised to other types of trauma. Further limitations were that the sample stemmed from different professional backgrounds and yet their differences were not elaborated on within the analysis. In addition, general domestic violence issues were also not discussed within the context of wider social issues.

One of the main studies which examined the impact of the degree of exposure found conflicting results to the above studies (Pearlman & Mac Ian, 1995). One hundred and eighty-eight (seventy-two female and twenty-eight percent male) self-identified trauma therapists were surveyed about specific demographic data, disruption to cognitive schemas, PTSD symptoms, general distress levels, their need for approval from authority, personal trauma history and their personal use of therapy. This study concluded that new therapists were most at risk of developing PTSD and often experienced negative changes to their beliefs system, including views on self-trust, self-esteem and self-intimacy. Underpinning these difficulties, the new therapists lacked adequate levels of supervision. This study also found that therapists who had prior personal experience of trauma were found to exhibit more negative effects from treating trauma victims. In contrast to the findings on experience and personal history of trauma, this study concluded that caseload was not predictor of the development of vicarious traumatisation.

There are however certain methodological problems within this study: females were over-represented as in previous studies noted earlier. In addition, the sample was self-selected and twenty-five percent of the questionnaires were returned blank. Therefore
people who do not self-identify as a trauma therapist and yet work with trauma clients were not represented. This limits the sampling procedure (Pearlman & Mac Ian, 1995) and prevents generalisation. A further problem was that a significance level of .05 was used for the study, which increased the likelihood of getting a significant finding when there was not one there. With respect to the differences between new and experienced therapists, they may be a self-selection process occurring within the sub-samples. ‘Experienced therapists’ have continued in this profession by choice and those who have had difficulties with vicarious trauma may no longer be present in the more experienced sub-sample. In addition, prior management of vicarious trauma may have been part of the experienced therapist’s personal development (Pearlman & Mac Ian, 1995). In addition, details were not given of the type of trauma that the therapists had personally experienced, which may be a pertinent factor in its affect on the therapist.

Most of the research indicates that a high percentage of trauma cases within a given caseload is a risk factor for the development of vicarious traumatisation (Munroe, 1991; Schauben & Frazier, 1995; Chrestman, 1995; Allt, 1999). However the only research study to dismiss caseload as a risk factor was conducted by one of the authors who developed the concept of vicarious traumatisation (Pearlman & Mac Ian 1995). How do we explain the differences in their conclusions? One of the main factors may be that Pearlman and McCann (1995) employed self-identified trauma therapists rather than the primary use of therapists in general practice. The caseload of a trauma therapist and a general therapist would therefore be different. The trauma therapists may have higher trauma victim caseloads but this would be in keeping with their expectations of their workload and self-concept as a therapist. In contrast therapists from general practice may have a different self-concept despite the presence of trauma cases. Attributions about clients, for example, negative clinical response, have been found to contribute to secondary traumatisation in previous studies (Follette, et al, 1994). Perceptions of stress within trauma work, in relation to the development of vicarious trauma may be an area for future research.
Personal Variables

Personal History of Abuse

Personal history of abuse has been assessed within many studies (Follette, et al, 1994; Allt, 1999; Schauben & Frazier, 1995; Kassam-Adams, 1994; Pearlman & Mac Ian, 1995). Most of the studies have claimed that a history of personal sexualised victimisation is a risk factor for developing vicarious traumatisation (Kassam-Adams, 1994; Pearlman & Mac Ian, 1995; Allt, 1999). Pearlman and Mac Ian (1995) found that therapists who had prior personal experience of trauma were found to exhibit more negative effects from treating trauma victims in terms of their view of ‘others’. The authors suggest that the therapist’s pre-existing schema may be a significant factor, however there was no measure of this within their study and so it remains unclear whether the current trauma beliefs are due to exposure to trauma or to pre-existing schema. In addition the details were not given of the type of trauma that the therapists had personally experienced, which may provide some indication of the types of personal beliefs that may be affected. Counsellors with a personal trauma history may seek to resolve personal issues within therapy and so are become attracted to trauma work. This may enable a therapist to be more sensitive to clients issues, but may makes them more vulnerable to traumatic stress reactions.

In contrast to these studies, personal history of sexual abuse has been excluded as a risk factor for vicarious traumatisation (Schauben & Frazier, 1995; Follette et al, 1994). It is however unclear why. One factor may be the way in which personal trauma is asked about, some ask generally: “Do you have a trauma history?” (Pearlman & Mac Ian, 1995), whilst others request more detail (Schauben & Frazier, 1995). This suggests that more in-depth research needs to take place regarding the influence of personal trauma history, trauma type and affects within therapy.

Coping style and attitude

In an early study, secondary traumatisation was assessed within two hundred and twenty-five mental health professionals and forty-six law enforcement officers who worked directly with childhood sexual abuse survivors (Follette, et al, 1994). As well
as personal history of abuse, additional risk factors were found for the development of vicarious trauma. The risk factors included “negative coping” styles, levels of personal stress and negative clinical response to sexually abused clients. In this study personal history and percentage of caseload was not significantly related to secondary traumatisation.

Attributions and negative attitudes towards victims have been found to be detrimental to the experience of empathy within the general rape literature (Ching & Burke, 1999). Recent literature has highlighted that women often have negative appraisals of female rape victims, supported by blaming attitudes and acceptance of rape myths (Anderson, 1999; Cowan, 2000), which has an impact on the degree of empathy they would feel for rape survivors (Ching & Burke, 1999). Rape myth acceptance, appraisals of blame and beliefs in ‘deservingness’ based in ideas surrounding a ‘just world’ are therefore contributory factors to the issue of empathy and risk of personal secondary traumatisation. These contributory factors can act as potential risk factors in the development of empathic strain and vicarious trauma within therapists, as they would find their experience of working with rape victims as traumatic and difficult.

Future research could be conducted into the contributions of different beliefs and attitudes to the experience of working with trauma victims and whether they present additional risk factors for the development of vicarious traumatisation.

*Gender*

Gender has been significantly correlated to PTSD symptoms (Kassam-Adams, 1994). Kassam-Adams, (1994) found that females were more vulnerable to the development of traumatic stress reactions. In contrast, Arvay and Uhlemann, (1996) found that males were more vulnerable to stress responses. The role of gender in the risk associated with vicarious trauma still remains unclear, as in most of the studies female participants dominate and so male reactions to working with trauma victims is underrepresented. This either suggests a lack of male trauma therapists or a reluctance for males to respond. Within the general literature men show reduced empathy for victims, especially for sexually traumatised victims (Sinclair & Bourne, 1998), this could be a protective factor for male therapists against the development of stress.
Research reactions. However as yet gender differences in responding to working with trauma victims has not been elaborated on and so is a future research concern.

The Response of the NHS and the Resulting Ethical Dilemmas

The literature suggests that that there are indeed negative consequences to working with victims of trauma. In more recent studies there has been some recommendations for supportive measures to combat these negative affects. These include the use of supervision (Chrestman, 1995; Pearlman & Saakvitne, 1995), debriefing (Mitchell, 1983), specific trauma training (Alpert & Paulson, 1990; Pope & Feldman-Summers, 1992), peer support (Catherall, 1995a; 1995b) and regular team meetings (Sexton, 1999). In addition, authors recommend that all support must be conducted within an atmosphere of acceptance (Catherall, 1995b), that therapists should have additional outside interests to decrease general life stress (Chrestman, 1995) and that they should ensure they attend to their spiritual life (Sexton, 1999). The use of personal coping strategies employed by therapists have been correlated with lower outcomes on the scales and PTSD symptoms (Schauben & Frazier; 1995; Sexton, 1999).

However, the guidelines with respect to supervision and support for trauma therapists has not been changed in line with the current research findings regarding their vulnerability to stress and vicarious trauma. In fact, trauma therapists are not requested to have any additional supervision or training according to current guidelines. Yet vicarious trauma, when it affects the therapists, has a subsequent affect on the organisation as a whole (Sexton, 1999). Clinical effectiveness is reported to be reduced, frequent resignations can lead to high staff turn over, which leads to extra costs in training and the intake of new therapists who are more vulnerable to vicarious trauma (Chrestman, 1995; Pearlman & Mac Ian, 1995). In addition, the organisation may be affected by general apathy. With the rise in awareness of vicarious traumatisation, if the NHS do not respond to the recommendations, then it may be open to occupational and safety issues, resulting in compensation claims.

This leads to an ethical issue within the NHS. Many guidelines have been set up to protect the client with little consideration to the care-giver (Munroe, 1995). Munroe (1995) argues that trauma services have a duty to warn new therapists when they
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employed into trauma services, a duty to train and to provide safe working conditions and to supply the support networks outlined above. Consideration must also be given to the client, as they will also be affected by the therapeutic interaction, especially if negative countertransference and empathic strain result. Also an issue regarding confidentiality must be explored, consultations about specific details of trauma cases in terms of the therapists reactions and countertransference are often lacking due to confidentiality and stigma, however this could be encouraged within services as a healthy model for coping with trauma (Munroe, 1995). A positive model of self-care for therapists should also be enforced within the NHS (Munroe, 1995) and yet with increasing emphasis on resource limitations, time-restricted therapy, pressures from extra expectations surrounding auditing, administration, training and research, there does not appear to be much time for self-care.

Conclusion

The rise in awareness of the negative affects of working within trauma is a positive move towards refining the therapeutic dilemmas to be faced and in ensuring a broader theoretical framework of PTSD. With this increasing awareness, support can be put in place to combat or guard against some of the negative affects of vicarious trauma, which in turn contributes towards evidence based and best care practice. However there are still gaps within our understanding of the risk factors of developing vicarious trauma. There has been a lack of comparative studies across different groups of trauma type, a lack of use of control groups, a lack of detailed examination of gender and cultural affects and a lack of an understanding of the complicated interplay between attribution processes and responses to victims within therapy. Future research should focus on these areas and on emphasising the support that can be available and yet so often isn’t.
References


disorder in the victims of a natural disaster. *Journal of Nervous and Mental Disease, 180*, 498-504.


Appendix 1

PTSD symptoms according to DSM-IV criteria
Posttraumatic Stress Disorder: diagnostic criteria (APA, 1994)

A subject is said to have PTSD if:

A. Existence of a recognisable stressor that would evoke significant symptoms of distress in almost everyone.

B. Reexperiencing of the trauma as evidenced by at least one of the following:
   1. Recurrent and intrusive recollections of the event.
   2. Recurrent dreams of the event.
   3. Sudden acting or feelings as if the traumatic event were reoccurring because of an association with an environmental or ideational stimulus.

C. Numbing of responsiveness to, or reduced involvement with, the external world beginning some time after the trauma, as shown by at least one of the following:
   1. Markedly diminished interest in one or more significant activities
   2. Feeling of detachment or estrangement from others
   3. Constricted affect

D. At least two of the following symptoms that were not present before the trauma:
   1. Hyperalertness or exaggerated startle response
   2. Sleep disturbance
   3. Guilt about surviving when others have not, or about behaviour required for survival.
   4. Memory impairment or trouble concentrating
   5. Avoidance of activities that arouse recollection of the traumatic event
   6. Intensification of symptoms by exposure that symbolise or resemble the traumatic event.
MAJOR RESEARCH PROJECT

THE INVESTIGATION OF VICARIOUS TRAUMA IN FACE TO FACE AND PHONE COUNSELLORS DEALING WITH RAPE VICTIMS: THE IMPLICATIONS OF TRAINING, NATURE OF EXPOSURE AND EMPATHY

Year 3

Word Count: 18243
ABSTRACT

The aim of this study was to analyse the contributing factors of training, medium of contact, empathy and personal history of sexual trauma on the possible development of vicarious trauma in rape crisis counsellors. 101 participants completed questionnaires, which included the Secondary Trauma Questionnaire (Motta, Kefer, Hertz & Hafeez, 1999), the Post-Traumatic Cognitions Inventory (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999), the Questionnaire Measure of Emotional Empathy (Mehrabian & Epstein, 1969) and personal questions to elicit past trauma history and demographic details. The Secondary Trauma Questionnaire measured symptoms of posttraumatic stress disorder associated with vicarious traumatisation and the Post-traumatic Cognitions Inventory examined beliefs which have been associated with vicarious traumatisation, which centre around negative beliefs about the self and negative beliefs about the world. This study appeared to suggest that age, exposure to sexual trauma work and a personal history of trauma and counselling were risk factors for vicarious trauma but that specific training in a formal counselling qualification or medium of contact were not contributing risk or protective factors. However these results were circumspect given the method of collection of the demographic information. This study appeared to also demonstrate a significant relationship between empathy and vicarious trauma which seemingly supports the theory on the development of vicarious traumatisation (Pearlman & Mac Ian, 1990a). However, the field of research needs to further contribute to the current conceptualisation of vicarious trauma and its’ associated risk factors, in order to provide more support and education to those at risk, namely rape crisis counsellors and volunteers.
INTRODUCTION

The literature recognising vicarious trauma and empathic stress reactions among mental health professionals is growing (Thomas, 1999; Long, 1999; Walton, 1997). Vicarious trauma has been reported to occur in emergency workers (Mitchell, 1985, cited in McCann & Pearlman, 1990a), police (Martin, McKean & Veltkamp, 1986), hospital staff (Lyon, 1993; Hartman, 1995), and ambulance workers (Grevin, 1996; Clohessy & Ehlers, 1999) and has been especially noted in counsellors (Arvay & Uhlemann, 1996). Vicarious traumatisation is reported to occur when indirect exposure to the details of another’s trauma experience leads to the development of posttraumatic stress disorder (PTSD)-type symptoms and a subsequent negative change in the individual’s beliefs about the self, others and the world.

Evidence for the Detrimental Effects of Listening to Trauma Accounts: Physiological Stress and PTSD Symptomology

For an individual to be diagnosed with PTSD there must be the presence of a recognisable stressor or trauma that would evoke distress in almost everyone. In the case of vicarious trauma, the indirect exposure to someone else’s trauma experiences constitutes the stressor. The symptoms of distress include re-experiencing of the trauma (having recurrent and intrusive recollections or dreams of the trauma or suddenly feeling as if the traumatic event were happening) and experiencing a numbing of affect towards, or reduced involvement with, the external world and others. In addition, there must be at least two of the following symptoms that were not present before the trauma: hyperalertness, sleep disturbance, memory or concentration problems and an avoidance of stimuli that may remind the individual of the trauma (DSM-IV, APA, 1994, see Appendix 1 for full details). Evidence for the detrimental effects of hearing about trauma has been well documented in the literature (for a review, see Clare, 2002) for more details. In summary, the effects of listening to trauma have been shown to be detrimental both physically (Shortt & Pennebaker, 1992) and psychologically (Arvay & Uhlemann, 1996). Further evidence is also available and will be explored later in line with discussions regarding significant risk factors, such as working with sexual trauma and having a personal history of assault.

In Shortt and Pennebaker’s (1992) study, physiological stress arousal was monitored
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in ‘disclosers’ of trauma and ‘listeners’ of the trauma account. Sixty-six participants (42 females, 24 males) were shown one-to-two hour videotaped interviews of the testimony of Holocaust survivors (‘disclosers’). The results showed that as the physiological arousal of the disclosers decreased during the telling of the trauma, the physiological arousal and stress levels of the listeners increased to a similar degree. Seventy-five percent of the participant’s skin conductance levels fluctuated in an inverse pattern to the ‘disclosers’ physiological levels. In addition, 70% of the listeners also had higher scores on the Epstein Feelings Inventory (EFI) and reported feeling similar emotions to the disclosers. This study had some limitations. The video dialogue was unnatural and did not involve any real interaction between the discloser and the listener, which precludes it from comparison with other studies (Levenson & Gottman, 1985). In addition, the passive dialogue may have prevented the listeners from engaging empathically with the discloser or it may have heightened the listeners’ distress as they could not offer support or influence the content of the disclosure (Barbee, 1989; cited in Scottt & Pennebaker, 1992). Further concerns were that the Holocaust Empathy Scale that was developed for this study was not empirically tested and although it had good internal consistency (α = .89), its validity was questionable as it did not correlate with the EFI.

A further study was also conducted which assessed the presence of vicarious traumatisation in 161 randomly selected trauma counsellors constituting social workers, psychologists, psychiatrists and child care workers (Arvay & Uhlemann, 1996). In this study the impact of the traumatic event was measured by the Impact of Event Scale (IES: Zilberg, Weiss & Horowitz, 1992), which explored symptoms of intrusion and avoidance on two subscales. The results highlighted that 16% of the participants had developed high levels of Intrusive symptoms and 37% exhibited high levels of Avoidance symptoms. Ninety percent of the respondents reported that they had been affected by clients’ material. Thirty-two percent stated that this happened ‘often’ and 64% felt that it affected their therapeutic interaction with clients. The most affected were younger, less experienced counsellors and males who had higher mean scores on the Depersonalisation subscale of the Malasch Burnout Inventory (Malasch & Jackson, 1981). Less experience was also correlated with total stress scores and on the IES’s Intrusion and avoidance subscales, highlighting that inexperience is a risk factor. Caseload was also positively correlated with the Emotional Exhaustion
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subscale on the Malasch Burnout Inventory \( r = .23, p < .01 \). A response rate of 64% was achieved within this study possibly due to the use of three mail shots, which was a significant strength of this study. However a limitation within the analysis was that the sample was treated as a homogenous group. Therefore the diversity of professionals in the sample and their lack of separation in the analysis means that it is not possible to ascertain whether this is a naturally homogeneous group or whether trauma affects them differently due to their different occupational backgrounds and training. Training has been found to effect vulnerability to vicarious traumatisation (Pearlman & Mac Ian, 1995) and it may be possible that disciplines with varied training experiences may be affected differently.

Evidence for the Detrimental Effects of Listening to Trauma Accounts: Changes to Beliefs about the Self, Others and The World

Vicarious traumatisation is also associated with changes in the affected individual’s ‘inner experience’, namely that there are detrimental changes to their basic belief system (McCann & Pearlman, 1990a). Vicarious trauma can be defined within a constructivist self-development theory (CSDT) (McCann & Pearlman, 1990b). CSDT proposes that an individual’s adaptation to trauma arises from the interplay between their personality (coping style, psychological needs) and the more salient characteristics of the trauma taken within the larger context of the social and cultural norms of the population (Pearlman & Mac Ian, 1995). The basis of this model is that human beings develop complex cognitive structures with which to interpret and extract meaning from the external world (Mahoney & Lyddon, 1988). The interpretation and meaning that is constructed from experience provides the individual with beliefs about the self, others and the world. These beliefs can be modified by new information, but are largely stable and come to represent an individual's sense of ‘reality’. Within this belief system there are believed to be seven basic psychological needs: safety, dependency/trust, power, esteem, intimacy (McCann, Pearlman, Sakheim & Abrahamson, 1988), independence and ‘frame of reference’ (how someone sees the world) (McCann & Pearlman, 1990a). These basic psychological needs to feel secure and in control manifest themselves in schemas, which form the basis of self-protective beliefs (Pearlman & Saakvitne, 1995a). The self-protective beliefs are that others are trustworthy, the world is safe and predictable, the self has
power, independence, autonomy, respect, is effective in the world and has an
complete understanding of why events occur (McCann & Pearlman, 1990a). The
belief in personal invulnerability, the view of the self as positive and the belief in the
world and others as benign allows an individual to function in the world without
excessive caution and fear. However, all of these self-protective psychological beliefs
can be challenged by exposure to trauma. Trauma as an experience has been
hypothesised to directly challenge the beliefs and assumptions about the self, others
and the world in terms of threatening an individual’s sense of security. The world and
others can suddenly appear to be untrustworthy, powerful and unsafe and the
individual becomes vulnerable and weak (Janoff-Bulman, 1985). The effects of
vicarious traumatisation resemble those of dealing with a direct traumatic experience,
namely challenging one’s sense of meaning, affect tolerance, identity, sensory
memory, worldview and interpersonal relationships (Pearlman & Saakvitne, 1995a).
The resulting change in the belief system is believed to be pervasive, permanent and
cumulative (McCann & Pearlman, 1990a; Pearlman & Saakvitne, 1995a).

Recent research has provided consistent evidence that changes in beliefs about the self
and others can occur in counsellors and victim advocates of trauma survivors (Van de
Water, 1996; Schauben & Frazier, 1995; Iliffe & Steed, 2000; Slover, 1998, Simonds,
1997). The newly developed Trauma Work Impact Scale was distributed to 130
female and 35 male therapists (Van de Water, 1996) in order to ascertain changes in
beliefs with regards to the basic ‘psychological needs’. The results suggested that
therapists with a high trauma caseload (76+%) expressed more concern for the safety
of themselves and others, and participants who had a personal trauma history had
particular problems with their interpersonal relationships and intimacy (Van de Water,
1996). In addition, using semi-structured interviews, 18 counsellors who had more
than a 50% caseload of clients in a domestic violence situation were asked about the
impact of the work on their beliefs and worldview (Iliffe & Steed, 2000). This study
used interpretative phenomenological analysis (Smith, 1996) to analyse the
interviews. Working with survivors of domestic abuse was found to lead to reported
changes in cognitive schema with regard to safety, world-view and gender issues. The
difficulties with working with these clients arose in response to issues regarding
confidentiality, feelings of isolation, loss of confidence, taking on too much
responsibility, losing trust, feeling less secure and a heightened sense of
powerlessness in the world. Iliffe and Steed (2000) suggested that the results of this study need to be validated with further research wherein the impact of working with domestic violence clients are compared to other non-domestic violence client groups.

Overall, the empirical evidence supporting vicarious traumatisation is growing and supports the theoretical discussions and clinical anecdotes that have been published about the phenomenon. Trauma counselling may change core beliefs surrounding the basic psychological needs and interfere with the counsellor’s adaptive assumptions of personal invulnerability and the world as meaningful and understandable which could lead to PTSD symptoms. Counsellors are particularly vulnerable to the effects of vicarious trauma as they attempt to integrate the traumatic material that they are exposed to with survivors of trauma on a regular basis. Vicarious traumatisation pertains solely to working with survivors of trauma and is differentiated from Secondary Traumatic Stress Disorder which is more associated with PTSD symptomology and less with the change in underlying core beliefs (Pearlman & Saakvitne, 1995a). Vicarious traumatisation arises from working with survivors of trauma, as the counsellor has to acknowledge difficult issues. The difficult issues trauma counsellors face include acknowledging the prevalence of childhood abuse, the potential vulnerability of the self as a victim and the possible effects of listening to other’s trauma experiences. The counsellor has also to consider whether therapy may impact them on a personal level, especially if they have a personal history of victimisation. In addition, within therapy the re-enactment of difficult, mistrusting relationships, and dealing with the associated projected roles, such as bystander, witness and perpetrator can also lead to strong negative responses (Pearlman & Saakvitne, 1995a). These strong negative responses can lead to problems in sustaining empathic engagement with the trauma survivors, which is thought to be essential for effective therapy (Sexton, 1999). Vicarious trauma then results from the affective distress and rupture in empathy (empathic strain) and the cumulative impact of working with survivors (McCann & Pearlman, 1990a).
The Role of Empathic Strain and Countertransference Reactions within Therapy: Implications for Vicarious Trauma

Vulnerability to changes in core beliefs and PTSD symptoms is believed to occur through the process of empathic engagement with trauma survivors, which is inherent in therapeutic work with clients with PTSD (Pearlman & Saakvitne, 1995b). The theory and empirical evidence of the contributing role of empathic engagement in the development of vicarious traumatisation will now be explored.

There are hypothesised to be four types of empathic engagement, ‘cognitive empathy’ for the survivor in both the past and the present and ‘affective empathy’ for the survivor in the past and the present state (Pearlman & Saakvitne, 1995b). Cognitive empathy is the ability to cognitively understand the client’s narrative of the event and the meaning they have taken from the trauma. Affective empathy is when the counsellor is able to sense the client’s feelings and emotions concerning the event. In addition to the two forms of empathy, there are two time frames within which the counsellor can have a sense of the survivor’s experience, both the survivor’s understanding and emotions at the time of the trauma and their thoughts and feelings at the present time. Pearlman and Saakvitne (1995b) believe that affective empathic engagement with the past survivor’s emotions is the realm in which counsellors are most vulnerable to vicarious traumatisation. For example, the counsellor’s empathic engagement with a child’s overwhelming emotions during childhood sexual abuse is believed to be more traumatic. Working in this realm is believed to be difficult as it forces the counsellor to acknowledge the undeniable reality of intentional cruelty by others, such as caregivers, which challenges the assumption that others are benign.

Empathic enquiry in all individual therapy is a necessary component for the facilitation of the clients’ recovery process within a safe therapeutic alliance (Sexton, 1999), and is a sought-after characteristic in counsellors (Pope & Kline, 1999). Within the context of the safe therapeutic environment facilitated by the counsellor’s capacity to listen and empathise, the client may start to explore and assimilate their experience of trauma into their existing beliefs about the self, others and the world (Wilson & Lindy, 1994). However in identifying with and understanding the client’s emotional experience it opens the counsellor to empathic strain and vicarious traumatisation.
Empathic strain is defined as a weakening or injuring of an empathic restorative response to clients due to the interpersonal events within the therapy usually as a result of a counsellor's negative countertransference reactions (Wilson & Lindy, 1994). Wilson and Lindy (1994) have identified four types of empathic strain, which result from countertransference processes: empathic withdrawal, empathic repression, empathic enmeshment and empathic disequilibrium. Empathic withdrawal and empathic repression both involve avoidance behaviours, which aim to enable the counsellor to deny, and withdraw from the therapeutic interaction. Withdrawal from emotional engagement can transpire when counsellors have not experienced personal trauma and so they tend to want to maintain the belief that the world is just and fair. Those who have experienced personal histories of trauma tend to show signs of empathic repression as they struggle to come to terms with their own traumas and issues. Empathic enmeshment and empathic disequilibrium tend to occur through over-involvement and over-identification responses, due to a loss of boundaries. Empathic enmeshment occurs within counsellors with a personal history of trauma, who respond to clients with overprotectiveness, guilt and responsibility and therefore attempt to rescue the client. Empathic disequilibrium results when trauma therapists have not experienced personal trauma and hearing others' trauma experiences ruptures their world view and creates discomfort and insecurity.

Empathic strain is largely a theoretical construct, however recent research has found evidence of empathic strain based on Wilson and Lindy's model (Thomas, 1999). Wilson and Lindy have provided case examples of empathic strain. For example, the authors described a psychotherapist's "failure to hear his (the patient's) memories accurately" (p 66) due to her reaction being "limited to the images and smells of faeces, which stirred in her reactions of disgust" (p.66). The negative reactions in this case lead to the psychotherapist's "withdrawal from engaging" (p.77) which "interfered with her empathizing" (p.77). The empirical evidence for Wilson and Lindy's (1994) model is limited and further exploration of the process of empathic disengagement or over-engagement needs to be conducted.

Psychodynamic theory has proposed that empathic strain may result from negative affective and countertransference reactions in the counsellor (Wilson & Lindy, 1994). The relationship between empathy and countertransference reactions is proposed to be
largely mediated by the counteridentification process within therapy (Slatker, 1987): “the analyst both identifies with the patient and at the same time pulls back from that identification so as to view the patient’s conflict with objectivity” (Slatker, 1987, p. 203). It is this process of counteridentification which enables the counsellor to be objective, which enhances the therapeutic use of empathy. However, as a component of countertransference, if objectivity is not achieved within the process of counteridentification, negative countertransferential reactions can occur which then act to reduce empathy. Countertransference reactions can be the affective response to a client or the material that a client brings to therapy. In addition, countertransference reactions can occur in response to the transference of affect from the client or to re-enactments of past relationships, or to the counsellor’s conscious or unconscious defenses against the intrapsychic conflicts that can arise from the therapeutic interaction (Pearlman & Saakvitne, 1995b). Such reactions include anger, depression, intolerance, sadness, irritability (Kinzie & Boehnlein, 1993), detachment and antagonism (van Wagoner, Gelso, Hayes & Diemer, 1991) intrusive imagery, somatic complaints, addictive or compulsive behaviours and functional impairment (Chrestman, 1995). Vicarious traumatisation can occur when the counsellor experiences strong countertransference responses to trauma material which makes the counsellor draw on his/her own familiar psychological defences which can act to distance them from the therapy (Pearlman & Saakvitne, 1995b). If countertransference reactions are unnoticed and unresolved, they can disrupt empathic enquiry (Arvay & Uhlemann, 1996; Sexton, 1999).

Evidence of negative countertransference reactions in trauma therapy has been found in recent studies (Danieli, 1988; Kinzie & Boehnlein, 1993). Sixty-one trauma therapists were interviewed regarding their emotional experiences of working with trauma clients who were Nazi Holocaust survivors (Danieli, 1988). Qualitative transcript analysis highlighted that therapists reported that they experienced defensive and negative emotions (anger, horror) and uncovered themes of shame, bystander guilt, grief/mourning and casting the client as a victim or hero. However it was unclear whether these countertransference reactions were specific to treating Nazi Holocaust survivors and therefore the generalisability of this study was in question. Further support was provided by a more general study which explored the countertransference reaction of psychotherapists working with victims of trauma,
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(Kinzie & Boehnlein, 1993). Again, negative emotional reactions were evident, including depression and anger; changes were also noted in the counsellor’s sense of safety, intolerance of violence and a sense of identification with the victim. However, it had little generalisability as it was based on two clinical single-case examples.

The Relationship between Empathy and Vicarious Trauma

It would appear from the literature that empathic strain (as a result of countertransference reactions) and the development of vicarious traumatisation are strongly related. However the exact role of empathy is unclear. The literature has described both low (Friedman, 2002) and high (Martin et al, 1986) levels of empathy as having a significant relationship to vicarious traumatisation.

A recent study exposed 88 female participants to a ‘high’ or ‘low’ trauma event (Friedman, 2002). The females were pre-selected in terms of their dispositional empathic abilities and were assigned low or high empathic status. The participants were then randomly assigned to observe a patient recounting either a low or a high trauma event. High empathisers exhibited greater physiological reactivity and no self-reported affective distress. The opposite was true of the low empathisers; they reported more affective distress than physiological reactivity (Friedman, 2002). This study suggests low empathy can lead to empathic distress, ‘a less extreme form of vicarious traumatisation’ (Friedman, 2002.p. 3799).

However, one other study looked at PTSD and the degree of empathy in police men and women, who worked with victims of crime (Martin, et al, 1986) and found that high empathy might also lead to reported vicarious traumatisation. In this study a questionnaire was devised to elicit demographic information, a checklist of possible stresses stemming from police work and a personal victimisation history. In addition, the 53 participants (N = 34 (64%) male, N = 19 (36%) female) were asked to check themselves against the symptoms of PTSD in the DSM-IV criteria, in response to their previously identified stresses with work. The respondents were also asked to check along a spectrum of descriptors of their relationship with survivors of rape ranging from empathic to antagonistic. Twenty-six percent of the participants reported meeting DSM-IV criteria in response to working with victims or their own
victimisation on the job. Eighty-three percent of the participants reported that they felt that personal trauma had increased the degree of empathy they felt towards survivors of rape. In addition, female officers were significantly more likely to describe their relationship to survivors of rape as more empathic than male officers. Female officers were also more likely to report dealing with rape and child sexual abuse as being stressful than males although it was believed to be unlikely that they were exposed to different ‘stressful’ events. Female officers were therefore more distressed by their work with rape victims and also felt more empathy for them than their male counterparts, who were less emotionally affected by their work with trauma survivors and reported less empathy. The authors concluded that this discrepancy may be due to female officers being exposed to more traumas with which they identify emotionally. They also felt that the males emotionally distanced themselves from the trauma, which may have had a direct impact on their low levels of reported empathy. This study was limited, as there were no standardised measures used within the research study and the sample size was too small to be able to generalise the findings. It may be that this is also a self-selected sample, and only the more empathic and interested officers took part in the study. Replication would therefore be necessary. One further problem is that it is difficult to ascertain whether the PTSD symptoms noted within this sample are a product of personal victimisation in the individual’s past, their victimisation within the workplace or from working directly with trauma survivors.

In summary, low empathy has been associated with vicarious trauma in non-professional participants (Friedman, 2002), however when examined in response to rape survivors, higher empathy was associated with vicarious trauma in a professional population (Martin et al, 1986). One possibility is that high empathy may lead to vicarious traumatisation when the trauma is highly emotive or personal for the professional, for example because identification with the victim has occurred or because of the nature of the work reminds the professional of their own trauma. This suggests that the role of empathy in the development of vicarious traumatisation needs to be explored further.
Risk Factors for Vicarious Trauma for Mental Health Workers

The presence of vicarious trauma in counsellors of survivors of trauma has been well documented (Pearlman & Mac Ian, 1995; Iliffe & Steed, 2000; Arvay & Uhleman, 1996; McCombie & Arons, 1980). Empirical studies have attempted to assess vicarious trauma by the presence of PTSD symptoms and cognitive changes in counsellors who can explicitly associate their symptoms of distress with exposure to the indirect trauma rather than due to any exposure to direct personal trauma. A number of different measures have been used within the literature, usually scales which examine PTSD symptomology, for example the Impact Event Scale (IES: Zilberg et al, 1992) and/or changes in beliefs, such as with the Traumatic Stress Institute Belief Scale (TSI: Pearlman, 1995).

Various studies have explored the contributing risk factors for the development of vicarious trauma. For a more extensive review of vicarious traumatisation and its risk factors in general, please refer to the literature review in this portfolio (Clare, 2002). In summary, risk factors for the development of vicarious trauma have included both work-related issues and personal influences. Examples of work related factors are lack of experience working with trauma cases (Chrestman, 1995; Pearlman & Mac Ian, 1995; Arvay & Uhleman, 1996) and the intensity of a trauma caseload (Munroe, 1991; Arvay & Uhleman, 1996; Schauben & Frazier, 1995). Personal influences included personal history of abuse (Allt, 1999; Kassam-Adams, 1994; Pearlman & Mac Ian, 1995), gender (Kassam-Adams, 1994; Arvay & Uhlemann, 1996), “negative coping” styles, levels of personal stress and negative clinical responses to clients (Follette, Polusny, & Milbeck, 1994). An increase in symptoms of vicarious traumatisation has been especially noted when working with sexually traumatised victims (Kassam-Adams, 1994; Schauben & Frazier, 1995; Astin, 1997; Blanchard & Jones, 1997; Johnson & Hunter, 1997; Cunningham, 1999; Allt, 1999). Two of the key reported risk factors for the development of vicarious trauma are working with sexual trauma (Johnson & Hunter, 1997; Schauben & Frazier) and having a personal history of trauma (Allt, 1999; Kassam-Adams, 1994; Pearlman & Mac Ian, 1995). These two key risk factors will be explored in more detail.
"all the therapists I know who do this work have been blindsided at least once by the horror of it. Their own vulnerability, their helplessness in the face of such abuse is staggering”

(Steele, 1991; p. 12)

In the literature there has been significant evidence of the risk of vicarious trauma in counsellors of survivors of sexual trauma (Johnson & Hunter, 1997; Astin, 1997; Cunningham, 1997). Johnson and Hunter (1997) compared two groups of counsellors, those who worked within specialist rape crisis services (N = 41) and more generic counsellors (N = 32). The counsellors were compared on a number of demographic variables and several measures including the Malasch Burnout Inventory (MBI: Malasch & Jackson, 1981), the Ways of Coping Scale (WCS: Folkman & Lazarus, 1980) and a specifically designed Beliefs and Values Questionnaire (BVQ: Johnson & Hunter, 1997). The BVQ measured the impact of the trauma work in terms of only five of the basic psychological needs (safety, trust, power, intimacy and esteem). An example of an item based on the intimacy factor was ‘I experience relationship difficulties with my family’ and therefore the higher the score on the Intimacy factor the higher the problems with interpersonal relationships. The nature and direction of the question items were similar for each factor based on the psychological needs. The questionnaires were distributed to volunteers at a statewide meeting of sexual assault workers and to social work and psychology departments within the larger cities in New South Wales. This study found that sexual assault counsellors experienced greater ‘emotional exhaustion’ on the MBI than the control group for both frequency and intensity. In addition sexual assault workers tended to use more escape/avoidance coping strategies. With respect to the findings on the BVQ the factors of intimacy, power and safety/trust all showed a significant positive relationship to the total burnout score within the sexual assault workers. Elevated intimacy and power scores were also associated with higher levels of emotional exhaustion and higher escape/avoidance ways of coping. The results show that sexual assault workers exhibited more burnout and employed more
escape/avoidant strategies, which were reminiscent of responses associated with vicarious traumatisation, and that this was associated with more negative disruptions to basic psychological beliefs and needs.

Schauben and Frazier (1995) also conducted one of the key studies into vicarious trauma in therapists who worked with sexual trauma. One hundred and eighteen female psychologists from an organisation of women psychologists and 30 female rape crisis counsellors were assessed for vicarious traumatisation. The female psychologists reported that about 45% of their caseload incorporated survivors of sexual trauma, compared to 95% of the caseloads of the rape crisis counsellors. A survey design was employed to explore burnout (using the MBI (Malasch & Jackson, 1981)), traumatic stress beliefs and PTSD (using a checklist of PTSD criteria). Participants were asked to rate the extent to which they felt they were experiencing vicarious traumatisation defined as "the enduring psychological consequences for therapists of exposure to the traumatic experiences of victim clients (e.g., nightmares, heightened fear, and increased feelings of vulnerability)." (p.53). In response to the vicarious trauma question, participants were asked to rate themselves on a 5-point scale (1 = not at all to 5 = a great deal). This measure was found to be significantly correlated with the reported presence of PTSD symptoms (r = .61, p< .001). Comorbidity with other mental health problems, personal victimisation history and general demographic details were also elicited from the participants. In addition, therapists were asked qualitative questions about difficult and enjoyable aspects of working with trauma clients. Vicarious trauma was evident as a result of working with victims of sexual trauma survivors, in that those with a higher percentage of sexual trauma clients in their workload had more disrupted beliefs, more self-reported vicarious trauma and more symptoms of PTSD. Symptoms of vicarious trauma were significantly correlated with negative affect (r = .45, p<.001) and belief disruptions (r = .33, p<.001). However, in this study vicarious traumatisation was not found to be related to a counsellor’s own history of victimisation as in other studies outlined below. One strength of this study was that the authors asked about enjoyable aspects of working with sexual trauma survivors, which made the results of this research more valid as the focus was not solely on the negative aspects of trauma work. However, limitations were also evident; the study did not employ a standardised measure to assess for vicarious trauma and the PTSD symptoms were not described in sufficient detail.
It would appear that a consistent finding in the literature is that counsellors who work with sexual trauma are more at risk of developing vicarious traumatisation. Therefore studying this population of counsellors may increase the understanding of how and why empathic stress and vicarious traumatisation develops.

*The Impact of a Counsellor’s Personal History of Abuse on the Development of Vicarious Traumatisation*

Statistically, two in five women will be raped within her lifetime (Hall, cited by the Rape Crisis Federation, 2002). The statistics imply that there may be a high percentage of counsellors who will have been sexually traumatised at one point in their lives. More counsellors have already been found to report a personal history of sexual or physical abuse than other professionals (Elliot, 1990; cited in Jones, 2001).

Most of the studies which have explored the influence of a personal history of sexual victimisation claim that it is a risk factor for developing vicarious traumatisation for counsellors (Kassam-Adams, 1994; Pearlman & Mac Ian, 1995; Allt, 1999). Pearlman and Mac Ian (1995) found that therapists who had prior personal experience of trauma were found to exhibit more negative effects from treating trauma victims in terms of their view of ‘others’, for example there were more positive replies to items such as ‘other people are no good’ (p.559). The negative effects were reflected in their participants’ responses to the TSI Belief Scale (TSI: Pearlman, 1995) which measures the negative disruptions to beliefs affected by trauma. Therapists with past personal trauma histories showed significantly higher total scores on the TSI than those without trauma histories and higher scores which indicate more negative beliefs on the safety, self-trust, self-esteem, other-trust and other-intimacy subscales. Those with a personal history of abuse also showed significant elevations on the Symptom Checklist-90- Revised (SCL-90-R: Derogatis, 1977), which measured general distress levels, and the Intrusion subscale on the IES (Zilberg et al, 1992). In addition, it was found that those therapists with personal trauma experiences who talked to their own counsellors about the personal effects of working with trauma cases within their own therapy showed more disturbances on all of the measures. Those without a history of
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personal abuse tended to find that the longer they worked within trauma the higher their negative view of others \( (r = .23, p < .05) \). The length of time working within trauma was negatively correlated the TSI scale to a significant degree. Those newer to trauma work exhibited more disruptions to self-trust, self-intimacy and self-esteem as well as overall symptoms as measured on the Symptom Checklist-90-Revised \( (\text{Derogatis, 1977}) \). Overall, less training was found to correlate with more disrupted schemas in the sample of counsellors without personal trauma histories. The authors suggest that the therapist’s pre-existing schema may be a significant factor, however there was no measure of this within their study and so it remains unclear whether the current trauma beliefs were due to exposure to trauma or to pre-existing schema.

Unfortunately, there were no details provided of the type of trauma that the therapists had personally experienced, and whether it was similar to that experienced by their clients. It was also not clear what the impact of a counsellor’s personal therapy was. There were no details of why the counsellors were in therapy, whether it was for specific issues or for personal development. The reason for undergoing therapy may be important, it may be that those who were in therapy for personal trauma difficulties found that their work exacerbated these problems and so their work was discussed more in their therapy. The finding that those who talked about their work in therapy were more likely to show disturbances on the measures may be due to the possibility that they already had other personal issues to contend with. Counsellors with a personal trauma history may seek to resolve personal issues within therapy and so become attracted to trauma work. This may enable a therapist to be more sensitive to a client’s issues, but may make them more vulnerable to traumatic stress reactions as it may reactivate therapists’ early memories and trauma experiences \( (\text{Farber, 1985}) \). Evidently the role of previous counselling for personal abuse needs to be further explored.

Kassam-Adams’ (1994) study further explores the impact of a personal history of trauma. One hundred psychotherapists were asked to complete self-report measures that included demographic details, personal trauma history, the Personal Strain Questionnaire \( (\text{PSQ: Osipow and Spokane, 1981}) \) and the IES \( (\text{Zilberg, et al, 1992}) \). Nearly half of the respondents scored high enough in PTSD symptomology measured on the IES to suggest clinical significance. These symptoms were associated with exposure to sexually victimised clients \( (r=.36, p<.001) \) and consisted of both
intrusions’ and ‘avoidance’. General stress was not associated with exposure to sexual trauma issues or any other type of trauma, suggesting that vicarious trauma symptoms were separate from general therapeutic stress and burnout. In this study females reported more trauma history \( r = .40 \), p value not stated) and the combined effect of being a female and having a personal trauma history was predictive of reported intrusion and avoidance (PTSD) symptoms. However a personal history of sexual assault alone was not significantly related to PTSD symptoms in the entire sample, although it did correlate with higher exposure levels to sexual trauma clients. Years of experience and current caseload were also not significantly correlated with general stress on the PSQ scores, which again differentiates stress from vicarious traumatisation. This study has some limitations. The use of the IES to determine symptoms of PTSD is incomplete as it only addressed symptoms of avoidance and intrusion and no further details of participants’ PTSD symptoms or beliefs were provided.

Other studies have also found that a personal history of sexual assault alone is not a risk factor for vicarious traumatisation (Schauben & Frazier, 1995; Follette et al, 1994; Badura & Stone, 1998). The difference in the findings may stem from how information about past trauma is elicited. The studies which request more details of past experiences of trauma appear to elicit more reporting of personal trauma. In response to a more general question “Do you have a trauma history?” (Pearlman & Mac Ian, 1995) 60% of the sample reported a personal assault history. This is in contrast to Schauben and Frazier’s (1995) study, which reported a prevalence of 70% for the psychologists and 83% of the sexual assault counsellors in their study. However Schauben and Frazier (1995) included sexual harassment as part of victimisation history criteria, unlike Pearlman and Mac Ian (1995) which may also explain the difference in prevalence rates of past sexual victimisation experiences. In Schauben and Frazier’s (1995) study 53% of psychologists reported incidences of sexual harassment, compared to 48% of sexual assault workers. It may be that some individuals would not necessarily see sexual harassment as a trauma and so would have responded to a more general question differently. The definition of what constitutes a trauma and how personal information is requested will naturally affect the responses of the participants and the conclusions of the study. This suggests that more in-depth research needs to take place regarding the influence of personal trauma
history, trauma type and its effect on empathic engagement and the development of vicarious traumatisation.

**Rape, Empathy and Attitudinal Studies amongst Professionals**

If personal history of assault and working with sexual trauma are risk factors for vicarious trauma then beliefs and attitudes towards survivors of sexual assault and their impact on empathy needs to be explored.

Professional females have been found to hold more positive attitudes towards rape victims than males, although males have more negative attitudes regardless of professional status (White & Cuprous, 1999). However, several factors have been found to influence the attitudes of professionals. Victims described as “respectable” (married, wore print dress, not known to assailant, struggled when assaulted and suffered serious injuries) were blamed less by nurses (Alexander, 1980). It would therefore appear that mental health workers are not completely immune to attributional and cultural biases related to rape (Hall, 1998) and have in fact been shown to show consistently negative attitudes towards victims and victim-blaming beliefs (Dye & Roth, 1990). When asked, most psychologists will not endorse victim-blaming attitudes, but 22% of the psychologists in one study provided qualitative responses which could be interpreted as victim-blaming (Huenefeld, 1999). As an example, psychologists attributed more responsibility to the rape survivor for the rape three days post rape than three months after the rape had occurred (Huenefeld, 1999). Although more experience with sexual assault survivors decreases victim-blaming attitudes amongst women psychologists (Popma, 1996), victim blaming has still been shown to be mediated by both victim behaviour and self-blame beliefs stemming from personal abuse experiences (Bobertz, 1996).

It may be that blaming attitudes towards rape victims stem from the difficulties of coping with strong negative countertransference reactions and empathic strain, and are an attempt to distance the self from the victim’s pain. As noted earlier, one study has looked at PTSD and the degree of empathy felt when working with rape victims within professional police men and women (Martin, et al, 1986). Symptoms of PTSD were only significantly related to working with rape victims. Eighty-three percent of the participants who had experienced personal trauma reported increased empathy
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towards survivors of rape. When vicarious trauma and empathy were explored earlier, low empathy was associated with vicarious trauma (Friedman, 2002), however when examined in response to rape survivors, higher empathy was associated with vicarious trauma.

Due to the lack of studies examining rape attitudes and empathy in the professional literature, studies examining empathy levels and attitudes towards rape survivors in the general population will now be explored. This literature is considered relevant as Rape Crisis Centres employ phone line volunteers directly from the general population.

**Rape Attitudes and Empathy Studies in the General Population**

Gender differences have been found in empathic responses to rape victims, with females tending to be more empathic than males (Ching & Burke, 1999; Krulewitz, 1982; Margolis, 1998; Schult & Schneider, 1991). However, recent literature has highlighted that women often have negative appraisals of female rape victims and support blaming attitudes (Anderson, 1999; Cowan, 2000; Muehlenhard & MacNaughton, 1988), which has an impact on the degree of empathy they would feel for rape survivors (Ching & Burke, 1999). This has been confirmed by other studies which show that behavioural blame (blaming the aspects of the victim’s behaviour) was significantly related to the maintenance to adaptive beliefs independent of the survivor’s character (Karuza & Carey, 1984). Empathy for a rape victim has been found to be mediated by the rape victim’s respectability (Luginbuhl & Mullin, 1981), her physical attractiveness (Dietz, Littman & Bentley, 1980; Calhoun, Selby, Cann & Keller, 1978) and her social role (Smith, Keating, Hester & Mitchell, 1976) on mock jurors’ decisions in cases surrounding rape. Potential protective factors from affective distress include rape victim stereotypes (Ford, Liwag-McLamb & Foley, 1998), just world beliefs (Rubin & Peplau, 1975), rape myth acceptance (Burt, 1980) and traditional sex role attitudes (Bell, Kuriloff, Lottes & Nathanson, 1992; Simonson & Subich, 1999; Margolis, 1998). These negative attitudes can help an individual distance themselves from the survivors of trauma. Although distancing attitudes may be advantageous against the development of vicarious traumatisation it has been noted that within the general population these attitudes reduce empathy for rape victims.
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(Ching & Burke, 1999).

A study of the empathic response of 42 female and 32 male undergraduate students found that when they knew a rape victim, participants reported experiencing more empathy in response to a rape victim than those who did not know a rape victim (Barnett, Feierstein, Jaet & Saunders, 1992). This was repeated in a more recent study when rape attitudes and empathy levels were assessed in 361 college students using the Attitudes Towards Rape questionnaire and the Rape Empathy Scale (Ching & Burke, 1999). Participants with no personal experience of rape held more rape intolerant attitudes, and lower levels of empathy.

Summary and Rationale for the Current Study

Vicarious trauma symptoms in response to working with rape victims have been well documented and several risk factors have been identified for its development (namely, defensive countertransference responses, number of trauma cases in a caseload, degree of experience, working with sexual trauma and having a personal history of trauma). However, the role of empathy in relation to vicarious traumatisation needs to be further explored. There are no studies, which explore empathy and the development of vicarious traumatisation in rape counsellors, despite several theories that link vicarious trauma and empathy, and empathic strain and attitudes towards rape. The role of empathy is important as a therapeutic task, however due to the recorded presence of negative attitudes towards victims in the general population and professionals there is a concern that empathic engagement is difficult to sustain. Negative attitudes in the general population have been shown to reduce victim empathy and lead to an increase in derogation of victims. Distancing and empathic withdrawal is hypothesised to be a risk factor for vicarious trauma and so needs to be further explored within the counsellors of rape victims. In addition, high empathic engagement and over-involvement has also been suggested to lead to vicarious trauma symptoms. Again the issue of whether it is a high degree of empathy or a low degree of empathy that is associated with the development of vicarious trauma needs further examination.

Rape crisis centre services offer short and long-term supportive counselling or psychotherapy for survivors of sexual assault. Survivors mainly self-refer or can be
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referred through the Rape Crisis Federation. The aims of the service are to provide culturally sensitive, accessible support for victims of sexual trauma and to provide practical and legal advice and to spread awareness of sexual violence. Although experience and training have been shown to be protective factors against the development of vicarious trauma (Pearlman & Mac Ian, 1995) rape crisis services employ a number of helpline volunteers who are largely drawn from the general population. In addition, helpline volunteers have been shown to experience a large degree of stress and are vulnerable to the development of vicarious trauma (Kinzel & Nanson, 2000). Phone volunteers have been reported to have negative reactions to working on crisis lines, experiencing "nightmares, intrusive thoughts, and negative emotions" (Cyr & Dowrick, 1991). Crisis line volunteers usually have a few weeks training by professional staff (Bobevski & Holgate, 1997) and come from a variety of different backgrounds. There has been some evidence that completing a graduate group counselling course which incorporates a specific personal growth component is significantly correlated with higher empathic understanding (Puleo & Schwartz, 1999). There is also a high turnover of staff (Kinzel & Nanson, 2000) and stress is felt to arise from the one-time nature of contact with the outcome remaining unknown (Cyr & Dowrick, 1991) and the problem of repeat callers (MacKinnon, 1998), who undermine the volunteer’s feelings of effectiveness. In one study the stress of working on a crisis line was believed to result in a loss of empathy with non-repeat or true crisis callers (Hall & Schloar, 1995). This study also aimed to explore whether the phone counsellors are more or less vulnerable to vicarious traumatisation due to the nature of their exposure to traumatic material (by phone) and due to their reduced levels of training. It is likely that phone counsellors experience more empathic strain and more vicarious traumatisation than face-to-face counsellors due to working via a precarious medium of contact.

Objective

The aim of this study was to analyse the contributing factors of training, medium of contact, empathy and personal history of sexual trauma on the possible development of vicarious trauma when working with rape victims in both face-to-face and phone-line counsellors.
Hypotheses

1: Phone counsellors will suffer more empathic strain and more vicarious trauma than counsellors who have face-to-face contact with survivors.

2: Qualified counsellors should exhibit less vicarious trauma symptoms and beliefs than unqualified counsellors.

3: Age, experience and reduced exposure to trauma survivors are protective factors against the development of vicarious traumatisation.

4: Counsellors without past experience of trauma will show less empathy and less vicarious trauma (symptoms and beliefs) and those counsellors with a history of personal sexualised trauma will show high empathy and more vicarious trauma (symptoms and beliefs). Prior therapy for personal trauma will also be related to the development of vicarious traumatisation.

4. Overall high empathy is related to the development of vicarious traumatisation (when dealing with highly affective experiences like sexual trauma)
METHOD

Design

This study used a postal survey design. A quantitative methodology was used to assess the impact of working with survivors of rape and childhood sexual abuse on rape counsellors using standardised questionnaires.

Participants

Six hundred and thirty-four questionnaires were distributed, of which 102 were returned. However, one of the questionnaires was discarded as not all of the measures had been completed, leaving a sample size of 101. The overall response rate was 15.9%. The response rate was low in comparison to other studies conducted in America, which had a response rate of 32% and 42% respectively (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). During the study some of the administrators explained that not all questionnaires were completed due to time and resource limitations. In addition, a third party distributed the questionnaires (see procedure section) so it is difficult to establish how many reached individual participants.

As in all other studies of this nature (e.g. Schauben & Frazier, 1995), all of the respondents were female. All of the participants worked in a Rape Crisis Centre. Most of the counsellors provided a primarily face-to-face service (77%) whilst fewer counsellors worked solely on the phone lines (24%). Slightly over half of the counsellors had some form of formal counselling qualification (54%), whilst the other counsellors either had unrelated qualifications or were students working towards a relevant qualification (47%). All of the participants had in-service training. The participants came from all of the age ranges (see Table 1).
Table 1: Age of Participants

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<tr>
<th>Age Range</th>
<th>N</th>
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<tr>
<td>Under 25</td>
<td>3</td>
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<tr>
<td>26-35</td>
<td>25</td>
<td>24.8%</td>
</tr>
<tr>
<td>36-45</td>
<td>32</td>
<td>31.7</td>
</tr>
<tr>
<td>46-55</td>
<td>29</td>
<td>28.7</td>
</tr>
<tr>
<td>56-65</td>
<td>8</td>
<td>7.9</td>
</tr>
<tr>
<td>Over 65</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Most of the participants were aged between 36-45 years (31.7%). The participants were comparable in age to other studies whose respondents had a mean age of 43 (Pearlman & Mac Ian, 1995) and 44 years (Schauben & Frazier, 1995). The range of experience fell between 4 months and 20 years, with most of the participants having between 1 (16.8%), 2 (17.8%) and 3 (11.9%) years experience working with survivors of rape. Overall the participants had a mean of 5.09 years experience, which was lower than that found in others studies: 9.59 years (Pearlman & Mac Ian, 1995) and 9 years (Schauben & Frazier, 1995). Most of the participants worked between 2 (21.8%) and 3 (21.8%) hours a week and received between 1 (22.8%) and 2 (32.7%) hours of supervision. This sample also tended to work less hours on average per week than an earlier study; the current participants worked on average 5.19 hours per week compared with 11 hours per week (Schauben & Frazier, 1995).

Thirty-three (32.7%) of the participants had been physically attacked in their past, whilst 60 (59.4%) of participants had been sexually harassed and 53 (52.5%) had survived a sexual assault. Overall, 75 (74.3%) of the participants had been the victim of at least one kind of either of the three types of assault with 26 (25.7%) having experienced multiple trauma. The level of past trauma was comparable to the prevalence rates to those reported in Pearlman and Mac Ian’s (1995) study which were around 60%. The prevalence rates were slightly under those reported in the sexual assault counsellors in the Schauben and Frazier’s (1995) study, of whom 83% reported having been the victims of at least one form of past trauma, with 37%
researching multiple traumas. However, consistently across all of the studies, a high percentage of sexual assault workers have been shown to have a personal trauma history.

**Procedure**

Ethics approval was obtained by the University Ethics Committee (Appendix 2).

A pilot questionnaire was sent to the co-ordinator of a local Rape and Sexual Abuse Centre and to a female trauma counsellor who works with vicarious trauma in counsellors. The pilot was conducted in order to check the acceptability and comprehensibility of the project to rape counsellors. In addition, the questionnaire was piloted to assess the clarity of the survey and that the sensitivity of the content was appropriate. The feedback was that the questionnaire took 15 minutes to complete and only minor changes were required. The subsequent changes were that the questions surrounding education and training were separated so that specific qualifications for working as counsellors and help-line volunteers could be elicited and questionnaire instructions were made more explicit. Other suggestions were to change the wording of certain items on the scales. However since the scales were standardised, the wording was not changed and the reasons for this were reported back to the counsellor who had provided the recommendations. In addition, recommendations in the literature to encourage a high response rate were followed. These included ensuring a clear layout for the questionnaire, unambiguous instructions for completing the separate measures and sending a clear rationale for the study to each service (Oppenheim, 1992, as cited in Allt, 1999). Each service was also informed that a summary of research findings would be available to each service after completion of the research study at their request.

The sample was recruited from a directory of Rape Crisis Centres across the United Kingdom, obtained from the Internet (www.rapecrisis.co.uk). There are 65 such centres across the United Kingdom. The administrator or the team co-ordinator/manager of each Rape Crisis Centre was approached by phone in order to seek permission to send the questionnaires. The study was outlined and the methodology was described. The number of questionnaires required was ascertained
at this point according to how many counsellors and volunteers were present in each Rape Crisis Centre. The centres’ administrators distributed the questionnaires and from this point recruitment was self-selective as each participant could respond to the questionnaire on an individual basis with no pressure or collaboration from the service administrator or manager. The questionnaires were distributed with a cover letter (Appendix 3) consent form (Appendix 4), information sheet (Appendix 5) and a freepost self-addressed envelope. A separate envelope was also sent to the service so that all of the consent forms could be sent back separately so as to not be able to identify participants from their questionnaires.

As the questionnaire asked for personal information regarding whether the participant had experienced a physical assault, sexual harassment or a sexual assault the survey was completely anonymous. Therefore reminders for individuals were not possible. However a reminder letter was sent two months later to each service administrator/manager who was acting as a link. The administrator was informed of the importance of the study and was asked if more questionnaires were required (Appendix 6).

**Measures**

The questionnaire included both validated measures (scales numbered 2 to 4) and additional questions regarding the participant (numbered sections 1 and 5). For full details see Appendix 7.

**1) Personal information**

The questions in this section referred to information regarding gender, age, post, education, specific training, length of experience with rape survivors, total hours worked in a week, how much supervision they received in a month and how much support they were able to access.

**2) Secondary Trauma Scale (Motta, Kefer, Hertz & Hafeez, 1999)**

This is a self-report scale which asks participants to name a negative experience that happened to a client that the counsellors remember vividly, and then asks the participant to rate their responses to that experience. This scale aims to evaluate the presence of vicarious trauma symptoms in response to hearing the trauma experienced
by a survivor of rape. The measure is based on the symptomology for Posttraumatic Stress Disorder described in the DSM-IV criteria (APA, 1994) and The Compassion Fatigue Self-test for Psychotherapists (Figley, 1995, cited in Motta et al, 1999).

The scale has an initial open question, which asks about the specific negative experience that the participant is responding to. The measure then consists of 20 items that ask whether the participants have experienced any post-traumatic symptoms related to the specific negative experience. PTSD symptoms are explored due to the hypothesis that post-traumatic stress and vicarious traumatic stress share the same PTSD symptomology. The participants rate their responses on a 1-5 point analogue scale (1 = rarely/never to 5 = very often). The criteria measured in the scale are persistent re-experiences of the victim’s distress, the persistent avoidance of stimuli, thoughts etc, which were reminiscent of the negative experience and increased arousal (for example, irritability). The overall score reflects a measure of the frequency and therefore the severity of their posttraumatic symptoms, although no cut-off score is available.

The Secondary Trauma Scale shows good internal consistency (.75 on a student sample (n = 157) and .88 on mental health workers (n = 261) who responded to a family member’s/friend’s or a client’s trauma respectively) (Motta, et al, 1999). The scale also significantly relates to established measures of trauma (with correlations ranging from .33 to .56, p<.01) across different sample groups which indicates good validity (Motta et al, 1999).

3) The Post-Traumatic Cognitions Inventory (Foa, Ehlers, Clark, Tolin & Orsillo, 1999).

This is a self-report measure, which tries to elicit the presence of trauma-related thoughts and beliefs, which can arise in an emotional response to trauma. The items in this scale have been derived from both clinical observations and current theories regarding post-trauma psychopathology, with particular relevance to emotional processing theory (Foa and Kozak, 1986). Emotional processing theory proposes that PTSD results from a disruption to the normal recovery processes, largely due to dysfunctional cognitions surrounding the self as incompetent and the world as dangerous. The perception of current ongoing threat maintains the disorder.
The measure consists of 33 statements or beliefs and participants rate their responses on a 1-7 point analogue scale, ranging from 1 (totally agree) to 7 (totally disagree). The scale measures three components: negative cognitions about the self, negative thoughts about the world and self-blame. The scale then produces four scores, the three subscale scores which reflect the components highlighted above and an overall score which reflects the overall presence of trauma-related beliefs. The number of items within each subscale divided the subscale scores in order to facilitate the comparison of means across the subscales. In contrast the total scale score is given as a sum of the subscale totals and is not divided by the number of items (Foa et al, 1999).

The three factors within the original Post-Traumatic Cognitions Inventory (PTCI) show good internal consistency in a sample of 601 adult volunteers who were seeking treatment for PTSD (Foa et al, 1999). Cronbach’s alphas were $\alpha = .97$ (total score), $\alpha = .97$ (negative cognition about the self), $\alpha = .88$ (negative cognition’s about the world) and $\alpha = .86$ (self-blame). The PTCI also shows good test-retest reliability using Spearman’s Rho calculations, $P = .74$ (total score), $P = .75$ (negative cognition about the self), $P = .89$ (negative cognition’s about the world) and $P = .89$ (self-blame). The PTCI also showed moderate to strong correlations with other measures of PTSD severity, depression and anxiety and was able to discriminate between non-traumatised individuals and individuals with PTSD. The PTCI also showed good convergent validity with the Personal Beliefs and Reactions Scale (Resick, Schnicke & Markway, 1991, cited in Foa et al, 1999) and the World Assumptions Scale (Janoff-Bulman, 1989; cited in Foa et al, 1999).

In this study the wording was changed for two of the items (17 and 26) in order to reflect that the responses were relevant to trauma material that was heard rather than experienced directly. In addition the self-blame items which formed the third subscale on the original scale were removed, as they were not deemed relevant to this population.
4) The Questionnaire Measure of Emotional Empathy (Mehrabian & Epstein, 1969)

This is a 33 item self-report scale, designed to measure a person’s emotional empathic tendency, based on two different definitions of empathy, namely an ability to imaginatively take the role of another and the vicarious emotional response to the perceived emotional experiences of others (Mehrabian & Epstein, 1969). The measure is reliable and demonstrates good discriminant validity (Mehrabian & Epstein, 1969). The items were scored with a dichotomous format (Eysenck & Eysenck, 1978) and were summed to make a total score for the scale.

5) Personal trauma history.

These additional questions referred to the participant's personal history of sexual trauma. The questions asked about prior physical assault, sexual harassment and sexual trauma, how long ago any event occurred and whether counselling was sought for the trauma event.

Because of ethical concerns regarding questions about personal histories of assault, participants were given the opportunity to discuss the questionnaire prior to completing it and were able to write to the researcher to discuss any queries. Their personal details were also anonymous and incoming questionnaires could not be identified for any given individual as the consent forms were sent back separately. The nature of the questions was also stressed on the information sheet, and potential participants advised not to proceed if they were likely to find it difficult. None of the participants contacted the researchers to discuss the questionnaire.

Power Analysis:

In multiple regression analysis, small samples will limit inferential power and so Tabachnik and Fidell, (1996) recommends that the sample should be: N > 104 + m (m is number of predictors = 6) = 110, assuming a medium sized relationship (R² ~ 0.15) with α = 0.05 and a power of 0.8.
An apriori power analysis was performed for an independent groups T-test. An appropriate sample size of 102 was calculated, assuming a medium effect size (0.05) with $\alpha = 0.05$ and a power of 0.8.

A power analysis was also performed for a correlational statistical analysis. An appropriate sample size of 82 was calculated assuming a medium effect size (0.3) with $\alpha = 0.05$ and a power of 0.8.
RESULTS

Statistical Analysis

The independent variables were qualification, medium of contact/exposure, personal history of trauma (physical, sexual attack and harassment. The dependent variables were the measures used to assess vicarious trauma) and a measure of empathy.

Separate independent group T-tests were conducted comparing phone volunteers and face-to-face counsellors, ‘qualified’ with ‘non-qualified’ counsellors and those who have experienced each of the different forms of abuse with those who have not, on all variables. In addition, the influence of whether people who have had therapy regarding personal history of trauma was explored. Each group as outlined above was compared with regard to demographic variables to assess comparability and other influencing factors. Then the groups were compared on the dependent variables, namely those that measured vicarious trauma, the Secondary Trauma Questionnaire (STQ) and the Posttraumatic Cognitions Inventory (PTCI), and the Mehrabian and Epstein Empathy Scale (MEEQ). The MANOVA’s and T-tests explored the hypotheses that phone counsellors would show signs of more vicarious trauma than face-to-face counsellors, and that qualified counsellors would show less vicarious traumatisation than non-qualified counsellors. In addition, they were used to explore the hypotheses that having a past trauma history and prior personal counselling would effect the dependent measures.

Correlations between continuous variables were also used to examine relationships. The correlations explored both the hypotheses that high empathy and vicarious trauma would be related to each other and the effect of continuous variables such as years of experience and hours of work on the dependent measures.

The study also employed an overall multiple regression analysis. The multiple regression analysis highlighted which of the related demographic and dependent measures predicted the main outcome measures.
Demographic Details of the Participants

A summary of the demographic details of the sample when it is split according to medium of contact is shown in Table 2.

Table 2: Demographic Details of the Sample: Groups Based on the Counsellors' Medium of Contact

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Face-to-Face/Phone Contact (N = 77)</th>
<th>Phone Contact Volunteers (N = 24)</th>
<th>Total</th>
<th>Statistic</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 45</td>
<td>N (%) 44 (57.1)</td>
<td>N(%) 16 (66.7)</td>
<td>60 (59.4)</td>
<td>χ² (1) = 0.69</td>
<td>0.41 ns</td>
</tr>
<tr>
<td>Over 45</td>
<td>33 (42.9)</td>
<td>8 (33.3)</td>
<td>41 (40.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years of Experience¹</td>
<td>Mean (s.d) 5.51 (5.19)</td>
<td>Mean (s.d) 3.62 (3.89)</td>
<td>5.09 (4.98)</td>
<td>Mann Whitney U = 575.5</td>
<td>0.07 ns</td>
</tr>
<tr>
<td>Counselling Qualification</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>N (%) 52 (67.5)</td>
<td>N (%) 3 (12.5)</td>
<td>55 (54.5)</td>
<td>χ² (1) = 22.34</td>
<td>0.01 sig.</td>
</tr>
<tr>
<td>No</td>
<td>25 (32.5)</td>
<td>21 (87.5)</td>
<td>46 (45.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work Hours per week²</td>
<td>Mean (s.d) 6 (5.40)</td>
<td>Mean (s.d) 2.81 (1.53)</td>
<td>5.19 (4.92)</td>
<td>Mann Whitney U = 494.5</td>
<td>0.01 sig.</td>
</tr>
<tr>
<td>Supervision Hours per month³</td>
<td>Mean (s.d) 2.34 (1.80)</td>
<td>Mean (s.d) 1.53 (0.48)</td>
<td>2.16 (1.63)</td>
<td>Mann Whitney U = 584.5</td>
<td>0.04 sig.</td>
</tr>
</tbody>
</table>

There were no significant differences between counsellors who at least had some face-to-face contact and those who worked solely on the telephone in terms of age or the number of year's experience working in the field. However, the groups did differ with respect to whether they were a formally qualified counsellor or not (χ² (1) = 22.34, p = 0.01), indicating that qualified counsellors tended to do significantly more face-to-face work than non-qualified counsellors. In addition, counsellors who worked face-to-face with survivors of rape tended to work significantly more hours a

¹ N = 74 (Face-to-face/both), N = 21 (Phone only)
² N = 71 (Face-to-face/both), N = 24 (Phone only)
³ N = 74 (Face-to-face/both), N = 22 (Phone only)
week (Mann-Whitney U = 494.5, p = 0.01, 2-tailed test) and also received significantly more supervision a month (Mann-Whitney U = 584.5, p = 0.04, 2-tailed test) than counsellors who worked solely on the phone lines. When these two groups are compared in future analysis it must always be considered that they differ in terms of the proportion of qualified counsellors, the number of hours worked per week, and in the amount of supervision received per month.

A summary of the demographic details of the sample when it is split according having a counselling diploma or equivalent is shown in Table 3.

Table 3: Demographic Details of the Counsellors: Groups Based on Qualifications

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Counselling Qualification (N = 55)</th>
<th>Other (N = 46)</th>
<th>Total</th>
<th>Statistic</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 45</td>
<td>N (%)</td>
<td>N(%)</td>
<td>N(%)</td>
<td>( \chi^2 )</td>
<td>0.50 ns</td>
</tr>
<tr>
<td>Over 45</td>
<td>31 (56.4)</td>
<td>29 (63)</td>
<td>60 (59.4)</td>
<td>(1) = 0.46</td>
<td></td>
</tr>
<tr>
<td></td>
<td>24 (43.6)</td>
<td>17 (37)</td>
<td>41 (40.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years of Experience(^4)</td>
<td>Mean (s.d) 5.78 (5.41)</td>
<td>Mean (s.d) 4.22 (4.27)</td>
<td>5.09 (4.98)</td>
<td>Mann Whitney U = 861.5</td>
<td>0.06 ns</td>
</tr>
<tr>
<td>Medium of Contact</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Face-to-face</td>
<td>N (%)</td>
<td>N(%)</td>
<td>N(%)</td>
<td>( \chi^2 )</td>
<td>0.01 sig.</td>
</tr>
<tr>
<td>Phone only</td>
<td>52 (94.5)</td>
<td>25 (54.3)</td>
<td>77 (76.2)</td>
<td>(1) = 22.34</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 (5.5)</td>
<td>21 (45.7)</td>
<td>24 (23.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work Hours per week(^5)</td>
<td>Mean (s.d) 6.49 (5.98)</td>
<td>Mean (s.d) 3.56 (2.30)</td>
<td>5.19 (4.92)</td>
<td>Mann Whitney U = 799.5</td>
<td>0.02 sig.</td>
</tr>
<tr>
<td>Supervision Hours per month(^6)</td>
<td>Mean (s.d) 2.37 (1.89)</td>
<td>Mean (s.d) 1.87 (1.16)</td>
<td>2.16 (1.63)</td>
<td>Mann Whitney U = 912.5</td>
<td>0.10 ns</td>
</tr>
</tbody>
</table>

The groups did not differ significantly in terms of age, years of experience or number of hours of supervision received per month. However, the qualified participants conducted significantly more face-to-face therapy with clients (either with or without

\(^4\) N = 53 (Qualified Counsellor), N = 42 (Other)

\(^5\) N = 53 (Qualified Counsellor), N = 42 (Other)
phone line work) \( \chi^2 (1) = 22.34, p = 0.01 \) and worked significantly more hours per week (Mann Whitney U = 799.5, p = 0.02, 2-tailed test) than non-qualified counsellors. When these two groups are compared in future analyses it must always be considered that they differ in terms of the proportion of face-to-face counsellors and in the number of hours worked per week.

Comparison of Groups Split on the Basis of Past Personal Trauma.

Due to the documented effect of past personal experiences of trauma on the development of vicarious trauma (Pearlman & Mac Ian, 1995; Kassam Adams, 1995), the sample was further split with respect to past personal trauma. The groups were not significantly different with respect to any of the demographic variables when they were separated according to whether the participants had any experience of physical or sexual attack in their past (see Appendices 8 and 9).

However, Table 4 shows that when the participants were compared with respect to whether they had experienced sexual harassment there was a significant difference between the groups with regard to number of years experience. Participants with a history of sexual harassment had significantly more years of experience than the participants that had not experienced sexual harassment (Mann Whitney U = 806.5, p = 0.03, 2-tailed test).

\[ N = 55 \text{ (Qualified Counsellor), } N = 41 \text{ (Other) } \]
Table 4: Demographic Details of the Sample: Groups Based on whether Counsellors have been Sexually Harassed in the Past

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>History of Harassment (N = 60)</th>
<th>No History of Harassment (N = 41)</th>
<th>Total (N = 101)</th>
<th>Statistic</th>
<th>p-value</th>
</tr>
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<tbody>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 45</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>35 (58.3)</td>
<td>25 (61)</td>
<td>60 (59.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over 45</td>
<td>25 (41.7)</td>
<td>16 (39)</td>
<td>41 (40.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years of Experience&lt;sup&gt;7&lt;/sup&gt;</td>
<td>Mean (s.d)</td>
<td>Mean (s.d)</td>
<td>Mann Whitney U =</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.04 (5.53)</td>
<td>3.66 (3.63)</td>
<td>5.09 (4.98)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium of Contact</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Face-to-face</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>44 (73.3)</td>
<td>33 (80.5)</td>
<td>77 (76.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone only</td>
<td>16 (26.7)</td>
<td>8 (19.5)</td>
<td>24 (23.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselling Qualification</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>32 (53.3)</td>
<td>23 (56.1)</td>
<td>55 (54.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>28 (46.7)</td>
<td>18 (43.9)</td>
<td>46 (45.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work Hours per week&lt;sup&gt;8&lt;/sup&gt;</td>
<td>Mean (s.d)</td>
<td>Mean (s.d)</td>
<td>Mann Whitney U =</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.88 (5.59)</td>
<td>4.12 (3.45)</td>
<td>5.19 (4.92)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervision Hours per month&lt;sup&gt;9&lt;/sup&gt;</td>
<td>Mean (s.d)</td>
<td>Mean (s.d)</td>
<td>Mann Whitney U =</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.23 (1.88)</td>
<td>2.05 (1.16)</td>
<td>2.16 (1.63)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A summary of the demographic details of the sample when it was split according to whether counsellors have sought personal therapy for the past trauma reported in the questionnaire is shown in Table 5. The two groups did not differ in terms of age, the medium of contact with clients or the amount of supervision provided. However counsellors who had undergone personal therapy for past trauma had significantly more experience (Mann-Whitney U = 659.5, p = 0.05, 2-tailed test) and worked significantly more hours (Mann-Whitney U = 699.5, p = 0.05, 2-tailed test) than counsellors with no personal experience of their own counselling. The counsellors who had sought their own counselling were also significantly more likely to have a counselling qualification ($\chi^2 (1) = 7.53, p = 0.01$) than those who had not sought counselling for themselves.

<sup>7</sup> N = 57 (History of Sexual Harassment), N = 38 (No History of Sexual Harassment)
<sup>8</sup> N = 58 (History of Sexual Harassment), N = 37 (No History of Sexual Harassment)
<sup>9</sup> N = 58 (History of Sexual Harassment), N = 38 (No History of Sexual Harassment)
Table 5: Demographic Details of the Sample: Groups Based on whether Counsellors have Personally had Counselling

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>History of Counselling (N = 29)</th>
<th>No History of Counselling (N = 72)</th>
<th>Total (N = 101)</th>
<th>Statistic</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 45</td>
<td>N (%)</td>
<td>N(%)</td>
<td>N(%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age Under 45</td>
<td>17 (58.6)</td>
<td>43 (59.7)</td>
<td>60 (59.4)</td>
<td></td>
<td>0.92</td>
</tr>
<tr>
<td>Age Over 45</td>
<td>12 (41.4)</td>
<td>29 (40.3)</td>
<td>41 (40.6)</td>
<td></td>
<td>ns</td>
</tr>
<tr>
<td>Years of Experience^{10}</td>
<td>Mean (s.d)</td>
<td>Mean (s.d)</td>
<td>Mean (s.d)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience</td>
<td>6.92 (5.81)</td>
<td>4.40 (4.48)</td>
<td>5.09 (4.98)</td>
<td></td>
<td>0.05</td>
</tr>
<tr>
<td>Medium of Contact</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Face-to-face</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Face-to-face counsellors</td>
<td>23 (79.3)</td>
<td>54 (75)</td>
<td>77 (76.2)</td>
<td></td>
<td>0.64</td>
</tr>
<tr>
<td>Phone only</td>
<td>6 (20.7)</td>
<td>18 (25)</td>
<td>24 (23.8)</td>
<td></td>
<td>ns</td>
</tr>
<tr>
<td>Counselling Qualification</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>22 (75.9)</td>
<td>33 (45.8)</td>
<td>55 (54.5)</td>
<td></td>
<td>0.01</td>
</tr>
<tr>
<td>No</td>
<td>7 (24.1)</td>
<td>39 (54.2)</td>
<td>46 (45.5)</td>
<td></td>
<td>sig</td>
</tr>
<tr>
<td>Work Hours per week^{11}</td>
<td>Mean (s.d)</td>
<td>Mean (s.d)</td>
<td>Mean (s.d)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours per week</td>
<td>6 (4.32)</td>
<td>4.86 (5.15)</td>
<td>5.19 (4.92)</td>
<td></td>
<td>0.05</td>
</tr>
<tr>
<td>Supervision Hours per month^{12}</td>
<td>Mean (s.d)</td>
<td>Mean (s.d)</td>
<td>Mean (s.d)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours per month</td>
<td>2.21 (1.18)</td>
<td>2.14 (1.80)</td>
<td>2.16 (1.63)</td>
<td></td>
<td>0.30</td>
</tr>
</tbody>
</table>

Exploration of the Presence of Personal Trauma History within the Sample.

The sample was divided on medium of contact and the presence of personal trauma history was explored with regard to each of the groups. Table 6 shows that there were no significant differences between the two groups with regard to trauma history or how long ago the most recent attack occurred (for those who survived an assault). However, face-to-face counsellors reported having experienced more multiple trauma and this difference approached significance.

^{10} N = 26 (Had counselling), N = 69 (Never had counselling)

^{11} N = 28 (Had counselling), N = 67 (Never had counselling)

^{12} N = 24 (Had counselling), N = 72 (Never had counselling)
Table 6: The Presence of Personal Attack and Experience of Counselling in the Participants Personal History with the Groups Split on the basis of Medium of Contact.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Face-to-Face/Phone Contact (N = 77)</th>
<th>Phone Volunteers (N = 24)</th>
<th>Total</th>
<th>Statistic</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Physical Assault</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>χ² (1) = 0.33</td>
<td>0.56 ns</td>
</tr>
<tr>
<td>Yes</td>
<td>24 (31.2)</td>
<td>9 (37.5)</td>
<td>33 (32.7)</td>
<td>0.56 ns</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>53 (68.8)</td>
<td>15 (62.5)</td>
<td>68 (67.3)</td>
<td>0.56 ns</td>
<td></td>
</tr>
<tr>
<td>History of Sexual Harassment</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>χ² (1) = 0.69</td>
<td>0.41 ns</td>
</tr>
<tr>
<td>Yes</td>
<td>44 (57.1)</td>
<td>16 (66.7)</td>
<td>60 (59.4)</td>
<td>0.41 ns</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>33 (42.9)</td>
<td>8 (33.3)</td>
<td>41 (40.6)</td>
<td>0.41 ns</td>
<td></td>
</tr>
<tr>
<td>History of Sexual Assault</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>χ² (1) = 0.04</td>
<td>0.85 ns</td>
</tr>
<tr>
<td>Yes</td>
<td>40 (51.9)</td>
<td>13 (54.2)</td>
<td>53 (52.5)</td>
<td>0.85 ns</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>37 (48.1)</td>
<td>11 (45.8)</td>
<td>48 (47.5)</td>
<td>0.85 ns</td>
<td></td>
</tr>
<tr>
<td>Had at least one kind of assault</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>χ² (1) = 1.36</td>
<td>0.24 ns</td>
</tr>
<tr>
<td>Yes</td>
<td>55 (71.4)</td>
<td>20 (83.3)</td>
<td>75 (74.3)</td>
<td>0.24 ns</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>22 (28.6)</td>
<td>4 (16.7)</td>
<td>26 (25.7)</td>
<td>0.24 ns</td>
<td></td>
</tr>
<tr>
<td>Multiple Trauma</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>χ² (1) = 2.89</td>
<td>0.09 ns</td>
</tr>
<tr>
<td>Yes</td>
<td>23 (29.9)</td>
<td>3 (12.5)</td>
<td>26 (25.7)</td>
<td>0.09 ns</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>54 (70.1)</td>
<td>21 (87.5)</td>
<td>75 (74.3)</td>
<td>0.09 ns</td>
<td></td>
</tr>
<tr>
<td>How Long Ago was attack¹³</td>
<td>Mean (sd)</td>
<td>Mean (sd)</td>
<td></td>
<td>t = -0.548</td>
<td>0.59 ns</td>
</tr>
<tr>
<td></td>
<td>17.75 (12.49)</td>
<td>19.6 (13.75)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹² N = 67 (Never had counselling)
¹³ N = 53 (Face-to-face), N = 20 (Phone)
When the sample was split in terms of qualification, it was found that participants did not differ significantly in terms of their history of personal trauma in the form or frequency of attack (see Table 7 for full details).

Table 7: The Presence of Personal Attack and Experience of Counselling in the Participants Personal History within the Groups Split on the basis of Having a Formal Counselling Qualification.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>counselling Qualification (N = 55)</th>
<th>Other (N = 46)</th>
<th>Total</th>
<th>Statistic</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of PA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>N (%) 21 (38.2)</td>
<td>N (%) 12 (26.1)</td>
<td>N (%) 33 (32.7)</td>
<td>$\chi^2$ (1) = 1.67</td>
<td>0.20 ns</td>
</tr>
<tr>
<td>No</td>
<td>34 (61.8)</td>
<td>34 (73.9)</td>
<td>68 (67.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of SH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>N (%) 32 (58.2)</td>
<td>N (%) 28 (60.9)</td>
<td>N (%) 60 (59.4)</td>
<td>$\chi^2$ (1) = 0.07</td>
<td>0.78 ns</td>
</tr>
<tr>
<td>No</td>
<td>23 (41.8)</td>
<td>18 (39.1)</td>
<td>41 (40.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of SA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>N (%) 32 (58.2)</td>
<td>N (%) 21 (45.7)</td>
<td>N (%) 53 (52.5)</td>
<td>$\chi^2$ (1) = 1.58</td>
<td>0.21 ns</td>
</tr>
<tr>
<td>No</td>
<td>23 (41.8)</td>
<td>25 (54.3)</td>
<td>48 (47.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of at least one assault of any kind</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>N (%) 44 (80)</td>
<td>N (%) 31 (67.4)</td>
<td>N (%) 75 (74.3)</td>
<td>$\chi^2$ (1) = 2.08</td>
<td>0.15 ns</td>
</tr>
<tr>
<td>No</td>
<td>11 (20)</td>
<td>15 (32.6)</td>
<td>26 (25.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple Trauma</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>N (%) 16 (29.1)</td>
<td>N (%) 10 (21.7)</td>
<td>N (%) 26 (25.7)</td>
<td>$\chi^2$ (1) = 0.71</td>
<td>0.40 ns</td>
</tr>
<tr>
<td>No</td>
<td>39 (70.9)</td>
<td>36 (78.3)</td>
<td>75 (74.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How Long Ago was attack$^{14}$</td>
<td>Mean (sd) 18.28 (12.15)</td>
<td>Mean (sd) 18.23 (13.84)</td>
<td>18.3 (12.78)</td>
<td>$t$ = -0.012</td>
<td>0.99 ns</td>
</tr>
</tbody>
</table>

Characteristics of Vicarious Trauma and Empathy Measures - Reliability of Dependent Measures

Secondary Trauma Questionnaire (STQ)

The Secondary Stress Questionnaire had good internal reliability (alpha = 0.89). The total score for the scale was calculated by adding together the scores indicated on each item (Likert item scores 1 to 5). The range of scores for this population was between 20 and 71, with a mean score of 32.12 and a standard deviation of 8.48.
Posttraumatic Cognitions Inventory (PTCI)

Overall the scale had very good internal reliability (alpha = 0.92). Two subscales were used from the total scale with the following reliabilities: negative cognitions about the self, (alpha = 0.91 (21 items)) and negative cognitions about the world, (alpha = 0.83 (7 items)). Following reference (Foa et al, 1999) the two subscale scores were generated according to responses on the Likert scale options (item scores 1 – 7) and totalled for each subscale and then divided by the number of items within each subscale. All items were summed for the Total score. The range of Total scores for this population was between 29 and 104, with a mean score of 55.46 and a standard deviation of 17.8.

Mehrabian and Epstein Empathy Questionnaire (MEEQ)

The original scale of 33 items was found to have low internal reliability (alpha = 0.51). In order to increase the reliability of the scale, items which failed to differentiate between participants (i.e. 90% or more participants gave the same answers (Tabachnick and Fidell, 1996)) were dropped, leaving 18 items. This increased internal reliability to an acceptable level (alpha = 0.61). The remaining 18 items were also checked to ensure that all of the factors of empathy that were present in the original scale were still accounted for in this smaller scale. The range of total scores for this population was between 3 and 17, with a mean score of 10.10 and a standard deviation of 2.93.

The Presence of Vicarious Traumatisation for the Whole Sample

Comparison studies which have used these scales did not present means (medians were given) and therefore T-tests were not possible. However, the median score was presented in a couple of studies using the PTCI (Foa et al, 1999; Allt, 2001) and has been used for comparison in other studies (Allt, 1999), see Table 7 for full details. In this study only 16.8% of the sample scored below the median for the negative beliefs

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14 N = 43 (Counsellors with a diploma or equivalent), N = 30 (Other qualifications)
about the world subscale indicating that most of the sample had more negative beliefs about the world than the normal population sample. Only 13.9% of the current sample scored below the median for the negative beliefs about the self, indicating that again the sample consistently exhibited higher negative beliefs about the self than the normal population. In comparison to another study which examined vicarious trauma in counsellors, the counsellors in the current study exhibited higher negative beliefs about the world and lower negative beliefs about the self.

Table 7: Median scores on the PTCI: A comparison

<table>
<thead>
<tr>
<th></th>
<th>Current median (sd)</th>
<th>Comparison Study median (sd)</th>
<th>Norms* median (sd)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTCI - world</td>
<td>3.14 (1.12)</td>
<td>2.50 (.96)</td>
<td>2.07 (1.43)</td>
</tr>
<tr>
<td>PTCI - self</td>
<td>1.33 (.579)</td>
<td>1.61 (.55)</td>
<td>1.08 (.76)</td>
</tr>
</tbody>
</table>

* Norms taken from participants who had never experienced a trauma (Foa et al, 1999).
**Norms taken from a population of counsellors who worked across a variety of settings and who had a high percentage of trauma clients in their caseload (Allt, 1999).

MANOVAS and T-tests to Explore the Effects of Medium of Contact, Qualification and Personal Trauma History on Measures of Vicarious Trauma and Empathy

MANOVA’s were conducted on the different sample groupings (based on medium of contact, qualification and personal history of trauma) to explore the effects of these different groupings on each of the dependent measures. However, PTCI-total score was not included in the MANOVA as the two sub-scales were included instead which make up the PTCI-total score.

T-tests were used to further explore the separate effects of each grouping on each of the dependent measures, namely the Secondary Trauma Questionnaire (STQ), the Post-traumatic Cognitions Inventory (PTCI ) and the Mehrabian and Epstein Empathy Questionnaire (MEEQ) when the results from the MANOVA’s were significant.
Since the STQ was positively skewed and not normally distributed, the data was transformed using a logarithmic transformation and the new variable (STQ-log) was used in all of the subsequent statistical analysis. Since the Negative Beliefs about the Self - subscale of the PTCI questionnaire was also positively skewed, an inverse transformation was used and this new variable (PTCI-sein) was used in all subsequent analysis. The transformations were used in order to achieve normality and to enable parametric statistics to be used.

A MANOVA was performed to explore the hypothesis that phone contact with survivors of rape would be associated with higher levels of vicarious trauma and empathy. Medium of contact did not appear to have a relationship with any of the measures assessing vicarious trauma and empathy, $F (4,96) = 0.94, p = 0.244)$. See Table 8 for details of the group means and those for the sample as a whole.

Table 8: The Effect of the Medium of Contact on Measures of Vicarious Trauma and Empathy

<table>
<thead>
<tr>
<th>Measure</th>
<th>Face-to-face Contact (N = 77)</th>
<th>Phone Contact only (N = 24)</th>
<th>Total (N = 101)</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>STQ</em>-Raw mean (sd)</td>
<td>32.32 (8.89)</td>
<td>31.46 (7.13)</td>
<td>32.12 (8.48)</td>
</tr>
<tr>
<td>STQ-log mean (sd)</td>
<td>1.50 (.10)</td>
<td>1.49 (0.10)</td>
<td>1.49 (.10)</td>
</tr>
<tr>
<td>PTCI (total) mean (sd)</td>
<td>54.19 (16.92)</td>
<td>59.5 (20.6)</td>
<td>55.45 (17.9)</td>
</tr>
<tr>
<td>PTCI-selfRaw mean</td>
<td>1.52 (.52)</td>
<td>1.75 (.73)</td>
<td>1.58 (.58)</td>
</tr>
<tr>
<td>PTCI -sein mean (sd)</td>
<td>.72 (.20)</td>
<td>.65 (.21)</td>
<td>.70 (.20)</td>
</tr>
<tr>
<td>PTCI (world) mean (sd)</td>
<td>3.17 (1.17)</td>
<td>.26 (.96)</td>
<td>3.19 (1.12)</td>
</tr>
<tr>
<td>MEEQ mean (sd)</td>
<td>9.91 (2.93)</td>
<td>10.71 (2.91)</td>
<td>10.10 (2.93)</td>
</tr>
</tbody>
</table>

A MANOVA was performed to explore the hypothesis that qualified counsellors would be less likely to suffer from vicarious traumatisation. Qualifications held by the participants did not appear to have a relationship with the measures of vicarious
Research

trauma and empathy, $F(4, 96) = 0.41, p = 0.80$). See Table 9 for details of the group means and those for the sample as a whole.

Table 9: The Effect of Having a Formal Counselling Qualification on Measures of Vicarious Trauma and Empathy,

<table>
<thead>
<tr>
<th>Measure</th>
<th>Counselling Qualification (N = 55)</th>
<th>Other (N = 46)</th>
<th>Total (N = 101)</th>
</tr>
</thead>
<tbody>
<tr>
<td>STQ – Raw mean</td>
<td>32.44 (7.42)</td>
<td>31.74 (9.67)</td>
<td>32.12 (8.48)</td>
</tr>
<tr>
<td>STQ-log mean</td>
<td>1.50 (.09)</td>
<td>1.48 (.11)</td>
<td>1.49 (.10)</td>
</tr>
<tr>
<td>PTCI (total) mean</td>
<td>56.4 (17.78)</td>
<td>54.33 (18.19)</td>
<td>55.45 (17.9)</td>
</tr>
<tr>
<td>PTCI – self Raw mean</td>
<td>1.60 (.57)</td>
<td>1.54 (.59)</td>
<td>1.58 (.58)</td>
</tr>
<tr>
<td>PTCI (sein) mean</td>
<td>.69 (.20)</td>
<td>.72 (.21)</td>
<td>.70 (.20)</td>
</tr>
<tr>
<td>PTCI (world) mean</td>
<td>3.25 (1.12)</td>
<td>3.12 (1.12)</td>
<td>3.19 (1.12)</td>
</tr>
<tr>
<td>MEEQ mean</td>
<td>9.94 (2.98)</td>
<td>10.28 (2.90)</td>
<td>10.10 (2.93)</td>
</tr>
</tbody>
</table>

Table 10: The Effect of having experienced a Physical Attack on Measures of Vicarious Trauma and Empathy,

<table>
<thead>
<tr>
<th>Measure</th>
<th>History of Physical Attack (N = 33)</th>
<th>No History of Physical Attack (N = 68)</th>
<th>Total (N = 101)</th>
</tr>
</thead>
<tbody>
<tr>
<td>STQ – Raw mean</td>
<td>31.76 (6.26)</td>
<td>32.29 (9.4)</td>
<td>32.12 (8.48)</td>
</tr>
<tr>
<td>STQ mean</td>
<td>1.49 (.08)</td>
<td>1.49 (.11)</td>
<td>1.49 (.10)</td>
</tr>
<tr>
<td>PTCI (total) mean</td>
<td>55.3 (16.64)</td>
<td>55.53 (18.61)</td>
<td>55.45 (17.9)</td>
</tr>
<tr>
<td>PTCI – self Raw mean</td>
<td>1.55 (.51)</td>
<td>1.59 (.61)</td>
<td>1.58 (.58)</td>
</tr>
<tr>
<td>PTCI (sein) mean</td>
<td>.70 (.19)</td>
<td>.71 (.21)</td>
<td>.70 (.20)</td>
</tr>
<tr>
<td>PTCI (world) mean</td>
<td>3.25 (1.24)</td>
<td>3.17 (1.06)</td>
<td>3.19 (1.12)</td>
</tr>
<tr>
<td>MEEQ mean</td>
<td>9.91 (2.71)</td>
<td>10.19 (3.05)</td>
<td>10.10 (2.93)</td>
</tr>
</tbody>
</table>
Further hypotheses were explored using MANOVAS and T-tests to examine whether a history of personal trauma (physical assault, sexual harassment or sexual assault) would increase the counsellors vulnerability to developing vicarious trauma as predicted (see Tables 10 to 12). A history of physical assault did not appear to have any significant relationship with the measures of vicarious trauma and empathy $F(4,96) = 0.11, p = 0.98)$. See Table 10 for details of the group means and those for the sample as a whole.

A MANOVA was performed to explore the hypothesis that a history of sexual harassment would make counsellors more vulnerable to developing vicarious traumatisation. There was a significant relationship between a history of sexual harassment and the measures, $F(4,96) = 2.74, p = 0.03$.

Table 11: The Effect of having been Sexually Harassed on Measures of Vicarious Trauma and Empathy

<table>
<thead>
<tr>
<th>Measure</th>
<th>History of Sexual Harassment (N = 60)</th>
<th>No History of Sexual Harassment (N = 41)</th>
<th>Total (N = 101)</th>
<th>Statistic – T-test (df)</th>
<th>p-value (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>STQ – Raw mean</td>
<td>32.77 (8.56)</td>
<td>31.17 (8.37)</td>
<td>32.12 (8.48)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STQ mean (sd)</td>
<td>1.50 (0.10)</td>
<td>1.48 (.10)</td>
<td>1.49 (.10)</td>
<td>1.08 (99)</td>
<td>0.28 ns</td>
</tr>
<tr>
<td>PTCI (total) mean (sd)</td>
<td>58.85 (18.59)</td>
<td>50.49 (15.78)</td>
<td>55.45 (17.9)</td>
<td>2.36 (99)</td>
<td>0.02 sig</td>
</tr>
<tr>
<td>PTCI –self – Raw mean</td>
<td>1.69 (.62)</td>
<td>1.41 (.48)</td>
<td>1.58 (.58)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTCI (sein) mean (sd)</td>
<td>.66 (.21)</td>
<td>.77 (.18)</td>
<td>.70 (.20)</td>
<td>-2.58 (99)</td>
<td>0.01 sig</td>
</tr>
<tr>
<td>PTCI (world) mean (sd)</td>
<td>3.34 (1.15)</td>
<td>2.98 (1.05)</td>
<td>3.19 (1.12)</td>
<td>1.61 (99)</td>
<td>0.11 ns</td>
</tr>
<tr>
<td>MEEQ mean (sd)</td>
<td>9.92 (3.0)</td>
<td>10.37 (2.85)</td>
<td>10.10 (2.93)</td>
<td>-0.75 (99)</td>
<td>0.45 ns</td>
</tr>
</tbody>
</table>
With further exploration in the T-tests a history of sexual harassment did not appear to have a significant relationship with the measure of empathy (see Table 11 for full details), the STQ-log, or the sub-scale measure of the effect of negative beliefs about the world on the PTCI. The counsellors who had a history of sexual harassment did have significantly more negative beliefs about the self ($t(99) = -2.58, p = 0.01$, 2-tailed test) and significantly higher scores on the PTCI total ($t(99) = 2.36, p = 0.02$, 2-tailed test) than the counsellors who had not experienced sexual harassment.

A MANOVA was performed to explore the hypothesis that a history of sexual assault would make counsellors more vulnerable to developing vicarious traumatisation. There was no significant effect of sexual assault $F(4,96) = 1.89, p = 0.12)$. See Table 12 for details of the group means and those for the sample as a whole.

**Table 12: The Effect of Having suffered a Sexual Assault on Measures of Vicarious Trauma and a Measure of Empathy**

<table>
<thead>
<tr>
<th>Measure</th>
<th>History of Sexual Assault (N = 33)</th>
<th>No History of Sexual Assault (N = 68)</th>
<th>Total (N = 101)</th>
</tr>
</thead>
<tbody>
<tr>
<td>STQ- Raw mean</td>
<td>32.81 (9.23)</td>
<td>31.35 (7.58)</td>
<td>32.12 (8.48)</td>
</tr>
<tr>
<td>STQ mean (sd)</td>
<td>1.50 (.11)</td>
<td>1.48 (.10)</td>
<td>1.49 (.10)</td>
</tr>
<tr>
<td>PTCI (total) mean (sd)</td>
<td>58.4 (20.23)</td>
<td>52.21 (14.45)</td>
<td>55.45 (17.9)</td>
</tr>
<tr>
<td>PTCI - self - Raw mean</td>
<td>1.71 (.67)</td>
<td>1.43 (.41)</td>
<td>1.58 (.58)</td>
</tr>
<tr>
<td>PTCI (sein) mean (sd)</td>
<td>.66 (.22)</td>
<td>.75 (.18)</td>
<td>.70 (.20)</td>
</tr>
<tr>
<td>PTCI (world) mean (sd)</td>
<td>3.21 (1.17)</td>
<td>3.18 (1.07)</td>
<td>3.19 (1.12)</td>
</tr>
<tr>
<td>MEEQ mean (sd)</td>
<td>10.30 (2.90)</td>
<td>9.87 (2.99)</td>
<td>10.10 (2.93)</td>
</tr>
</tbody>
</table>
A MANOVA was performed to explore the hypothesis that personal experience of counselling would make counsellors more vulnerable to developing vicarious traumatisation. There was a significant relationship between a history of personal counselling and the dependent measures $F(4,96) = 3.44, p = 0.01$).

In addition, whether or not the participants had counselling or not appeared to have a significant relationship to several of the measures according to several T-tests. Those participants who had received counselling for personal trauma had significantly more symptoms of vicarious trauma on the STQ-log ($t(99) = 2.27, =0.03$, 2-tailed test) and on the total score on the PTCI ($t(99) = 2.59, p = 0.01$, 2-tailed test) than those who had not sought counselling for personal trauma. Those counsellors who had received counselling also showed greater elevations in their negative beliefs about the self than the counsellors who had never received counselling ($t(99) = -2.79, p = 0.01$, 2-tailed test) (see Table 13 for full details).

Table 13: The Effect of having experienced Counselling in the past on Measures of Vicarious Trauma and Empathy,

<table>
<thead>
<tr>
<th>Measure</th>
<th>Had Counselling (N = 29)</th>
<th>Never Had Counselling (N = 72)</th>
<th>Total (N = 101)</th>
<th>Statistic T-test (df)</th>
<th>p-value (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>STQ - Raw mean</td>
<td>35.31 (11.08)</td>
<td>30.83 (6.85)</td>
<td>32.12 (8.48)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STQ mean (sd)</td>
<td>1.53 (.12)</td>
<td>1.48(.09)</td>
<td>1.49 (.10)</td>
<td>2.27 (99)</td>
<td>0.03 sig</td>
</tr>
<tr>
<td>PTCI (total) mean (sd)</td>
<td>62.52 (20.28)</td>
<td>52.61 (16.15)</td>
<td>55.45 (17.9)</td>
<td>2.59 (99)</td>
<td>0.01 sig</td>
</tr>
<tr>
<td>PTCI - self - Raw mean</td>
<td>1.83(.69)</td>
<td>1.47 (.49)</td>
<td>1.58 (.58)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTCI (sein) mean (sd)</td>
<td>.62 (.22)</td>
<td>.74 (.19)</td>
<td>.70 (.20)</td>
<td>-2.79 (99)</td>
<td>0.01 sig</td>
</tr>
<tr>
<td>PTCI (world) mean (sd)</td>
<td>3.42 (1.14)</td>
<td>3.10 (1.11)</td>
<td>3.19 (1.12)</td>
<td>1.31 (99)</td>
<td>0.19 ns</td>
</tr>
<tr>
<td>MEEQ mean (sd)</td>
<td>9.72 (3.16)</td>
<td>10.25 (2.85)</td>
<td>10.10 (2.93)</td>
<td>-0.81 (99)</td>
<td>0.42 ns</td>
</tr>
</tbody>
</table>
Correlations

An analysis of the correlations between the measures of vicarious trauma, empathy and continuous demographic variables were conducted, namely hours of work, hours of supervision, experience, age and recency of past trauma if relevant. The correlations were explored to test the hypotheses that some demographic variables may be related to measures of vicarious trauma (such as experience and hours of exposure to trauma clients). Firstly the demographic variables were checked for significant relationships with each other (see Table 14 for full details).

<table>
<thead>
<tr>
<th>Table 14: Correlations of Demographic Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Group</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>Age Group</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Recency of trauma (N = 73)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Experience</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Hours of Work</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Hours of Supervision</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

All significant correlations are shaded. All correlations are Pearson’s except those involving age group which are Spearman’s.

The only demographic variables which correlated with each other were as follows:

- Age Group was positively correlated with experience (r (101) = 0.32, p = 0.01, 2-tailed test), therefore the older the counsellors were the more experienced they were.
- The more experienced the participant were the more hours a week they worked (r (101) = 0.41, p= 0.01, 2-tailed test).
- The number of hours of supervision available a month was negatively related to the recency of the most recent past personal trauma (where relevant). Therefore, the longer ago the most recent trauma occurred the less hours of supervision were made available to them (r (73) = -0.04, p = 0.69, 2-tailed test).
Secondly the demographic variables were checked for significant relationships with the measures of vicarious trauma and empathy (see Table 15 for full details).

Table 15: Correlations between Demographic Variables and the STQ, PTCI and the MEEQ.

<table>
<thead>
<tr>
<th></th>
<th>Age Group</th>
<th>Recency of trauma (N = 73)</th>
<th>Experience</th>
<th>Hours of Work</th>
<th>Hours of Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>STQ-log</td>
<td>r = -0.16</td>
<td>r = 0.02</td>
<td>r = 0.12</td>
<td>r = 0.03</td>
<td>r = -0.11</td>
</tr>
<tr>
<td></td>
<td>p = 0.10</td>
<td>p = 0.84</td>
<td>p = 0.23</td>
<td>p = 0.80</td>
<td>p = 0.28</td>
</tr>
<tr>
<td>PTCI-total</td>
<td>r = -0.22</td>
<td>r = 0.06</td>
<td>r = 0.09</td>
<td>r = 0.06</td>
<td>r = 0.14</td>
</tr>
<tr>
<td></td>
<td>p = 0.03</td>
<td>p = 0.60</td>
<td>p = 0.38</td>
<td>p = 0.57</td>
<td>p = 0.17</td>
</tr>
<tr>
<td>PTCI-world</td>
<td>r = -0.20</td>
<td>r = -0.08</td>
<td>r = 0.15</td>
<td>r = -0.15</td>
<td>r = 0.08</td>
</tr>
<tr>
<td></td>
<td>p = 0.05</td>
<td>p = 0.50</td>
<td>p = 0.14</td>
<td>p = 0.14</td>
<td>p = 0.43</td>
</tr>
<tr>
<td>PTCI-sein</td>
<td>r = 0.19</td>
<td>r = -0.12</td>
<td>r = -0.07</td>
<td>r = -0.01</td>
<td>r = 0.18</td>
</tr>
<tr>
<td></td>
<td>p = 0.06</td>
<td>p = 0.29</td>
<td>p = 0.48</td>
<td>p = 0.95</td>
<td>p = 0.08</td>
</tr>
<tr>
<td>MEEQ</td>
<td>r = -0.05</td>
<td>r = -0.03</td>
<td>r = -0.16</td>
<td>r = -0.32</td>
<td>r = -0.08</td>
</tr>
<tr>
<td></td>
<td>p = 0.62</td>
<td>p = 0.77</td>
<td>p = 0.12</td>
<td>p = 0.01</td>
<td>p = 0.44</td>
</tr>
</tbody>
</table>

*All significant correlations are shaded. All correlations are Pearson’s except those involving age group which are Spearman’s.*

As the PTCI-sein scale is an inverse scale, all relationships to the raw data are in the opposite direction. Age was significantly related to measures of negative beliefs about the world and the total score on the PTCI. From the data it would appear that the younger the counsellor the higher the vicarious trauma beliefs overall ($r (101) = -0.22$, $p = 0.03$, 2-tailed test) and the higher the negative beliefs about the world ($r (101) = 0.20$, $p = 0.05$, 2-tailed test).

The only other demographic variable, which had a significant relationship with any of the dependent measures, is the number of hours of work per week, which had a negative relationship with empathy. The more hours the counsellors work per week the less empathy they have reported on the MEEQ ($r (101) = -0.32$, $p = 0.01$, 2-tailed test).

Thirdly the dependent measures were correlated with each other to assess whether any relationship exists between the measures and subscales of vicarious trauma and the measure of empathy. These correlations were explored to examine the hypothesis that
high levels of empathy would be associated with high levels of vicarious
traumatisation (see Table 16 for full details).

Table 16: Significant Correlations: For the Dependent Measures

<table>
<thead>
<tr>
<th></th>
<th>STQ-log</th>
<th>PTCI -total</th>
<th>PTCI -world</th>
<th>PTCI -sein</th>
<th>MEEQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>STQ-log</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>r = 0.59</td>
<td>p = 0.01</td>
<td>r = 0.44</td>
<td>p = 0.01</td>
<td>r = -0.64</td>
<td>p = 0.01</td>
</tr>
<tr>
<td>PTCI -total</td>
<td>r = 0.59</td>
<td>p = 0.01</td>
<td>r = 0.83</td>
<td>p = 0.01</td>
<td></td>
</tr>
<tr>
<td>r = 0.44</td>
<td>p = 0.01</td>
<td>r = -0.63</td>
<td>p = 0.01</td>
<td>r = 0.33</td>
<td>p = 0.01</td>
</tr>
<tr>
<td>PTCI -world</td>
<td>r = 0.44</td>
<td>p = 0.01</td>
<td>r = -0.92</td>
<td>p = 0.01</td>
<td></td>
</tr>
<tr>
<td>r = -0.64</td>
<td>p = 0.01</td>
<td>r = 0.28</td>
<td>p = 0.01</td>
<td>r = 0.38</td>
<td>p = 0.01</td>
</tr>
<tr>
<td>PTCI -sein</td>
<td>r = 0.33</td>
<td>p = 0.01</td>
<td>r = 0.28</td>
<td>p = 0.01</td>
<td></td>
</tr>
<tr>
<td>r = 0.38</td>
<td>p = 0.01</td>
<td>r = 0.40</td>
<td>p = 0.01</td>
<td>r = 0.40</td>
<td>p = 0.01</td>
</tr>
<tr>
<td>MEEQ</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>r = 0.33</td>
<td>p = 0.01</td>
<td>r = 0.38</td>
<td>p = 0.01</td>
<td>r = 0.40</td>
<td>p = 0.01</td>
</tr>
</tbody>
</table>
| *All significant correlations are shaded.*

The STQ-log was significantly positively correlated with the total score of the PTCI (r (101) = 0.59, p = 0.01, 2-tailed test) and with negative beliefs about the world (r (101) = 0.44, p = 0.01, 2-tailed test). The STQ-log was also significantly positively correlated with the negative beliefs about the self subscale (inverse) of the PTCI (r (101) = -0.64, p = 0.01, 2-tailed test). This suggests that as symptoms of vicarious trauma increase on the STQ-log so do the negative beliefs about the self. The STQ-log is also positively correlated with the empathy scale (r (101) = 0.33, p = 0.01, 2-tailed test) to a significant degree which suggests that the higher the feelings of empathy the higher the level of symptoms of vicarious traumatisation.

As highlighted above, the total PTCI score was positively correlated with the STQ-log score. The PTCI total score was also significantly positively correlated with the empathy scale score (r (101) = 0.38, p = 0.01, 2-tailed test), which indicates that the higher the degree of empathy measured the more prominent the presence of beliefs associated with vicarious trauma.

The PTCI subscale reflecting negative beliefs about the world showed similar patterns of correlations to the overall total PTCI score. Namely, positive significant correlations with the STQ-log score (r (101) = 0.44, p = 0.01, 2-tailed test) and the
empathy score \((r (101) = 0.28, p = 0.01\text{-}2\text{-}tailed\text{ test})\). The PTCI- negative beliefs about the world subscale also showed a significantly negative relationship with the negative beliefs about the self (inverse) subscale \((r (101) = -0.63, p = 0.01\text{-}2\text{-}tailed\text{ test})\), highlighting that as negative beliefs about the world increase so do the negative beliefs about the self (raw scores).

The PTCI negative beliefs about the self subscale, as noted above, tended to have a positive relationship to the other measures of vicarious traumatisation symptoms and beliefs. In addition the inverse subscale showed a significantly positive relationship to the empathy measure \((r (101) = -0.40, p = 0.01\text{-}2\text{-}tailed\text{ test})\), which suggests that a higher empathy score is related to more negative beliefs about the self (raw score).

**Multiple Regression**

A number of exploratory multiple regression analyses were conducted to ascertain the contribution of various variables to the scores on the STQ-log, the PTCI total and the MEEQ. The variables that were put into the regression equation were based on the above analysis, namely those variables that were significantly related to the vicarious traumatisation and the empathy measures in each case. In addition, the contribution of the measure of empathy and the remaining measure of vicarious trauma were also calculated (i.e. if the STQ-log measure was being examined the contribution of empathy and the PTCI-total score would be explored). The ENTER method of multiple regression was implemented in each case.

**STQ-log**

The STQ-log scale measured symptoms of PTSD which had arisen in response to an identified trauma case. Symptoms included avoidance of reminders and startle responses.

The variables entered into the regression equation for the STQ-log were:

**First set of Predictors**
- Whether counselling was sought for the identified trauma
Second set of Predictors
• Empathy scale

Third set of Predictors
• PTCI – world
• PTCI - sein

Table 17: Multiple Regression Analysis – Contributing variables to STQ-log.

<table>
<thead>
<tr>
<th>Predictor Set</th>
<th>R</th>
<th>R²</th>
<th>Adjusted R²</th>
<th>R² change</th>
<th>F change</th>
<th>df1</th>
<th>df2</th>
<th>Sig. F change</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>0.22</td>
<td>0.05</td>
<td>0.04</td>
<td>0.05</td>
<td>5.131</td>
<td>1</td>
<td>99</td>
<td>0.03</td>
</tr>
<tr>
<td>Second</td>
<td>0.42</td>
<td>0.17</td>
<td>0.16</td>
<td>0.12</td>
<td>14.726</td>
<td>1</td>
<td>98</td>
<td>0.01</td>
</tr>
<tr>
<td>Third</td>
<td>0.65</td>
<td>0.42</td>
<td>0.40</td>
<td>0.25</td>
<td>20.839</td>
<td>2</td>
<td>96</td>
<td>0.01</td>
</tr>
</tbody>
</table>

Table 17 shows that whether counselling was sought or not has a significant relationship to the STQ-log, ($R^2 = 0.05$, adjusted $R^2 = 0.04$, $F (1, 99) = 5.131$, $p = 0.03$). The introduction of the empathy questionnaire added significantly over and above the contribution of whether counselling was sought or not, ($R^2 = 0.17$, adjusted $R^2 = 0.16$, $F (1, 98) = 14.726$, $p = 0.01$). In addition, the PTCI subscale scores added significantly over and above counselling and empathy scores to the STQ-log score ($R^2 = 0.42$, adjusted $R^2 = 0.40$, $F (2, 96) = 20.839$, $p = 0.01$). These results suggests that the use of counselling for past trauma, empathy and negative beliefs about the world and the self contribute independently to the presence of vicarious trauma symptoms elicited from the STQ-log.

The contribution of each variable to the overall variance was next considered to see which variables account for most of the STQ-log score. Table 18 shows that when only empathy and counselling are in the equation, empathy contributes more to the variance than the effect of having had counselling, although both are significant. When the subscale measures of negative beliefs about the world and the self are added, negative beliefs about the self appear to contribute the most to the STQ-log score ($t (96) = -4.856$, $p = 0.01$, 2-tailed test) accounting for most of the variance.
When negative beliefs about the self are considered as a contributing factor it tends to overwhelm the contribution of the other variables, which are otherwise significant.

### Table 18: Significance of the Partial Correlations to the STQ-log Score

<table>
<thead>
<tr>
<th>Model</th>
<th>Standardised Coefficient – Beta</th>
<th>t</th>
<th>Sig.</th>
<th>Correlations Zero-Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. (Constant) 40.21</td>
<td>0.01</td>
<td>Was counselling sought -0.22</td>
<td>40.21</td>
<td>-2.26</td>
</tr>
<tr>
<td>2. (Constant) 30.98</td>
<td>0.01</td>
<td>Was counselling sought -0.25</td>
<td>30.98</td>
<td>-2.72</td>
</tr>
<tr>
<td>3. (Constant) 22.77</td>
<td>0.01</td>
<td>Was counselling sought -0.08</td>
<td>22.77</td>
<td>-0.95</td>
</tr>
</tbody>
</table>

**PTCI – total**

The PTCI measured posttraumatic beliefs associated with the development of vicarious trauma. The variables entered into the regression equation for the PTCI - total were:

**First set of Predictors**
- Experience of personal counselling
- A history of sexual harassment
- Age

**Second set of Predictors**
- Empathy scale

**Third set of Predictors**
- STQ – log

### Table 19: Multiple Regression Analysis – Contributing variables to PTCI - total.

<table>
<thead>
<tr>
<th>Predictor Set</th>
<th>R</th>
<th>R²</th>
<th>Adjusted R²</th>
<th>R² change</th>
<th>F change</th>
<th>df1</th>
<th>df2</th>
<th>Sig. F change</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>0.39</td>
<td>0.15</td>
<td>0.13</td>
<td>0.15</td>
<td>5.84</td>
<td>3</td>
<td>97</td>
<td>0.001</td>
</tr>
<tr>
<td>Second</td>
<td>0.56</td>
<td>0.32</td>
<td>0.29</td>
<td>0.16</td>
<td>22.86</td>
<td>1</td>
<td>95</td>
<td>0.001</td>
</tr>
<tr>
<td>Third</td>
<td>0.68</td>
<td>0.47</td>
<td>0.44</td>
<td>0.15</td>
<td>26.97</td>
<td>3</td>
<td>95</td>
<td>0.001</td>
</tr>
</tbody>
</table>
Table 19 shows that the age of the counsellor, the history of sexual harassment and whether counselling was sought or not for past trauma significantly predict the PTCI-total, \( R^2 = 0.15, \) adjusted \( R^2 = 0.13, F (3, 97) = 5.84, p = 0.001 \). Empathy ratings contribute significantly over and above these initial variables regarding past trauma and age to the PTCI-total \( R^2 = 0.32, \) adjusted \( R^2 = 0.29, F (1, 96) = 22.86, p = 0.001 \). A further significant contributing factor to the PTCI-total score was the total STQ-log score which again significantly added to the other variables \( R^2 = 0.68, \) adjusted \( R^2 = -0.47, F (3, 95) = 26.97, p = 0.001 \). The results show that age, a history of sexual harassment, past counselling, empathy and vicarious trauma symptoms contribute significantly to the PTCI-total score.

Table 20: Significance of the Partial Correlations to the PTCI-total Score

<table>
<thead>
<tr>
<th>Model</th>
<th>Standardised Coefficient - Beta</th>
<th>t</th>
<th>Sig.</th>
<th>Correlations Zero-Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. (Constant) Was counselling sought</td>
<td>Was counselling sought</td>
<td>Age</td>
<td>-0.22</td>
<td>-2.35</td>
</tr>
<tr>
<td></td>
<td>Sexually harassed</td>
<td>-0.18</td>
<td>-1.93</td>
<td>0.06</td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>-0.23</td>
<td>-2.47</td>
<td>0.01</td>
</tr>
<tr>
<td>2. (Constant) Was counselling sought</td>
<td>Was counselling sought</td>
<td>Age</td>
<td>-0.25</td>
<td>-2.93</td>
</tr>
<tr>
<td></td>
<td>Sexually harassed</td>
<td>-0.21</td>
<td>-2.44</td>
<td>0.02</td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>-0.21</td>
<td>-2.43</td>
<td>0.02</td>
</tr>
<tr>
<td></td>
<td>MEEQ</td>
<td>0.41</td>
<td>4.78</td>
<td>0.01</td>
</tr>
<tr>
<td>3. (Constant) Was counselling sought</td>
<td>Was counselling sought</td>
<td>Age</td>
<td>-0.15</td>
<td>-1.89</td>
</tr>
<tr>
<td></td>
<td>Sexually harassed</td>
<td>-0.17</td>
<td>-2.23</td>
<td>0.03</td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>-0.15</td>
<td>-1.95</td>
<td>0.06</td>
</tr>
<tr>
<td></td>
<td>MEEQ</td>
<td>0.25</td>
<td>3.14</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>STQ-log</td>
<td>0.43</td>
<td>5.19</td>
<td>0.01</td>
</tr>
</tbody>
</table>

Table 20 shows that when the initial relevant variables of age, past trauma and counselling are considered, age and counselling emerged as significant predictors of the PTCI total score. When empathy was added to the above list of variables, all four predictors emerged as significant. However, when the STQ-log score was added to the list of variables, sexual harassment \((t(95) = -2.23, p = 0.03, 2\text{-tailed test})\), empathy \((t\)
(95) = 3.14, p = 0.01, 2-tailed test) and the STQ-log (t (95) = 5.19, p = 0.01, 2-tailed test) became the most significant contributors to the PTCI-total score.

**MEEQ**

Predictive factors for the measure of empathy: the Mehrabian and Epstein Questionnaire (MEEQ) was next explored. The variables entered into the regression equation for the MEEQ were:

**First set of Predictors**
- Hours of work

**Second set of Predictors**
- STQ
- PTCI -sein
- PTCI -world

Table 21 shows that the hours of work predicts empathy measured, \((R^2 = 0.10, \text{adjusted } R^2 = 0.09, F (1, 93) = 10.61, p = 0.001)\). The introduction of the vicarious trauma measures highlights that these measures contribute to the degree of measured empathy over and above the number of hours worked \((R^2 = 0.51, \text{adjusted } R^2 = 0.27, F (3,90) = 6.67, p = 0.001)\). These results suggest that hours worked per week and negative beliefs about the world and the self contributes to the reported empathy levels.

**Table 21: Multiple Regression Analysis – Contributing variables to the Empathy Scale**

<table>
<thead>
<tr>
<th>Predictor Set</th>
<th>R</th>
<th>R^2</th>
<th>Adjusted R^2</th>
<th>R^2 change</th>
<th>F change</th>
<th>df1</th>
<th>df2</th>
<th>Sig. F change</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>0.32</td>
<td>0.10</td>
<td>0.09</td>
<td>0.10</td>
<td>10.61</td>
<td>1</td>
<td>93</td>
<td>0.001</td>
</tr>
<tr>
<td>Second</td>
<td>0.51</td>
<td>0.27</td>
<td>0.23</td>
<td>0.16</td>
<td>6.67</td>
<td>3</td>
<td>90</td>
<td>0.001</td>
</tr>
</tbody>
</table>

Table 22 shows that when all variables are included, the number of hours worked makes the only significant contribution to empathy \((t (90) = -3.725, p = 0.01, 2-tailed test)\).
Table 22: Significance of the Partial Correlations to Empathy

<table>
<thead>
<tr>
<th>Model</th>
<th>Standardised Coefficient</th>
<th>t</th>
<th>Sig.</th>
<th>Correlations Zero-Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Constant)</td>
<td></td>
<td></td>
<td></td>
<td>-0.32</td>
</tr>
<tr>
<td>Hours worked</td>
<td>-0.32</td>
<td>26.61</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-3.26</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>2 (Constant)</td>
<td></td>
<td></td>
<td></td>
<td>-0.32</td>
</tr>
<tr>
<td>Hours worked</td>
<td>-0.34</td>
<td>1.39</td>
<td>0.17</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-3.72</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>STS-log</td>
<td>0.12</td>
<td>0.91</td>
<td>0.36</td>
<td>0.30</td>
</tr>
<tr>
<td>PTCI - world</td>
<td>0.12</td>
<td>1.01</td>
<td>0.31</td>
<td>0.26</td>
</tr>
<tr>
<td>PTCI - sein</td>
<td>-0.24</td>
<td>-1.80</td>
<td>0.07</td>
<td>-0.38</td>
</tr>
</tbody>
</table>
DISCUSSION

**Hypotheses 1: Phone counsellors should suffer more empathic strain and more vicarious trauma than counsellors who have face to face contact with survivors.**
The first hypothesis centred on the nature of the exposure to hearing about trauma (face-to-face versus phone). The study revealed that there were roughly two different sample groupings with some degree of overlap. Firstly, those who worked predominantly face-to-face with clients mainly consisted of qualified counsellors, worked more hours, received more supervision and were more likely to have experienced counselling in their personal lives. Those who worked mainly on the phone lines were largely unqualified counsellors, who worked fewer hours, received less supervision and had largely not received counselling themselves. When the groups were compared according to medium of contact there were no significant differences with respect to personal trauma history or in terms of outcomes on the dependent measures of vicarious trauma or empathy.

**Hypotheses 2: Qualified counsellors should exhibit less vicarious trauma symptoms and beliefs than unqualified counsellors.**
The second hypothesis centred on the contribution of training (qualified versus volunteer counsellors) to the development of empathy and vicarious traumatisation. The study revealed that those who were qualified worked predominantly face-to-face with clients, worked more hours, received more supervision and were more likely to have experienced counselling in their personal lives. The second group consisted of mainly unqualified counsellors, who worked mainly on the phone lines, who worked fewer hours, received less supervision and had largely not received counselling themselves. When the groups were compared according to qualification there were no significant differences with respect to personal trauma history or in terms of outcomes on the dependent measures of vicarious trauma or empathy.

It would appear that medium of contact and training do not have significant relationships with outcome measures of vicarious trauma and empathy. Therefore hypotheses one and two were not supported. The new element of this study was to explore the particular vulnerability of phone line volunteers. This was due to the reported negative reactions to working on crisis lines and the stress of working with
Research

one-time contact with an unknown outcome (Cyr & Dowrick, 1991) and the resulting loss of empathy due to repeat callers and feelings of ineffectiveness (Hall & Schloar, 1995). This study has found that there was no particular increase in vulnerability for phone line volunteers over and above the experiences of the counsellors who work face-to-face. In addition, although it may be that face-to-face workers have more exposure to trauma per week, the protective factors of increased supervision (Pearlman & Mac Ian, 1995) may balance this risk factor. For phone line volunteers the reduced exposure in terms of the number of hours worked per week may counterbalance the effects of the precarious medium of contact they have with clients.

These results appear to directly counter earlier studies, which stated that only a graduate counselling course qualification correlates with empathic understanding (Puleo & Schwartz, 1999). This may also be due to the quality of the in-house training that is provided in today’s Rape Crisis Centres and the level of support that is provided. It may also be that empathy has stemmed from other factors, which heighten compassion, for example, personal experience of trauma (Ching & Burke, 1999). However, it must be considered that the questions eliciting information regarding training, supervision, and other work experiences prior to, and in conjunction with, working at the Rape Crisis Centre were not requested in sufficient detail. The information requested specific training for working with survivors of rape and general education, however the counsellors may have had other relevant experience, work or training which may have been pertinent to the study. For example, the counsellors may be employed elsewhere in conjunction with their volunteer work at the Rape Crisis Centre, which would have been additional confounding variables if they were exposed to other forms of trauma caseloads, supervision and training outside of the Rape Crisis Centre.

**Hypothesis 3: Age, experience and reduced exposure to trauma survivors are protective factors against the development of vicarious traumatisation**

Age was significantly negatively correlated with vicarious trauma on the PTCI, highlighting that the younger the counsellors the more negative beliefs about the world was expressed. Other studies have also found that younger and less experienced counsellors are more vulnerable to developing vicarious traumatisation (Arvay & Uhleman, 1996; Neuman & Gamble, 1995; Chrestman, 1995; Pearlman &
Mac Ian, 1995). It must also be noted that age was significantly and positively correlated with experience, although experience was not significantly related to any of the measures. There was no relationship between age and the degree of empathy reported on the MEEQ. This finding could be explained that with age comes experience and with experience comes an increase in coping skills and knowledge which helps to contain and assimilate exposure to trauma.

Another finding was that the more hours a week the counsellors worked the less empathy was expressed on the MEEQ. Other studies have also found a significant relationship between the percentage of trauma cases in their caseload and PTSD symptomology (Munroe, 1991, Arvay & Uhleman, 1996; Schauben & Frazier, 1995). Both caseload intensity and the number of hours worked involve the degree of exposure to trauma within the workplace. This result is therefore not surprising as the counsellors who are exposed to more trauma during the week may find that they are exposed to longer periods of required empathic engagement with traumatic material and repeated strong negative countertransferences. As empathic strain and vicarious traumatisation is cumulative (McCann & Pearlman, 1990a); the greater the exposure the more vulnerable counsellors become to empathic strain. It would appear that a reduction in empathy is related to increased exposure to sexually traumatised clients as consistent with the literature. Again the questions eliciting information regarding age and experience were not specific which limited this study.

**Hypothesis 4: Counsellors without past experience of trauma will show more empathy and less vicarious trauma (symptoms and beliefs) and those counsellors with a history of personal sexualised trauma will show low empathy and more vicarious trauma (symptoms and beliefs). Personal experience of counselling is associated with vicarious traumatisation and empathic strain**

The high prevalence of past histories of personal trauma in this sample was comparable to that reported in other studies (Pearlman & Mac Ian, 1995). It was clear from the data that if one form of past physical trauma was acknowledged then there was an increased likelihood of other trauma types occurring. This may have been because one incident had occurred which involved all aspects of the trauma requested. For example, someone who had been raped may have responded in the affirmation to the question about past sexual assault, but also ticked the sexual harassment and
physical assault questions, as this would have occurred within the experience of rape. Therefore one incident could have been accounted for in several ways leading to a high association between the trauma types. It may also be true that someone who has had one experience of assault may be more vulnerable to further assault. For example someone who was abused as a child may go on to repeat relationship patterns in the future with potential abusers and so are re-abused as an adult due to problems with low self-esteem (Meiselman, 1978; cited in Hall & Lloyd, 1993).

In this sample, the participants who had been sexually harassed had significantly more years experience than those who had not been the victim of sexual harassment. The fact that a history of sexual harassment was significantly related to more years of experience working with rape survivors may be due to the level of exposure to sexual victimisation and gender issues which may increase awareness of those power issues within one’s own experiences. In addition, this may also be a cohort effect, in recent years there has been an increase in general awareness of, and intolerance to, sexual harassment that prevails now, which may mean that sexual harassment may be either more subtle or be less evident in society now. No other changes had been noted between groups who had experienced either a physical or sexual assault or not.

In this study, a history of sexual harassment was significantly associated with having more negative beliefs about the self, although had no impact on empathy. In addition, those with a history of sexual harassment had higher total scores on the PTCI than those who had not been sexually harassed. Although it remains unclear whether the high negative beliefs about the self scores are due to the assault itself or due to the assault history making counsellors less able to deal with client’s experiences. The elevated scores on the measures of vicarious trauma were in line with most of the literature, which proposes a personal experience of being a victim of a trauma is a risk factor (Allt, 1999; Kassam-Adams, 1994; Pearlman & Mac Ian, 1995). In particular, a history of sexualised victimisation appears to have the most significant relationship to vicarious trauma symptoms as physical abuse alone did not have any significant relationship with any of the dependent outcome measures. This is seemingly in contrast to most studies which show that in general counsellors are at risk of developing negative beliefs about ‘others’ rather than the self (Schauben & Frazier, 1995; Pearlman & Mac Ian, 1995). In Schauben and Frazier’s study however,
negative beliefs about the world was not related to a personal history of trauma (Schauben & Frazier, 1995). In addition, Pearlman and Mac Ian (1995) did elicit negative beliefs about the self in terms of self-esteem and self-trust as well as negative beliefs about ‘others’ when participants had a personal trauma history. Therefore it would appear that working with sexual assault survivors in conjunction with a personal sexualised victimisation history does significantly relate to negative beliefs about the self. Within the literature, it was suggested that childhood abuse has a stronger relationship to vicarious traumatisation than trauma that has occurred in adulthood (Kassam-Adams, 1994). However due to the imprecise nature of the way respondents answered the ‘how long ago did the assault occur?’ and the group categorisation of the age variable it was not possible to separate the group out in this way (child abuse versus adult abuse). This is a limitation of the present study.

Whether or not the participants had counselling or not appeared to have a significant relationship to several of the measures. Those participants who had received counselling for personal trauma had significantly higher levels of vicarious trauma on the STQ and the PTCI. Counsellors who had received counselling reported more negative beliefs about the self than the counsellors who had never received counselling. An association between past counselling and heightened levels of vicarious trauma had been found in an earlier study (Pearlman & Mac Ian, 1995) with regard to whether people had spoke about their client work within their personal sessions. This study did not explore whether or not the participants discussed their work in therapy or not but instead examined the effect of having personal therapy for a past traumatic assault or episode of harassment. The results suggest that those who have personal therapy have higher levels of reported vicarious traumatisation. This may be because those who had gone into counselling may have had been more seriously affected by their personal experiences. Those who had undergone personal therapy had significantly more experience, worked significantly more hours a week and were more likely to be qualified. However, working more hours a week, being qualified and having more experience alone did not significantly affect the measures of vicarious trauma. Therapy may increase an individual’s awareness of the impact of their work which may heighten reports of those effects. It may be possible that other counsellors may be less aware of their beliefs or be explaining vicarious trauma symptoms as resulting from other phenomenon, for example, losing sleep from
feeling unwell. The effect of counselling needs further exploration in any follow-up studies. The possible influence of having a past trauma alone will be discussed next.

**Hypothesis 5: Overall high levels of empathy are related to the development of vicarious traumatisation (when dealing with highly affective trauma like sexual trauma).**

The higher the reported levels of empathy, the higher the reported symptoms of vicarious trauma on the STQ and the higher the reported negative beliefs about the world and the self. High levels of empathy are therefore associated with higher reported experiences of vicarious traumatisation within rape counsellors. This finding appears to support the theories of the impact of empathic engagement with rape victims (Martin et al, 1996). The theory that high empathy may lead to vicarious traumatisation when the trauma is highly emotive or personal for the professional appears to have support within this study. The participants also have a significant personal history of similar trauma experiences to their clients, which may have increased their vulnerability to developing vicarious traumatisation.

In the multiple regression analysis, empathy always significantly predicted the measures of vicarious trauma (STQ and PTCI-total) over and above other contributing variables such as personal counselling, past experience of sexual harassment and age. The role of empathy is therefore strongly implicated in the development of vicarious trauma as hypothesised within the literature (McCann & Pearlman, 1990a; Wilson & Lindy, 1995). The most significant contributing variable to empathy was the number of hours worked, the more hours worked the less empathy respondents reported that they felt, which is supported by theories surrounding empathic strain (Wilson & Lindy, 1994). The number of hours worked contributed over and above the value of negative beliefs about the world and the self, which may support the hypothesis of the cumulative effects of exposure to trauma.

**Implications of Research**

In determining the risk factors for vicarious trauma, this study tentatively found that working on the phone-lines and being less qualified did not appear to have a significant relationship with empathic strain and vicarious trauma. However being younger, having personally been the victim of a past sexual assault and receiving
counselling for that assault seemed to increase a counsellor’s risk of developing vicarious trauma. In line with most of the research, specifically a history of sexual trauma rather than physical assault was significantly associated with vicarious trauma (Allt, 1999; Kassam-Adams, 1994; Pearlman & Mac Ian, 1995). In addition, the demonstrated relationship between vicarious trauma and empathy further appeared to support the theory surrounding the development of vicarious traumatisation. The theory that high empathy may lead to vicarious traumatisation when the trauma is highly emotive for the professional appears to have support within this study.

The contribution of age is however an interesting phenomenon, age was significantly negatively correlated with vicarious trauma on the PTCI, highlighting that the younger counsellors reported more vicarious trauma beliefs as found in other studies (Arvay & Uhleman, 1996; Pearlman & Mac Ian, 1995). However, if vicarious trauma results from a cumulative process and, age is significantly related to experience, then it could be expected that the older, more experienced counsellors, having had greater exposure would have reported more vicarious traumatisation. Although, the finding that more hours of work a week relates to less empathy supported the theory that empathic strain and vicarious traumatisation results from a cumulative process (McCann & Pearlman, 1990a), this was not true for experience or age. The theory has not accounted for this discrepancy in the literature. This finding could be explained that with age comes an increase in coping skills, which may help older more experienced counsellors cope with working with trauma. A longitudinal study would be of interest, which could monitor the changes that occur in beliefs and symptoms of vicarious trauma over time. It may be that younger counsellors who find it distressing to work with survivors of sexual assault leave and those who cope well continue to work with trauma cases. Therefore over time the sample may split into older counsellors who do not experience affective distress and younger counsellors who do and who may leave soon. The role of ageing and experience needs to be further considered with regard to its effects on empathic strain and vicarious traumatisation.

Critique

The main strengths of the study are that for the first time the relationship between empathy, vicarious trauma and the affects of working with rape victims has been
explored in rape counsellors. This has brought some broad areas of research together and has hopefully contributed to the theory. In addition, this study has also looked at the specific impact of a variety of different interpersonal forms of past trauma and found a relationship between a past history of sexual victimisation and an increase in vicarious traumatisation. A further strength of the study is that it has found an effect of having had counselling in the past and the vulnerability involved in working longer hours with trauma survivors rather than examining caseload alone.

The first important criticism of the study was the low return rate (15.9%) of the questionnaires. During this study a few of the counsellors stated that they are asked to participate in a number of studies and due to most of the counsellors working a few hours a week on a volunteer basis, they do not always have the time to co-operate with research projects. However, compared to other studies who have used a similar population of volunteer part-time workers and who had a response rate of 32% and 42% respectively (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995) the response rate was still low. They may be several reasons for this, it may be due to practical considerations but it may also be due to the nature of the project. In addition, the study relied on a third party to distribute the questionnaires, which means that it was not possible to ensure that all of the potential participants were reached. The study was exploring counsellors’ responses in terms of empathic strain and the presence of vicarious trauma symptoms. One of the ways individuals cope with difficult emotions and empathic strain is to deny and withdraw from engagement with material which may make them have to deal with and accept the nature of trauma work and its impact (Wilson & Lindy, 1994). The lack of participation with this study may be an indication of the level of denial and withdrawal evident within this population given the extent of the negative beliefs about the self and the world present within the sample that did take part in the project. Otherwise, the lack of response may be a reflection of the sensitive nature of some of the questions, which asked about prior personal victimisation. In addition, there were a couple of comments with regard to the way items were phrased in the standardised questionnaires, which may have reduced interest in the project.

Further limitations of the study are that although the counsellors past trauma history has been investigated in more detail, the way the question was asked lead to vague
answers wherein it was difficult to establish whether past assaults happened as a child or as an adult. The questions referring to demographic information and occupational training and experience also limited the study due to their lack of specificity. More information on past work experience, concurrent practice, and possible additional training and supervision outside of the Rape Crisis Centre would have been more helpful. Further criticisms were that other measures would have been useful to have incorporated into the study. The Traumatic Stress Institute Belief Scale (Pearlman, 1995) which assesses the disruptions to the basic psychological needs and the Posttraumatic Stress Disorder Scale (PSS-SR: Foa, Riggs, Dancu and Rothbaum, 1993) which would have been better to establish the percentage of the sample who had PTSD symptoms at a clinical level could have been used instead. In addition, using questionnaires can mean that the subtleties of the emotional responses in therapy, the empathic engagement and the effect on beliefs can be missed and confined to the concepts and factors used to create the questionnaires. This may mean that further relevant issues have not been discovered. In addition it is hard to establish whether the level of vicarious trauma beliefs and symptoms found within this population is due to their exposure to trauma work with survivors or to their past trauma experiences due to the high prevalence of past personal trauma in the counsellors' histories.

The sample in this study consisted solely of female respondents. The view of male counsellors would also be of interest to this area of study, as would the specific view of counsellors of male survivors of rape and whether gender biases occur within therapy between counsellor and victim. Within the general literature, men show reduced empathy for victims, especially for sexually traumatised victims (Sinclair & Bourne, 1998). However, the contributory factor of gender still remains unclear as in most of the studies female participants dominate and so male reactions to working with trauma victims is not represented. In addition, due to the low return rate this sample may be self-selective and not representative of the sample population as a whole; those who did not respond may have different views and responses.

**Implications for Future Research**

In future research it would be useful to ask a more direct question about whether the counsellor has experienced their trauma has a child versus as an adult and to elicit
more specific demographic and occupational information. It would also be interesting for further research to be conducted within a qualitative model as the interplay between past trauma, the effects of personal counselling, the changes of beliefs about the self and others over time in the possible development of empathic strain and vicarious trauma is complicated.

The introduction of male therapist’s responses or the responses of counsellors to male survivors of rape and sexual abuse would also be relevant for future research. In Hartman and Jackson’s chapter on rape and countertransference reactions, a male therapist talks of meeting an attractive man who had been forcibly raped: “A part of me thought, “Why didn’t he do something?...for me rape happens to females, not to me, not to males...the first time I really felt traumatised was, I heard this guy tell of his rape.. I notice that things are impacting on me more” (Hartman & Jackson, 1994, p.228).

Conclusion

This study has suggested that age, exposure to sexual trauma work and a personal history of trauma and counselling are risk factors for vicarious trauma but that specific training in a formal counselling qualification or the medium of contact are not contributing risk or protective factors. This study has also appeared to demonstrate a significant relationship between empathy and vicarious trauma which supports the initial theory on vicarious traumatisation (Pearlman & Mac Ian, 1990a). Further exploratory studies would be of some benefit for future research as they could examine in more detail the particular impact of having experienced personal counselling and potentially exploring changing beliefs in counsellors within a longitudinal methodology. Future research within this area would help to make explicit the vulnerabilities of rape crisis counsellors who work within a very challenging area, which would hopefully enable adequate training, supervision, support and awareness of vicarious traumatisation to take place to guard against its effects. Although support and awareness is apparent within rape crisis centres, the field of research needs to further contribute to our understanding of this area to enable more support and education to be provided.
References


Clare, S (2002). *What are the risk factors associated with the development of vicarious trauma in therapists?* Unpublished Thesis


Appendix 1

Posttraumatic Stress Disorder: Diagnostic Criteria (APA, 1994).
A subject is said to have PTSD if:

A. Existence of a recognisable stressor that would evoke significant symptoms of distress in almost everyone.

B. Reexperiencing of the trauma as evidenced by at least one of the following:
   1. Recurrent and intrusive recollections of the event.
   2. Recurrent dreams of the event.
   3. Sudden acting or feelings as if the traumatic event were reoccurring because of an association with an environmental or ideational stimulus.

C. Numbing of responsiveness to, or reduced involvement with, the external world beginning some time after the trauma, as shown by at least one of the following:
   1. Markedly diminished interest in one or more significant activities
   2. Feeling of detachment or estrangement from others
   3. Constricted affect

D. At least two of the following symptoms that were not present before the trauma:
   1. Hyperalertness or exaggerated startle response
   2. Sleep disturbance
   3. Guilt about surviving when others have not, or about behaviour required for survival.
   4. Memory impairment or trouble concentrating
   5. Avoidance of activities that arouse recollection of the traumatic event
   6. Intensification of symptoms by exposure that symbolise or resemble the traumatic event.
Appendix 2

Ethics approval letter
I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol, and the subsequent information supplied, and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, these Guidelines can be downloaded from the Committee's website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (ACE/2001/47/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Date of approval by the Advisory Committee on Ethics: 11 September 2001
Date of expiry of approval by the Advisory Committee on Ethics: 10 September 2006

Please inform me when the research has been completed.

Yours sincerely

Secretary, University Advisory Committee on Ethics

cc: Chairman, ACE
    Supervisor, Dept of Psychology
Appendix 3

The cover letter
Dear Sir/Madam

Re: The investigation of vicarious trauma in face-to-face and phone counsellors dealing with survivors of rape.

Thank you for considering taking part in this research project. Please find the enclosed information sheet, consent form and questionnaire.

Please return all responses as soon as possible in the envelopes provided, preferably by the end of December. Could each individual’s consent form be sent back separately in the collection envelope provided.

I will automatically send a follow-up letter at the beginning of December in order to remind potential participants about the questionnaire.

Thank you

Yours sincerely

Trainee Clinical Psychologist
Psychology Department
Clinical Psych.D
Appendix 4

The consent to research form
CONSENT TO RESEARCH FORM

The Investigation of Vicarious Trauma in Face-to-face and Phone Counsellors Dealing with Rape Victims

Please answer the following questions below:

Have you read the information sheet about the research project? Yes/No

Has the study been explained to you clearly so that you understand what is involved? Yes/No

Do you feel you have enough information about the study to make a decision? Yes/No

Do you understand that you are free to leave the study at any time, without having to give a reason? Yes/No

If you have answered yes to all of the above questions and are satisfied then please read the following statements and sign below.

I consent to participate in the research into the impact of working with rape victims on female therapists' in terms of empathic strain and vicarious trauma. I understand that participation is voluntary and I can withdraw my consent at any time.

I understand that participation will involve the completion of six very brief questionnaires which will take approximately fifteen to twenty minutes of my time. I consent to the use of the information obtained from the questionnaires for research purposes.

I understand that data collection will be confidential and identifiable by an assigned number only.

Signed by participant: Date:

Signed by witness: Date:

As the researcher, I agree to maintain confidentiality by assigning the data a number, by which the participants shall be known thereafter.

Signed by researcher: Date:

Please return in main Consent Form Collection envelope
Appendix 5

Information sheet.
INFORMATION SHEET

The Investigation of Vicarious Trauma on Face to Face and Phone Counsellors Dealing with Rape Victims

Researcher:

Supervised by:

What is the research about?

The research is trying to establish whether female rape counsellor's exposure to the trauma experienced by their clients leads to the development of vicarious trauma.

Why are rape counsellor's of interest?

The literature recognising vicarious trauma and empathic stress reactions among counsellors of rape victims is growing. This study hopes to contribute to the literature by examining rape counsellor's attitudes towards, and therapeutic relationship with, survivors of rape. In addition, some questions are concerned with counsellor's level of training and personal experience of trauma. This study has the potential benefit of being able to examine counsellor's experiences of posttraumatic stress symptoms, which will help inform supervision practices and support for rape crisis counsellors.

What do I have to do?

Participation in this research will involve completing a questionnaire and a consent form which will take about 15 to 20 minutes. The questionnaire consists of a number of standardised measures, and will include a number of closed questions about your beliefs about rape and some personal questions about your experience of trauma. If you do not feel comfortable about this, then please do not complete the questionnaire. If you have any questions or would like to discuss the questionnaire in advance, you can contact a researcher at the address below, please write and provide a contact name and number so that a researcher can contact you. The personal details at this stage will not be used for identification of questionnaires subsequently received. If you have completed the questionnaire and consent form please send them back separately in the prepaid envelopes provided. Consent can be withdrawn at any point until the receipt of the questionnaire and no explanation is required. After this time it will no longer be possible to identify a questionnaire as any individuals.

When will this happen?

The aim is to distribute the questionnaire at the end of September 2001 and the hope would be that all questionnaires will be returned by the end of December 2001. During December a reminder will be sent to the organisation as a whole about the questionnaires.

Then what happens?

The information from the questionnaires will be analysed and treated confidentially and used only for the purpose of the study. All responses will be anonymous.

Thank you for your time and co-operation. Should you wish to ask for more information, then please contact
Appendix 6

The reminder letter
Dear Sir/Madam

Re: The Investigation of Vicarious Trauma in Face to Face and Phone Counsellors Dealing with Rape Victims

I recently sent some questionnaires regarding the above research study. The research was trying to establish whether the rape trauma that counsellors of sexual violence are exposed to, leads to the development of vicarious trauma.

This study is very important, as your experiences will help contribute to the growing literature and awareness of vicarious posttraumatic stress symptoms in trauma counsellors. It is hoped that this research will help inform future supervision practices and support within the NHS.

Participation in this research will involve completing the questionnaire and consent form that were provided last September, which will take about 15 to 20 minutes of your time. Your contribution will make a difference, however if you do not feel comfortable about this, then please do not complete the questionnaire. Consent can be withdrawn at any time until receipt of the questionnaire due to their anonymity and no explanation is required. All questionnaires will be treated confidentially. It is hoped that the questionnaires will be returned by the end of December 2001.

If more questionnaires are required please contact the researcher at the address below. If you have already sent in your questionnaire, please ignore this letter.

Thank you for your time and co-operation.

Yours sincerely,

Should you wish to ask for more information, then please contact
Appendix 7

The Questionnaire
The Investigation of Vicarious Trauma in Face to Face and Phone Rape Counsellors Dealing With Rape Victims

DEMOGRAPHIC INFORMATION SHEET
Please answer as fully as you can or circle appropriate information when necessary.

Gender:  
| Female | Male |

Post:  
| Counsellor | Phone Counsellor |

Brief job description:  

Age Group:  
| Under 25 | 26 to 35 | 36 to 45 | 46 to 55 | 56 to 65 | Over 66 |

Years of Experience with Rape Victims:
Education:
Specific training for rape counselling (past and ongoing):

Approximately how many hours contact a week do you work with victims of rape?:
Approximately how many hours of supervision a month do you receive?:
Approximately how much support are you able to access?

QUESTIONNAIRE
Consider a negative experience or experiences that happened to a client, which you remember vividly. What was the negative experience?

For the items below, circle the number that best describes how you think and feel about the events above.

<table>
<thead>
<tr>
<th>Rarely/never</th>
<th>At times</th>
<th>Not sure</th>
<th>Often</th>
<th>Very often</th>
</tr>
</thead>
</table>

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/memories) related to their problems

6. I am frightened by things that 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 experiences.

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 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.
For the items below, please think about how you think and feel generally. Please tick any statements that you agree with and put a cross next to any that do not apply to you.

1. It makes me sad to see a lonely stranger in a group. _____
2. People make too much of the feelings and sensitivity of animals. _____
3. I often find public displays of affection annoying. _____
4. I am annoyed by unhappy people who are just sorry for themselves. _____
5. I become nervous if others around me seem to be nervous. _____
6. I find it silly for people to cry out of happiness. _____
7. I tend to get emotionally involved with a friend's problems. _____
8. Sometimes the words of a love song can move me deeply. _____
9. I become nervous if others around me seem to be nervous. _____
10. The people around me have a great influence on my moods. _____
11. Most foreigners I have met seemed cool and unemotional. _____
12. I would rather be a social worker than work in a job training centre. _____
13. I don't get upset just because a friend is acting upset. _____
14. I like to watch people open presents. _____
15. Lonely people are probably unfriendly. _____
16. Seeing people cry upsets me. _____
17. Some songs make me happy. _____
18. I really get involved with the feelings of the characters in a novel. _____
19. I get very angry when I see someone being ill-treated. _____
20. I am able to remain calm even though those around me worry. _____
21. When a friend starts to talk about his problems, I try to steer the conversation to something else. _____
22. Another's laughter is not catching for me. _____
23. Sometimes at the movies I am amused by the amount of crying and sniffling around me. _____
24. I am able to make decisions without being influenced by people's feelings. _____
25. I cannot continue to feel OK if people around me are depressed. _____
26. It is hard for me to see how some things upset people so much. _____
27. I am very upset when I see an animal in pain. _____
28. Becoming involved in books or movies is a little silly. _____
29. It upsets me to see helpless old people. _____
30. I become more irritated than sympathetic when I see someone's tears. _____
31. I become very involved when I watch a movie. _____
32. I often find that I can remain cool in spite of the excitement around me. _____
33. Little children sometimes cry for no apparent reason. _____

For the next items, please tick the statements you agree with and put a cross next to the statements that you do not agree with.

1. I've found that a person rarely deserves the reputation he has. _____
2. Basically, the world is a just place. _____
3. People who get "lucky breaks" have usually earned their good fortune. _____
4. Careful drivers are just as likely to get hurt in traffic accidents as careless ones. _____
5. It is a common occurrence for a guilty person to get off free in British courts. _____
6. Students almost always deserve the grades they receive in school. _____
7. Men who keep in shape have little chance of suffering a heart attack. _____
8. The political candidate who sticks up for his principles rarely gets elected. _____
9. It is rare for an innocent man to be wrongly sent to jail. _____
10. In professional sports, many fouls and infractions never get called by the referee. _____
11. By and large, people deserve what they get. _____
12. When parents punish their children, it is almost always for good reasons. _____
13. Good deeds often go unnoticed and unrewarded. _____
14. Although evil men may hold political power for a while, in the general course of history good wins out. _____
15. In almost any business or profession, people who do their job will rise to the top. _____
16. British parents tend to overlook the things most to be admired in their children. _____
We are also interested in the kind of thoughts which you may have had after working as a counsellor with clients who have experienced traumatic events. Below are a number of statements that may or may not be representative of your thinking. Read each statement carefully and tell us how much you AGREE or DISAGREE with each statement by circling the appropriate number. People react to hearing traumatic events in different ways. There are no right or wrong answers to these statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Totally disagree</th>
<th>Disagree very much</th>
<th>Disagree slightly</th>
<th>Neutral</th>
<th>Agree slightly</th>
<th>Agree very much</th>
<th>Totally agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I can't trust that I will do the right thing.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2. I am a weak person.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3. I will not be able to control my anger and will do something terrible.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4. I can't deal with even the slightest upset.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5. I used to be a happy person but now I am always miserable.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6. People can't be trusted.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7. I have to be on guard all the time.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8. I feel dead inside.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9. You can never know who will harm you.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10. I have to be especially careful because you never know what can happen next</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>11. I am inadequate.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>12. I will not be able to control my emotions, and something terrible will happen</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>13. If I think about the events described to me, I will not be able to handle it.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>14. My reactions since hearing about the events mean that I am going crazy.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>15. I will never be able to feel normal emotions again.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>16. The world is a dangerous place.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>17. Somebody else would have been able to help more.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>18. I have permanently changed for the worst.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>19. I feel like an object, not like a person.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>20. Somebody else would not have got into this situation.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>21. I can't rely on other people.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>22. I feel isolated and set apart from others.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>23. I have no future.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>24. I can't stop bad things from happening to me.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>25. People are not what they seem.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>26. My life has been destroyed by hearing about the traumatic events.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>27. There is something wrong with me as a person.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>28. My reactions since hearing about the traumatic events show that I am a lousy cop.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>29. I will not be able to tolerate my thoughts about the events described to me, and I will fall apart.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>30. I feel like I don't know myself anymore.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>31. You never know when something terrible will happen.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>32. I can't rely on myself.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>33. Nothing good can happen to me anymore.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
17). It is often impossible for a person to receive a fair trial in Britain.

18). People who meet with misfortune have often brought it on themselves.

19). Crime doesn't pay.

20). Many people suffer through absolutely no fault of their own.

For the next items, please tick the statements you agree with and put a cross next to the statements that you do not agree with.

1). A woman who goes to the home or apartment of a man on their first date implies that she is willing to have sex. ____

2). Any female can get raped. _ _ _

3). One reason that women falsely report a rape is that they frequently have a need to call attention to themselves. ____________

4). Any healthy woman can successfully resist a rapist if she really wants to. ____________

5). When women go around braless or wearing short skirts and tight tops, they are just asking for trouble. ____________

6). In the majority of rapes, the victim is promiscuous or has a bad reputation. ____________

7). If a girl engages in necking or petting and she lets things get out of hand, it is her own fault if her partner forces sex on her. ____________

8). Women who get raped while hitchhiking get what they deserve. ____________

9). A woman who is stuck-up and thinks she is too good to talk to guys on the street deserves to be taught a lesson. ____________

10). Many women have an unconscious wish to be raped, and may then unconsciously set up a situation in which they are likely to be attacked. ____________

11). If a woman gets drunk at a party and has intercourse with a man she's just met there, she should be considered "Fair game" to other males at the party who want to have sex with her too, whether she wants to or not. ____________

12). What percentage of women who report a rape would you say are lying because they are angry and want to get back at the man they accuse? ____________

13). What percentage of reported rapes would you guess were merely invented by women who discovered they were pregnant and wanted to protect their own reputation? ____________

The following questions ask about traumatic events that may have happened to you, either when you were a child or an adult. This information is important as we are trying to establish if prior traumatic experiences have an impact on a professionals' experience of working with trauma victims. We appreciate that answering this may be difficult, but we would be very grateful if you could answer the questions below. Please indicate with a tick whether you have experienced the traumatic event/s outlined below:

- Being physically assaulted or mugged?
- Have you ever been sexually harassed?
- Have you ever been sexually assaulted?
- If yes to any of the above questions, how long ago did the attack occur?
- If yes, was counselling sought for the attack?
- Any additional comments? (Especially about more positive aspects of your work)

Your individual information will not be fed back to your employers. The research project will be submitted during summer 2002. If after this time your organisation would like a copy of the report then please contact Sarah Clare at the address outlined on the information sheet, separate from the mailing of your consent form or questionnaire. Any report would be given to the organisation as a whole and will be representative of all participants' views.
Appendix 8

The groups were not significantly different with respect to any of the demographic variables when they were separated according to whether the participants had any experience of physical assault in their past.
Background Characteristics of the Sample: Groups Based on whether Participants have been Physically Attacked in the Past

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>History of Physical Attack (N = 33)</th>
<th>No History of Physical Attack (N = 68)</th>
<th>Total</th>
<th>Statistic</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 45</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N(%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>20 (60.6)</td>
<td>40 (58.8)</td>
<td>60 (59.4)</td>
<td></td>
<td>.864 ns</td>
</tr>
<tr>
<td>Over 45</td>
<td>13 (39.4)</td>
<td>28 (41.2)</td>
<td>41 (40.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years of Experience$^1$</td>
<td>Mean (s.d)</td>
<td>Mean (s.d)</td>
<td>Mean (s.d)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.40 (5.86)</td>
<td>4.94 (4.53)</td>
<td>5.09 (4.98)</td>
<td></td>
<td>.638 ns</td>
</tr>
<tr>
<td>Medium of Contact</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Face-to-face</td>
<td>24 (72.7)</td>
<td>53 (77.9)</td>
<td>77 (76.2)</td>
<td>U = 933.0</td>
<td>.564 ns</td>
</tr>
<tr>
<td>Phone only</td>
<td>9 (27.3)</td>
<td>15 (22.1)</td>
<td>24 (23.8)</td>
<td>(1,1) = .333</td>
<td></td>
</tr>
<tr>
<td>Counselling Qualification</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>21 (63.6)</td>
<td>34 (50)</td>
<td>55 (54.5)</td>
<td>(1,1) = 1.666</td>
<td>.197 ns</td>
</tr>
<tr>
<td>No</td>
<td>12 (36.4)</td>
<td>34 (50)</td>
<td>46 (45.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work Hours per week$^2$</td>
<td>Mean (s.d)</td>
<td>Mean (s.d)</td>
<td>Mean (s.d)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.74 (6.11)</td>
<td>4.92 (4.26)</td>
<td>5.19 (4.92)</td>
<td>U = 956.</td>
<td>.773 ns</td>
</tr>
<tr>
<td>Supervision Hours per month$^3$</td>
<td>Mean (s.d)</td>
<td>Mean (s.d)</td>
<td>Mean (s.d)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.58 (2.35)</td>
<td>1.95 (1.07)</td>
<td>2.16 (1.63)</td>
<td>U = 898.5</td>
<td>.318 ns</td>
</tr>
</tbody>
</table>

$^1$ N = 31 (History of Physical Attack), N = 64 (No History of Physical Attack)
$^2$ N = 31 (History of Physical Attack), N = 64 (No History of Physical Attack)
$^3$ N = 32 (History of Physical Attack), N = 64 (No History of Physical Attack)
Appendix 9

The groups were not significantly different with respect to any of the demographic variables when they were separated according to whether the participants had any experience of sexual assault in their past.
Background Characteristics of the Sample: Groups Based on whether Participants have been Sexually Attacked in the Past

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>History of Sexual Attack (N = 53)</th>
<th>No History of Sexual Attack (N = 48)</th>
<th>Total</th>
<th>Statistic</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>N (%)</td>
<td>N(%)</td>
<td>N (%)</td>
<td>Chi²</td>
<td></td>
</tr>
<tr>
<td>Under 45</td>
<td>28 (52.8)</td>
<td>32 (66.7)</td>
<td>60 (59.4)</td>
<td>(1,1) = 2.0</td>
<td>.157 ns</td>
</tr>
<tr>
<td>Over 45</td>
<td>25 (47.2)</td>
<td>16 (33.3)</td>
<td>41 (40.6)</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Years of Experience⁴</td>
<td>Mean (s.d) 6.01 (5.47)</td>
<td>Mean (s.d) 4.07 (4.19)</td>
<td>5.09</td>
<td>U = 890.5</td>
<td>.079 ns</td>
</tr>
<tr>
<td>Medium of Contact</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>Chi²</td>
<td></td>
</tr>
<tr>
<td>Face-to-face</td>
<td>40 (75.5)</td>
<td>37 (77.1)</td>
<td>77 (76.2)</td>
<td>(1,1) = 0.036</td>
<td>.849 ns</td>
</tr>
<tr>
<td>Phone only</td>
<td>13 (24.5)</td>
<td>11 (22.9)</td>
<td>24 (23.8)</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Counselling Qualification</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>Chi²</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>32 (60.4)</td>
<td>23 (47.9)</td>
<td>55 (54.5)</td>
<td>(1,1) = 1.577</td>
<td>.209 ns</td>
</tr>
<tr>
<td>No</td>
<td>21 (39.6)</td>
<td>25 (52.9)</td>
<td>46 (45.5)</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Work Hours per week⁵</td>
<td>Mean (s.d) 5.86 (5.48)</td>
<td>Mean (s.d) 6.73 (3.27)</td>
<td>5.19</td>
<td>U = 917.</td>
<td>.129 ns</td>
</tr>
<tr>
<td>Supervision Hours per month⁶</td>
<td>Mean (s.d) 2.20 (1.80)</td>
<td>Mean (s.d) 2.11 (1.42)</td>
<td>2.16</td>
<td>U = 1136.</td>
<td>.952 ns</td>
</tr>
</tbody>
</table>

⁴ N = 50 (History of Sexual Attack), N = 45 (No History of Sexual Attack)
⁵ N = 52 (History of Sexual Attack), N = 43 (No History of Sexual Attack)
⁶ N = 52 (History of Sexual Attack), N = 44 (No History of Sexual Attack)