A SURVEY OF QUALIFIED CLINICAL PSYCHOLOGISTS WORKING WITH PEOPLE WHO HAVE EXPERIENCED TRAUMA

and

RESEARCH PORTFOLIO

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Many thanks to all the patients and supervisors who have taught me so much, the brilliant class of '99 and of course Sheila. Finally all my love to Greg for his help and devotion.

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What do people think and feel about being neuropsychometrically assessed?

Prepared in accordance with guidelines for submission to Clinical Psychology Forum

(Appendix 1.3)

What do people think and feel about being neuropsychometrically assessed?

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Introduction

The aim of this study was to find how people had found being neuropsychometrically tested. No published studies have examined this area, although in occupational psychology work has been carried out which examines "impact validity", a term used to describe "the extent to which a measuring instrument has an effect on the subject's psychological characteristics", (Robertson and Smith 1989). Within clinical psychology

research has looked at how people found filling in psychometric questionnaires, (Elcombe and Westbrook, 1996; Milne and Dawson, 1997).

The following areas were thought relevant:

i) Perceived reason for referral and feedback of results.

ii) Possible client concerns that the assessment may have had a hidden agenda.

iii) Ecological validity. How relevant did the individual find the testing to their everyday lives?

iv) Impact. What did the assessment make individuals feel about themselves?

v) Value, to the client and the service providers, of the client providing formal feedback regarding the psychometric assessment.

Design and Method

Participants: People who had been neuropsychometrically assessed within the last year were identified using the department's database. The psychologists who had seen them were supplied with their basic details, the proposed interview's content, and asked to

comment on suitability for interviewing. 7 people were not deemed suitable as were 4 too cognitively impaired, 3 unlikely to agree or attend and 1 had died. 18 opt out letters were sent and 4 people declined to be interviewed. 14 interviews were arranged, but 1 person had gone into residential care, and 1 interview was unusable because the person was unable to recall any part of the assessment. The 7 female and 5 male participants had been seen in 3 main specialties, adult mental health (6), older adults (4) and substance misuse (2). Reasons for the referrals ranged from memory difficulties (7) and other specific difficulties, such as concentration (1), to referrals for the assessment of suspected multiple cognitive impairments (4).

Design: Suitable individuals were sent an opt out letter **(Appendix 1.1)**. An addressed, stamped envelope was provided and if they did not return the tear off strip within a week, they were contacted by telephone or post to arrange a suitable venue (the department, or their home) and time. The interviews were semi-structured, consisting of open ended questions, analogue scales and a word checklist **(Appendix 1.2)**, and were designed to answer the aims of the project. The interviews lasted about twenty minutes and the tests that had been used were taken to the interview and used as a prompt as required.

Results

Before the psychometric testing

A. Had anyone told you that you were being referred to a Clinical Psychologist?

6 recalled being referred, 2 said that they had not been told, and 2 were unable to recall. 2 self referred.

B. What was the explanation given?

7 gave a clear account, whilst 3 were unable to remember, and 2 said they had not been given any reason.

C. Who gave you the explanation?

8 described the referrer, 2 could not remember, and 2 said that they had not been given an explanation.

D. What were the worries or concerns that you had before you did the tests?

Results ranged from not having any at all (5), through to feelings of apprehension and general concern (2), to more specific anxieties such as lack of concentration (1), lots of people being present (1), concerns about their state of mind (2), and the possibility that doing badly might lead to being placed in a residential home (1).

During the testing

E. How seriously were your problems taken?

Only 1 person said they were not taken totally seriously, rating this at 80%.

F. How much of a relief was it for you to do the tests?

4 said it provided total relief, 6 thought it had been some relief (rating between 40% and 80%), and 2 said it offered none.

G. How traumatic was it for you?

6 said it had not been at all traumatic, 1 said 40% traumatic, 2 50% and 3 60%.

H. Were the tests a waste of time?

Nobody thought the tests a waste of time.

I. How valuable did you find the tests?

Only 1 person said they had not been valuable. 10 rated the tests' value at 100% and 1 at 20%.

J. How much relevance did you think the tests had to your everyday life?

1 said the tests had had 100% relevance, 2 said 80%, 3 50%, 1 40%, 1 30% and 2 said none. 1 person said they were "just answering the questions and trusting the doctors", and another said that the questions "would need to be relevant to be doing it at all".

K. What were your fears during the testing?

6 had none. The others ranged from annoyance that they could not say the answers even though they thought they knew them (1), feeling silly or a bit stupid (2), fears about becoming confused (1), not getting a good result (1), and not being able to concentrate (1).

L. <u>What was it like being tested?</u>

This part of the interview was analysed using S.P.S.S./P.C.+. The 5 most commonly chosen words were interesting (9), helpful (8), satisfying (7), reassuring (7) and thorough (7). Affective tone was assigned to each word (i.e. positive, negative or neutral) and the overall affective balance of words chosen by each person was calculated. 3 selected more negative than positive words, 1 an equal number and 8 more positive words. There was a strong association between individuals choosing on balance more negative words if they had received negative news after the testing, and vice versa.

M. What information did you receive after testing, from the psychologist?

8 were able to summarise the information they had received, and 4 said they had received none.

N. Who else gave you information on how you had done on the tests?

3 said they had received information from others.

O. How much of the results did you understand?

6 said they understood everything, 2 understood most of it (95%, 80%), and the remaining 4 said they had not been given feedback.

P. To what extent did the information cover all your questions?

5 of the participants said that the feedback they received from the Psychologist and others covered all their questions, 2 said 80% had been covered. 1 said 60%. 3 said they had not been given any feedback and 1 person said they had had no questions.

Q. Do you think that this questionnaire should be a regular feature for people who have been tested?

Everybody thought it should be.

R. What changes would you make to it?

1 person suggested it could be put into a different format.

S. Are there any questions that you would like to have been asked but were not?

No suggestions were made.

T. Are there questions that you found difficult to answer?

1 person said that question **J** was difficult to answer because he felt that the tests themselves didn't have much relevance to his everyday life, but that the results certainly did.

U. Are there questions that you would rather have not answered?

Nobody said there were.

Discussion

The results from the "before the psychometric testing" part of the questionnaire are very positive, indicating that only a very low number of people said the they had not been given any details regarding their referral to clinical psychology. It also needs to be borne in mind that some of the cognitive assessments had been carried out a year before the questionnaire was administered, and that some of the participants experienced cognitive impairments. They were also aware that the interviewer was from the same department as the clinical psychologist who had carried out the neuropsychometric assessment, and this may have biased the results.

With regards to the client having concerns that the neuropsychometric assessment had a hidden agenda only 1 person voiced this worry (question **D**), and indeed thought that the research interview had a similar aim. However in contrast to this another participant actually emphasised that she felt nothing had been kept from her.

With regards to the ecological validity (question **J**), only 1 person said that the tests had not had much relevance but added that the results certainly had. It's also interesting to note that 2 people said that they took the tests' relevance for granted.

A gauge of the way the neuropsychometric assessment made the individual feel during the testing was provided by question **L**, and it is encouraging the four most commonly chosen words have positive meanings. Two thirds of the group selected on balance more positive words, which could be interpreted as them having found the experience overall a positive one. This however must be tempered again by the fact that a member of the department was administrating the questionnaire. Correlations of 1 between a number of the words suggest that they mean similar things or that people were choosing them in clusters.

There was a consensus that the questionnaire should be a regular feature and only minor alterations were suggested.

Conclusions

Before and during the testing 50% of the sample described themselves having had anxieties of some sort regarding their performance (question **D** and **K**), and 7 people said it had been traumatic (question **G**), but in contrast to this 10 said it had provided some relief and nobody thought the tests were a waste of time (question **H**).

It would therefore seem that the majority of people described the process of testing as raising anxieties and being traumatic to some extent, but chose mainly positive words to describe the actual testing, and described it as having been valuable. This was in spite of

the fact that half of the sample had received outcome information that had not been positive. This could indicate that although the process of testing may be difficult for some people, the knowledge or reassurance gained is perceived by them to outweigh the difficulties of the testing process.

Recommendations for service provision

The results indicated that a third of the group said they had received no feedback with regards the testing. A possible way of addressing this would be to provide the client with the feedback in a form other than verbal, possibly in written or audio form. This however may not be suitable in all cases.

Reduction of anxieties before and during the testing could also be possibly reduced by the provision of written, or audio taped material which explained the aim of the assessment and outlined some of the common concerns that people may have.

Continued sensitive interaction between the service user and psychologist should also be emphasised in clinical practice.

Recommendations for future research

In retrospect the questionnaire attempted to cover too many different areas of how people may have found neuropsychometric testing. Therefore a possibility for future research might be to look again at some specific questions addressed by this research. The relationship between the purpose of assessment and it's outcome, and the individual's perceptions may be a critical factor, and a worthwhile area of future research.

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Major Research Project Literature Review

A Review of the Literature on Helping Induced Trauma

Prepared in accordance with guidelines for submission to The British Journal of Clinical Psychology (Appendix 2.1)

A Review of the Literature on Helping Induced Trauma

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A Review of the Literature on Helping Induced Trauma

Abstract

The diversity of the concepts of helping induced trauma literature is reviewed, and the main theoretical models, studies and measures used in this area are identified and outlined. The organisational and legal implications of vicarious traumatisation, compassion fatigue and secondary traumatic stress are also examined, and gaps in the literature suitable for possible further research are identified.

Introduction

A large amount of trauma literature has been published since the diagnostic recognition of Post Traumatic Stress Disorder (P.T.S.D.), in 1980, (American Psychiatric Association, 1980), with the majority of this literature focusing upon those who have been directly traumatised, to the exclusion of those who have been traumatised indirectly. This is in spite of the third, and subsequent editions of the Diagnostic and Statistical Manual of Mental Disorders, in their definitions of P.T.S.D., indicating that the mere knowledge of another's experiences can be traumatising. Secondary trauma effects have been observed in family members of Holocaust survivors, (Davidson, 1980); amongst the families of combat veterans, (Solomon et al., 1992), and Figley,

(1989), hypothesised that the same type of mechanisms within a family, that makes trauma 'contagious', operates between traumatised clients and the therapist. It is this last concept that this literature review will focus upon.

Definition of helping induced trauma

Stamm, (1997), reviewed nearly two hundred references from PILOTS, Psychlit, Medline and the Social Sciences Index. Her findings were that, "...there was no routinely used term used to designate exposure to another's traumatic material by virtue of one's role as a helper." However she did find that the four most commonly used terms were, compassion fatigue (Figley, 1989), secondary traumatic stress (Stamm, 1995), vicarious traumatization (McCann and Pearlman, 1990a) and countertransference (Wilson and Lindy, 1994). Compassion fatigue, secondary traumatic stress and vicarious traumatisation, whilst having their own specific definitions, are all thought to develop as a result of the therapist's exposure to their patients' experiences of trauma. Countertransference is seen as being a broader concept, which refers to therapists' reactions to their patients, and can take place outside of exposure to traumatic material. Other terms are also used, the most common of these being burnout. With regards to burnout, the precipitating factors are thought to be increased work load and institutional stress, not trauma.

Theoretical models

There are two main theoretical models which attempt to explain the phenomenon of helping induced trauma.

One of them is the contructivist self-development theory, (C.S.D.T.), (McCann and Pearlman, 1990b), which is the theoretical model underpinning the concept of vicarious traumatisation. This incorporates contemporary psychoanalytic and social cognition theories, with the therapist's responses to hearing clients' traumatic material being shaped by situational characteristics, and the therapist's psychological needs and cognitive schemas. The underlying premise of C.S.D.T. is that individuals construct their own personal reality as they interact with their environment, and therefore create their own unique representational models of the world, (Mahoney, 1981).

C.S.D.T. hypothesises that continuing psychological development depends upon the evolution, and development of three psychological systems. These are, the individual's sense of self, their psychological needs and cognitive schemas. These three systems evolve over the course of an individual's life span, by the processes of assimilation and accommodation. These processes were first described in cognitive developmental theory, (Piaget, 1971), and the evolution of the three systems are referred to by McCann and Pearlman as progressive self development.

In C.D.S.T. the therapist's memory system is also hypothesised to be open to change, in that therapists who listen to accounts of trauma may internalise the memories of their patients, and may have their own memory systems altered either temporarily, or permanently. This idea is based upon the connectionist model of memory, (Lindsay and Read, 1994), and the concept of source monitoring errors, (Whittlesea, 1993). The connectionist model conceptualises memory as being distributed across a network, which consists of interconnected input and output fibres. Whilst the idea of source monitoring errors hypothesises that under certain external conditions, or affective states, an idea based upon a memory or fantasy can be perceived as being original.

Therefore McCann and Pearlman, (1990a), believe that all therapists working with people who have experienced trauma, experience lasting changes to their basic cognitive systems, and that this in turn, may have an impact on their behaviour, feelings, relationships and beliefs. These changes are also thought to have the potential to be pervasive, affect many aspects of the therapist's life, and to be cumulative and permanent.

The other main model of helping induced trauma is that of Figley, (1995). He conceptualises secondary traumatic stress, and secondary traumatic stress disorder, (which he sees as being identical to compassion fatigue), as a syndrome of symptoms equivalent to P.T.S.D., except that the exposure is not directly to the trauma, but to knowledge about a traumatising event, which has been experienced by a significant other. Figley, (1995), hypothesises that the traumatic stress first found in one person,

which can then be found in their helper, is explained by the trauma transmission model. This model suggests that in order to help understand the survivor, the helper needs to identify with the victim and their suffering. In doing this they attempt to answer for themselves the five victim questions. These are, "What happened? Why did it happen? Why did I act as I did then? Why have I acted as I have since? If this happens again, will I be able to cope?", (Figley, 1989). Figley puts forward the idea that the helper tries to answer these questions, for the survivor, in order to change their own behaviour. However in the process of generating new information the helper may experience emotions that are very similar to those of the survivor, and as a consequence may develop compassion fatigue or secondary traumatic stress.

Figley's model of compassion fatigue and McCann and Pearlman's model of vicarious traumatisation, are the main dominant models of vicarious traumatisation in the current literature. There are however a number of critical differences between these models. The model of compassion fatigue is conceptually far simpler than the model of vicarious traumatisation and has fewer supportive studies. It focuses primarily on symptoms and draws a direct analogy with P.T.S.D. Whilst McCann and Pearlman's model places vicarious traumatisation within a larger developmental and systemic context, and draws upon a large number of different theories. The concept of the therapist's memory system being altered either temporarily or permanently, may be brought into question as the evidence cited to support this idea is minimal. McCann and Pearlman, (1990a), also state that all therapists working with people who have experienced trauma, experience

lasting changes to their basic cognitive systems. The currently available research literature does not support this view.

There a number of similarities between the models. Both hypothesise that helping induced trauma develops due to cognitive change. Both theories also attempt to address the variability in individual's schema changes resulting from helping induced trauma. This is an area of cognitive change that is generally poorly understood, (Janoff-Bulman, 1989).

Studies examining helping induced trauma

Although there is a large body of theoretical literature regarding vicarious traumatisation and allied concepts, to the author's knowledge, only three published empirical studies have been carried out in this area, which vary in their emphasis and measures.

Follette, Polusny and Milbeck, (1994), carried out a comparative survey of two hundred and twenty five mental health professionals, and forty six law enforcement officers, who worked with childhood sexual abuse survivors. The measures they used were, the Therapist Response Questionnaire, (T.R.Q.), which was modified from the Therapist Reaction Questionnaire, (Kelly, 1993), the Law Enforcement Response Questionnaire, (L.E.R.Q.), a modified version of the T.R.Q. and the Trauma Symptom Checklist-40, (T.S.C.-40), (Briere and Runtz, 1989).

The results of this study showed that overall, the mental health professionals had low levels of traumatic symptoms and psychological distress, and moderate levels of personal stress. However, they did find that the participants who reported having experienced childhood abuse had significantly higher levels of trauma specific symptoms, but they had significantly more positive coping behaviours to deal with sexual abuse cases. They also found that the proportion of the therapist's current caseload involving sexual abuse was not predictive of trauma symptoms.

By using stepwise multiple regression, they identified use of negative coping, level of personal stress and negative clinical response to sexual abuse cases, as factors which were significantly predictive of trauma symptoms, as measured by the T.S.C.-40. With regards to coping responses, education related to sexual abuse, supervision, consultation and humour were most frequently used.

In 1995, Schauben and Frazier published a study which surveyed one hundred and eighteen psychologists and thirty sexual violence counsellors. The participants were asked details regarding their work and their own victimisation history. They also completed five subscales from the Traumatic Stress Institute (T.S.I.) Belief Scale, (Pearlman and MacIan, 1993), a post traumatic disorder (P.T.S.D.) checklist developed by the authors based upon the revised third edition of the Diagnostic and Statistical Manual of Mental Disorders, (D.S.M.-III-R.), (American Psychiatric Association, 1980), and rated on a five point scale the extent to which they were currently experiencing vicarious traumatisation. They also completed four subscales from the Brief Symptom

Inventory, (Derogatis, 1977), to assess negative affect, the Maslach Burnout Inventory, (Maslach and Jackson, 1986), and answered two open ended questions, regarding the difficult and enjoyable aspects of working with sexual violence survivors.

The results showed that the counsellors who had a higher percentage of sexual violence survivors as clients reported more disruptions in their basic schemas about themselves and others (particularly with regards to the goodness of other people), more symptoms of P.T.S.D. and more self-reported vicarious traumatisation. The most commonly reported difficult aspect of working with survivors were, concerns regarding therapy management, dealing with clients' emotions about the abuse, systemic issues which made it difficult, dealing with their own emotions about the abuse, and hearing about the abuse and changes in their beliefs about the world. The most frequently mentioned positive aspects of working with survivors were, watching clients grow and change, enjoying being part of the healing process, the creativity, strength and resilience of clients, the importance of the work, and various characteristics of the work environment. The strategies most commonly used by counsellors included active coping, seeking emotional support, planning, seeking instrumental social support and humour.

In the same year, Pearlman and MacIan carried out a survey of one hundred and eighty eight self identified trauma therapists, (Pearlman and MacIan, 1995). The measures used included the T.S.I. Belief Scale (Pearlman, 1996), the Impact of Event Scale, (Horowitz, Wilner and Alvarez, 1980), the Symptom Checklist-90-Revised, (S.C.-90-R.), (Derogatis, 1977), and the Marlowe-Crowne Social Desirability Scale,

(Crowne and Marlowe, 1964). They found that the greater proportion of the therapist's clinical work devoted to trauma work, the fewer disruptions there were in the therapist's self-trust schemas. As regards the length of time doing trauma work, those therapists who had less experience had the most disruptions in their self-trust, self-intimacy and self esteem schema, as measured by the T.S.I. Belief Scale, and also higher overall symptoms as measured by the S.C.-90-R.

A number of related studies have also been published which support the concept of vicarious traumatisation. These include Lyon, (1993), who looked at staff reactions, reported during supervision and training, over a one year period whilst working with hospitalised patients' who had been abused as children, and also examined the results of an informal staff questionnaire. They found after an analysis of the staff reactions that there were three major themes: 1) the contaminating quality of the abuse descriptions, 2) feelings of isolation from other staff and from friends, 3) questions of good and evil.

In 1997 an article was published by Astin which described her personal experiences of working with people who have been raped, and how her work challenged her schemas about the world and others.

Alexander, de Chesnay, Marshall, Campbell, Johnson and Wright, (1989), looked at a more indirect way in which people were affected, when they reported that several nurse researchers, whilst assisting in a case record review of over a thousand rape crisis centre records, to determine demographic predicators of sexual abuse, experienced reactions

such as anger, dreams, fear of physical injury and sleep disorders. These responses were thought to closely parallel those reported in the literature on rape victims.

There have also been a number of unpublished studies which have empirically examined vicarious traumatisation. These include Munroe, (1991), who found in a study of one hundred and thirty eight therapists in Veterans Administration facilities, that current and cumulative exposure to combat-related clients correlated significantly with intrusive symptoms. Whilst Kassam-Adams, (1994), reported from her survey of a hundred psychotherapists that their exposure to sexually traumatised clients was directly related to the therapists' P.T.S.D. symptoms. It was also found that gender (female), personal trauma history (positive), and exposure, all contributed significantly to the prediction of P.T.S.D. symptoms.

It would therefore seem that there has been no published research carried out in this country, which examines the relationship between the nature of the vicarious traumatisation, and the therapist's current, and cumulative general "trauma work" caseload. This would seem to be a particularly relative area of research, as in Britain most therapists working in the adult field encounter a variety of trauma related cases.

Measures of vicarious traumatisation

From the concepts and models of vicarious traumatisation, compasssion fatigue and secondary traumatic stress, a number of measures have been developed to empirically examine these areas.

The Traumatic Stress Institute (T.S.I.) Belief Scale, revision L, (Pearlman, 1996), is a eighty item, six point, Likert Scale questionnaire. It assesses disruptions in five cognitive schema areas, arising directly from psychological trauma, or from exposure to traumatic material through a helping relationship. The schema areas measured are, safety, trust, esteem, intimacy and control. Revision M is currently under development. (Pearlman 1999).

Derived from the T.S.I. Belief Scale, are the T.S.I. Autonomy and Connection Scales, (Stamm and Pearlman, 1996). These thirty five item, six point Likert scales assess disruptions in cognitive schemas in two areas, the self and others, by yielding two subscale scores, one for the "Experience of Connection", the other for the "Experience of Autonomy".

With regards to the related area of compassion fatigue a measure has also been developed. This is a sixty six item Compassion Satisfaction/Fatigue Self-Test for Helpers (Hudnall Stamm, 1998). It has been developed to be used as a self administrated indicator of both trauma and burnout symptoms, and yields the

individual's potential for compassion satisfaction, and risk for burnout and compassion fatigue.

To empirically examine the area of secondary traumatic stress Figley (1996) is developing the Secondary Traumatic Stress Disorder Scale. This is intended to measure secondary traumatic stress disorder, its separate symptoms and the source of stress connected with them, by replicating the items in the symptom criteria for P.T.S.D. in the Diagnostic and Statisical Manual of Mental Disorders, fourth edition, (D.S.M.-IV), (American Psychiatric Association, 1994).

With regards to the concept of burnout, Maslach and Jackson (1986), developed the Maslach Burnout Inventory (M.B.I.), which consists of twenty two, seven point Likert Scale statements of "job related feelings". These questions concern emotional exhaustion (nine items), depersonalisation (five items) and a lack of a sense of personal accomplishment (eight items).

However it would however seem that although the main theories of helping induced trauma hypothesise cognitive and behavioural changes within the individual, that the majority of measures developed to examine this area have concentrated upon cognitive rather than behavioural changes. This is therefore a potential area of further development and research.

Organisational, training and legal implications

If vicarious traumatisation, compassion fatigue or secondary traumatic stress is present in a therapist, it has a number of far reaching implications for them, the patients they see, and the organisation employing the therapist. Rudolph, Hudnall Stamm and Stamm's study, (1997), carried out a policy analysis, and an empirical study looking at the level of burnout and compassion fatigue in a wide variety of participants. Their results showed that a third of the subjects reported a high risk of secondary traumatic stress, and half of the subjects reported a high risk for developing burnout, as measured by the Compassion Satisfaction/Fatigue Self-Test for Helpers (Figley, 1996), and that the preliminary data from the policy analysis warranted further research.

The relevant literature in this area seems to indicate that, to reduce the risk of therapists developing vicarious traumatisation, their training and that of clinical supervisors' needs to incorporate into it what is known about the concept of vicarious traumatisation, how the likelihood of it occurring can be reduced, and if it does develop how it can be most effectively dealt with.

Recognition of vicarious traumatisation is a organisational and legal dilemma in that it could lead to vicarious traumatisation based compensation cases. In English and Welsh common law a claim requires fault to be shown on the part of the defendant. Howard (1995), puts forward the fact that in other jurisdictions fault does not need to be established. Therefore in countries such as America the case law with regards to stress

related claims has developed quicker in recent years compared to than in England and Wales.

Conclusions and recommendations for research

From reviewing the relevant literature in this field, it would seem that the area of helping induced trauma has developed radically since the definition of P.T.S.D. However due to the very small number of empirical studies that have been carried out, and the eclectic concepts and measures used there appears to be a great number of areas which require further clarification and research. These include the conceptual confusion surrounding the idea of helping induced trauma, whether the level of vicarious traumatisation is related to the amount of trauma work and if it is cumulative, whether the level of controllability of a caseload has an effect on the level of vicarious traumatisation experienced by the therapist, in what ways do therapists use to cope with "trauma work" and the development of a behavioural scale.

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Major Research Project Application for Ethical Approval

A Survey of Qualified Clinical Psychologists working in Britain with People who have experienced Trauma

Prepared in accordance with guidelines for submission to the Greater Glasgow Community and Mental Health Services N.H.S. Trust Research Ethics Committee

Appendix 3.6

GREATER GLASGOW COMMUNITY AND MENTAL HEALTH SERVICES N.H.S. TRUST

APPLICATION FORM FOR ETHICAL APPROVAL

NOTES: This application form must be *typed*, not hand written.

All questions must be answered: it is not an acceptable answer to put see *'separate protocol'*; *not applicable'* is a satisfactory answer where appropriate.

Where a separate protocol exists, this should be submitted in addition to the application form.

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1. Name and status of proposer:

Miss. Laura Toplis, Trainee Clinical Psychologist.

Supervisor:

Dr. Elizabeth Campbell, Senior Lecturer in Clinical Psychology.

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2. Address for correspondence:

Division of Clinical Psychology, University Department of Psychological Medicine, Academic Centre, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

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3. Employing authority:

Greater Glasgow Community and Mental Health Services N.H.S. Trust.

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4. In which hospital(s) or other location will the study be undertaken:

The attached covering letter (**Appendix 3.1**), and questionnaire (**Appendix 3.2**), will be sent out to all National Health Service employed qualified clinical psychologists working in adult mental health and forensic services in Scotland, and also to National Health Service employed qualified clinical psychologists employed at specialised trauma clinics in England, Wales and Northern Ireland. A telephone interview (**Appendix 3.3**) will be conducted with approximately thirty clinical psychologists who give consent to be interviewed (**Appendix 3.4**).

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5. Title of project:

A survey of qualified clinical psychologists working in Britain with people who have experienced trauma.

---

6. Has the proposed research been approved by any other committee on ethics? (Give details):

Not applicable.

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7. Has the proposed, or similar, research been carried out in any other centre? (Give details)

The only published research looking at the area of vicarious traumatisation has been carried in America. This research used different combinations of measures to those proposed for this study, and looked at different populations.

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8. Please give a summary of the project, including the question to be answered, the procedures to be used, the measurements to be made and how the data will be analysed (please see question 15 for recording details of how consent is to be obtained):

summary of project

This study is designed to examine vicarious traumatisation experienced by qualified clinical psychologists who work with people who have had traumatic experiences. (Vicarious traumatisation is defined as, "...the transformation that occurs within the therapist (or other trauma worker) as a result of the empathic engagement with the clients' trauma experiences and their sequelae", Pearlman and Mc Ian (1995)).

question to be answered

1. How does vicarious trauamtisation manifest itself? Is it cognitively, i.e. with a change in schema, or behaviourally?

2. Is the level of vicarious traumatisation related to the number of hours per week the clinical psychologist treats people who have trauma related problems?

3. Is the level of vicarious traumatisation related to the previous amount of contact the clinical psychologist has had with people who have experienced trauma?

4. How much control do therapists exhibit over the content of their case load, and does an element of controllability have an effect on the level of vicarious traumatisation experienced?

5. With regards to vicarious traumatisation how do clinical psychologists think it comes about? Do they think it develops due to **a)** unresolved difficulties of their own?, **b)** because they are hearing details of the person's traumatic experience and it is affecting their schema? or **c)** because of the degree of emotional distress the person is communicating.

the procedures to be used

The attached covering letter (**Appendix 3.1**), and questionnaire (**Appendix 3.2**), will be sent out to all National Health Service employed clinical psychologists working in adult mental health and forensic services in Scotland, and also to National Health Service employed clinical psychologists employed at specialised trauma clinics in England, Wales and Northern Ireland. A telephone interview (**Appendix 3.3**) will be conducted with approximately thirty clinical psychologists who give consent to be interviewed (**Appendix 3.4**).

the measurements to be made

The postal questionnaire (**Appendix 3.2**) will consist of:

1. Demographic data.

2. Asking whether the therapist has a personal history of traumatic events.

3. Asking whether the therapist has experienced any adverse events in the last twelve months.

4. Their current caseload of "trauma work" and their previous caseload of people with trauma related issues.

5. The amount of control they have over their work, i.e. can they consciously limit the number of "trauma cases" they see, do they consciously not take on certain types of cases.

6. The Traumatic Stress Institute (T.S.I.) Belief Scale (revision L), Pearlman (1996). This is an eighty item Likert Scale Questionnaire which assesses disruptions in cognitive schemas in five psychological needs areas which are impacted by trauma. These are safety, trust, esteem, intimacy and control. Basic psychometric properties of this measure are intact, Pearlman (1996).

7. Behavioural measures of vicarious traumatisation, (designed by the author).

8. Asking the therapist's opinion as to the causation of vicarious traumatisation (multiple choice, but the options are not mutually exclusive), and the theoretical orientation of the therapist.

The telephone interview (**Appendix 3.3**) will consist of:

1. Asking more detailed questions as regards the controllability they have over the size of their case load, the type of referrals they take on, the control they have over clinical decisions and the resources that they have to work with.

2. Whether the clinical psychologist has had any experiences which they feel are indicative of vicarious traumatisation which has not been picked up by the postal questionnaire.

3. Asking more details about the coping methods used by the clinical psychologist, details of any additional specific training, the degree of supervision, personal support and therapy they receive.

4. Defining the type of cases they work with where people have experienced trauma.

how the data will be analysed

A database will be built up on S.P.S.S. for Windows, release 7.5.1. (Statistical Package for Social Sciences). The data from the pilot and final postal questionnaire and telephone interview will be put onto the database. Statistical analysis will involve the use of the Spearman rank correlation coefficient to test the hypotheses put forward, and stepwise multiple regression analyses using selected independent variables, to predict the dependent variables. (The study's independent variables are defined as the questions about the clinical psychologists' and themselves, whereas the study's dependent variables are defined as the T.S.I. Belief Scale and the behavioural measure).

References

Pearlman, L. A. and Mc Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*, **26**, 558-565.

Pearlman, L. A. (1996). Psychometric review of T.S.I. Belief Scale, Revision-L. In B. H. Stamm (Ed.) *Measurement of stress, trauma and adaptation*. Lutherville, MD: Sidran Press.

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9. Please state whether there are any expected benefits to patient care and, if so, summarise:

There may be an indirect benefit to patient care, in that the study attempts to clarify the level and effect of vicarious traumatisation experienced by clinical psychologists in Scotland and some other areas in Britain. This research will also have a potential benefit in informing the training of clinical psychologists and service managers.

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10. Please state the likely duration (a) of the project itself and (b) for individual patients:

(a) The project will be completed by 1st August, 1999.
(b) The postal questionnaire (**Appendix 3.2**) takes approximately twenty minutes to complete, and the telephone interview (**Appendix 3.3**) will also take approximately twenty minutes.

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11. Please state who will have access to the data and what steps will be taken to keep data confidential:

The proposer and supervisor will have access to the data, and it will be stored securely within the Division of Clinical Psychology, Gartnavel Royal Hospital. A listing of participants' individual scores and demographic information will also be sent to Dr. Laurie Anne Pearlman, Research Director of the Traumatic Stress Institute to help establish normative data on her scoring instrument used in the research, (the T.S.I. Belief Scale).

All results will be anonymous. The written questionnaire has been designed in such a way as to protect the anonymity of the participant. Whilst the anonymity of the respondent clinical psychologist will be protected during the telephone interview, by them being telephoned by a research assistant, and once contact has been established the principal researcher will conduct the anonymous interview where the identity of the participant will not be asked.

If however extreme psychopathology is revealed in the postal questionnaire or the telephone interview, which is thought to constitute a danger to the individual themselves or their patients, then this will be dealt with in accordance with British Psychological Society guidelines, after consultation with the named supervisor.

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12. Please give details of how consent is to be obtained. A copy of the proposed consent form, along with a separate patient information sheet, written in simple, non-technical language, must be attached to this proposal form.

A covering letter will be sent with the postal questionnaire which indicates the content and aims of the study, (**Appendix 3.1**), and the participants will be asked to indicate on the front sheet of the questionnaire (**Appendix 3.2**), that they have read and understood the content and aims of this study, and whether they consent to participate in the study.

The participant will also be asked to complete a separate telephone interview consent form to indicate if they are willing to be contacted by telephone to answer additional questions, which will take approximately twenty minutes. **(Appendix 3.3)**.

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13. Is the power of the study sufficient to answer the question that is being asked? Please indicate the calculations used for the required sample size, including any assumptions you may have made. (If in doubt, please obtain statistical advice).

This is not applicable as this study is designed to examine associations between variables rather than differences. However with the number of proposed participants, (n=200 for the postal questionnaire and n=20 for the telephone interview), an adequate number of data points will be obtained.

---

14. What statistical tests will you apply to your results?
Please give details of proposed methods:

As the data is expected to be non-parametric, analysis will involve the use of the Spearman rank correlation coefficient to test the hypotheses put forward. Stepwise multiple regression will also be used with selected independent variables to see which predict the dependent variables. (Independent variables are the questions asked about the clinical psychologists' work and themselves, whilst the dependent variables are the T.S.I. Belief Scale and the behavioural measure).

---

15. Scientific background to study (give a brief account of relevant research in this area with references):

Only three published empirical studies have been carried out in the area of vicarious traumatisation, none of these were carried out in Britain, or looking specifically at clinical psychology. They also varied in their emphasis and the measures used.

Follette, Polusny and Milbeck, (1994), carried out a comparative survey of two hundred and twenty five mental health professionals, and forty six law enforcement officers, who worked with childhood sexual abuse survivors.

In 1995, Schauben and Frazier published a study which surveyed one hundred and eighteen psychologists and thirty sexual violence counsellors.

In the same year Pearlman and Mac Ian carried a survey of one hundred and eighty eight self identified trauma therapists, (Pearlman and Mac Ian, 1995).

References

Follette, V. M., Polusny, M. M. and Milbeck, K. (1994). Mental health and law enforcement professionals: trauma history, psychological symptoms, and impact of providing services to child abuse survivors. *Professional Psychology: Research and Practice*, **25**, 275-282.

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Schauben, L. J, and Frazier, P.A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly*, **19**, 49-54.

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16. Does the research involve additional invasive procedures over and above the normal treatment of the patient? If so, are there any hazards associated with the procedure?

Not applicable.

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17. Please state any other potential hazards to participants arising from the research, their estimated probability (if possible) and the precautions to be taken to meet them:

Not applicable.

---

18. Please describe any procedures which may cause discomfort or distress to participants, the degree of discomfort or distress entailed and their estimated probability:

The completion of the postal questionnaire (**Appendix 3.2**) may cause an extremely small number of participants to become distressed. Therefore the participant is advised within the covering letter that if they become distressed that they should stop completing the questionnaire, and are provided with details of places they can seek help. They are also invited to contact the proposer should they have any questions or concerns about the questionnaire.

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19. Who are the proposed participants in the research (and controls if appropriate), and how are they to be selected? Please give details of age, sex, numbers involved and any other relevant details:

The covering letter (**Appendix 3.1**) and postal questionnaire (**Appendix 3.2**) will be sent out to all qualified N.H.S. employed clinical psychologists working in adult mental health, primary care and forensic fields in Scotland and all qualified clinical psychologists working in specialist clinics in England, Wales and Northern Ireland. In total this is approximately two hundred participants. The participants who reply will be asked to opt into a telephone or face to face interview (**Appendix 3.3**), and approximately thirty will be interviewed.

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20. Give names, strengths, doses and route of administration of investigational drugs to be used:

Not applicable.

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21. Are the drugs to be used subject to the terms of:-

A Product Licence: Not applicable.

A Clinical Trial Certificate (CTC) or Certificate Exemption (CTS): Not applicable.

Is an unlicensed Product, but is registered under the DDX Scheme: Not applicable.

Which ever is applicable, please provide documentary evidence.

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22. **Are the drugs used being given in accordance with the Product Licence, with the agreed protocol (in the case of CTX or DDX) or with the CTC?** Not applicable.

If no, give details:

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23. **Which manufacturer is organising the trial or supplying investigational drugs?**

Not applicable.

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24. **If the trial is being undertaken in general practice and involves the supply of drugs, please state the arrangements for storage, labelling and dispensing.**

Not applicable.

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25. **Are questionnaires to be used? If yes, a copy must be attached to this application form.**

Yes.

---

26. **How is the project to be funded?**

By the Division of Clinical Psychology, University Department of Psychological Medicine, Academic Centre, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 0XH.

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27. **Please state any 'interests', i.e. profit, personal or departmental, financial or otherwise, relating to the study. Details of payments per patient recruited, and/or any other remuneration details must be included.**

For the principal investigator the completion of the research is required as part of the University of Glasgow's Doctorate in Clinical Psychology Course.

The participants will be offered a copy of the results of the completed research, free of charge. **(Appendix 3.5)**.

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28. **Will the research have revenue consequences for the N.H.S.? If yes, please tick the box(es) applicable below:-**

Nursing

Pharmacy

Medical Records

Laboratory services

Other clinical services of the Trust

Other
Which? .....

If you answer yes to any of these, please give details of the revenue consequences.

---

29. Please attach other relevant material: for instance, letters to subjects (which must be in simple non-technical language).

The information supplied above is to the best of my knowledge and belief accurate. I have read the notes to investigators and clearly understand my obligations and the rights of the subject, particularly in so far as to obtaining freely given informed consent. I also confirm that I have read and understood *"The Declaration of Helsinki"*

Date of Submission: .....

Signature of Principal Investigator: .....

Finally, please ensure that you have enclosed, if appropriate:

- **Questionnaires**
- **Letters to General Practitioners**
- **Letters, information sheets, for the participants**
- **Copies of consent forms**
- **Copy of protocol**
- **Documentation relating to drugs**
- **Any other material which you think is of relevance to your application**

Major Research Project

A Survey of Qualified Clinical Psychologists working in Britain with People who have experienced Trauma

Prepared in accordance with guidelines for submission to The Journal of Traumatic Stress (Appendix 4.5)

A Survey of Qualified Clinical Psychologists working in Britain with People who have experienced Trauma

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A Survey of Qualified Clinical Psychologists working in Britain with People who have experienced Trauma

Abstract

A survey of British clinical psychologists looking at the cognitive and behavioural effects of vicarious traumatisation, by anonymous postal questionnaire and telephone interview. The greatest cognitive disruptions were reported by female therapists with a low level of exposure to trauma related work. Whereas the greatest behavioural disruptions were reported by female therapists who had had additional training, had used personal therapy, limited their case load and had a high level of exposure to trauma related work. Psychologists cited informal and social support, recreational activities and supervision as the main ways in which they coped with trauma work. People moving on and helping people to make major changes in their lives, were described as the most rewarding aspects of trauma work.

Keywords

vicarious traumatisation, clinical psychologists, schemas, behaviour.

Introduction

A large amount of trauma literature has been published since the diagnostic recognition of Post Traumatic Stress Disorder (P.T.S.D.) in 1980 (American Psychiatric Association, 1980) with the majority of this focusing upon those who have been directly traumatised, to the exclusion of those traumatised indirectly. There are however a number of models which have emerged which hypothesise the phenomenon of helping induced trauma, and a limited number of empirical studies have researched this area. The two main theoretical models of helping induced trauma are those of McCann and Pearlman (1990) and Figley (1995), with the concepts being known as vicarious traumatisation and compassion fatigue respectively.

Vicarious traumatisation is based upon the contructivist self-development theory (C.S.D.T.), and holds that therapists working with people who have experienced trauma experience lasting changes to their cognitive systems, and that this in turn may have an impact on their behaviour, feelings, relationships and beliefs. While Figley (1995) conceptualises compassion fatigue as a syndrome equivalent to P.T.S.D., except that the exposure is not directly to the trauma but to knowledge about a traumatising event which has been experienced by a significant other. He explains this phenomenon in the trauma transmission model, which suggests that the helper identifies with the victim and their suffering and asks themselves questions about the trauma that generates emotions and behaviours similar to those of the survivor.

Review of the literature

A comprehensive review of the literature is presented in Toplis (1999), but in summary although a large body of theoretical literature regarding vicarious traumatisation and allied concepts has been produced, only three published empirical studies have been carried out in this area which vary in their emphasis and measures.

Follette, Polusny and Milbeck (1994), carried out a survey of mental health professionals and law enforcement officers who worked with childhood sexual abuse survivors. They found that participants who reported having experienced childhood abuse had significantly higher levels of trauma specific symptoms, but significantly more positive coping behaviours to deal with sexual abuse cases. They also identified use of negative coping, level of personal stress and negative clinical response to sexual abuse cases as factors which were significantly predictive of trauma symptoms. With regards to coping responses, education related to sexual abuse, supervision, consultation and humour were most frequently used.

In 1995 Schauben and Frazier published a study which surveyed psychologists and sexual violence counsellors. The results showed that the counsellors who had a higher percentage of sexual violence survivors as clients reported more disruptions in their basic schemas about themselves and others, more symptoms of P.T.S.D., and more self-reported vicarious traumatisation. The most frequently mentioned positive aspects of working with survivors were watching clients grow and change, enjoying being part

of the healing process, the creativity, strength and resilience of clients, the importance of the work and various characteristics of the work environment. The strategies most commonly used by counsellors included active coping, seeking emotional support, planning, seeking instrumental social support and humour.

In the same year, Pearlman and MacIan carried out a survey of self identified trauma therapists (Pearlman and MacIan, 1995). They found that the greater proportion of the therapist's clinical work devoted to trauma work the fewer disruptions there were in the therapist's self-trust schemas. As regards the length of time doing trauma work those therapists who had less experience, had the most disruptions in their self-trust, self-intimacy and self esteem schemas, and higher overall symptoms.

There have also been a number of unpublished studies which have empirically examined vicarious traumatisation. These include Munroe (1991) who found in a study of therapists that current and cumulative exposure to combat-related clients correlated significantly with intrusive symptoms. Whilst Kassam-Adams (1994) reported from her survey of psychotherapists that exposure to sexually traumatised clients was directly related to the therapists' P.T.S.D. symptoms. It was also found that gender (female), personal trauma history (positive), and exposure all contributed significantly to the prediction of P.T.S.D. symptoms.

No published research has been carried out in Britain which looks at the area of helping induced trauma, even though within the National Health Service there are a large

number of mental health professionals who come into contact with a variety of people who have experienced trauma. This study attempts to look at the effects on one particular group of therapists, qualified clinical psychologists, and test the following hypotheses: The level of vicarious traumatisation is related to the number of hours spent working with people who have experienced trauma, the effects of working with trauma are cumulative, the level of controllability that a psychologist has over the number of people they see who have experienced trauma, is related to the level of vicarious traumatisation they experience.

Method

The first draft of the postal questionnaire was piloted on 7 qualified clinical psychologists working in adult mental health settings. Adjustments were made and the attached covering letter (Appendix 4.1), and anonymous postal questionnaire (Appendix 4.2), were sent out to all National Health Service employed qualified clinical psychologists working in adult mental health and forensic services in Scotland, of whom there were 214, and all National Health Service employed qualified clinical psychologists employed at specialist trauma clinics in Britain, of whom there were 8. 119 postal questionnaires were returned, giving a return rate of 56%. Other studies of therapists have obtained return rates ranging from 32% (Pearlman and MacIan, 1995) to 58% (Pope & Feldman-Summers, 1992). Psychologists working in Scotland who returned the questionnaires can be considered a representative sample in terms of

gender, when compared to the clinical psychologists in the Register of Chartered Psychologists, The British Psychological Society (1998). There are 145 (63.32%) B.P.S. registered female and 84 (36.68%) male psychologists working in Scotland, and 81 (69.83%) female and 35 (30.17%) male psychologists returned their questionnaires.

46 (38.66% of the total sample) psychologists completed the opt in form (Appendix 4.3) and agreed to take part in the anonymous telephone interview (Appendix 4.4). The anonymous telephone interview was conducted with a random sample of 20 participants (16.81% of the total sample), a number which provided sufficient qualitative data. The anonymity of the participants was preserved by initial telephone contact being made by a research assistant, who then transferred the call to the principal researcher without revealing the participant's identity.

Measures

Postal questionnaire.

The postal questionnaire developed by the author took approximately 20 minutes to complete. It asked questions about the participant's history of traumatic events within the last twelve months and their lifetime; their current and previous caseload of "trauma work"; the amount of control they have over the number of people they see who have experienced trauma; whether they consciously limit the number of "trauma cases" they see and whether they do not take on certain types of cases due to personal reasons. They

were also asked whether they worked in a multidisciplinary framework, the amount of supervision they gave and received, whether they had used personal therapy, if they had undergone additional training or attended trauma related conferences, their opinion as to the causation of vicarious traumatisation and their theoretical orientation. As part of the postal questionnaire the participants were also asked to complete the T.S.I. (Traumatic Stress Institute) Belief Scale, revision M (Pearlman 1999), and the Vicarious Traumatisation (V.T.) Behaviour Scale (Toplis 1999b).

T.S.I. (Traumatic Stress Institute) Belief Scale, revision M (Pearlman 1999).

The T.S.I. Belief Scale is a seventy seven item, six point, Likert Scale. It assesses disruptions in five cognitive schema areas, arising directly from psychological trauma or from exposure to traumatic material through a helping relationship. The schema areas measured are, safety, trust, esteem, intimacy and control for the individual themselves and others.

The self-safety schema is measured by eight items and is defined as, "...the need to feel one is reasonably invulnerable to harm inflicted by self or others". Nine items are used to measure the other-safety schema which is, "...the need to feel that valued ones are reasonably protected from harm inflicted by oneself or others". "...The belief that one can trust one's judgement" is the self-trust schema and is measured by nine items. The other-trust schema is measured by six items and is defined as, "...the belief that one can rely on others". Nine items are used to measure the self-esteem schema which is, "...the belief one is valuable and worthy of respect". "..The belief that others are valuable and

worthy of respect" is the other-esteem schema and is measured by six items. The self-intimacy schema is measured by eight items and is defined as, "...the belief that time spent alone is enjoyable". Seven items are used to measure the other-intimacy schema which is "...the belief that one is close and connected with others". "...The need to be in charge of one's own feelings and behaviours" is the self-control schema and is measured by seven items. Finally the other-control schema is measured by eight items and is "...the need to manage interpersonal situations".

The total score for the T.S.I. Belief Scale ranges from seventy seven to four hundred and sixty two. In terms of the individual schemas the mean score for each is calculated, ranging from one (no disruption) to six (which is the greatest level of disruption). Therefore a higher mean score indicates a more disrupted cognitive schema. Revision M is the latest version of the T.S.I. Belief Scale which is a slightly reworded version of the previous version, Revision L. The basic psychometric properties of revision L are intact, with the overall reliability (Cronbach's alpha) of the T.S.I. Belief Scale (revision L) being 0.98, and studies have found significant differences (more disruptions) in trauma survivors than non trauma survivors (Stamm, 1996). Normative data is available for both version L and M. The former was standardised on 247 mental health professionals (mean total score = 166.83 (SD = 36.23)), 256 students (mean total score = 192.41 (SD = 43.39)), 186 outpatient clients (mean total score = 227.08 (SD = 51.35)) and 118 chronic patients (mean total score = 280.64 (SD = 59.60)). Revision M has been standardised on a mixed group of 94 mental health professionals, students and outpatients (mean total score = 173.45 (SD = 48.36).

Vicarious Traumatisation (V.T.) Behaviour Scale (Toplis 1999b).

The V.T. Behaviour Scale is a 15 question behavioural measure of vicarious traumatisation developed by the author, based upon the vicarious traumatisation and related literature. It attempts to address an unmet need as the main theories of helping induced trauma hypothesise cognitive and behavioural changes within the individual, but with all measures concentrating on the former. The V.T. Behaviour Scale has a range from zero to fifteen and correlates positively with the T.S.I. Belief Scale score, and the other-control, other-esteem, self-control and self-safety schemas. Table 1.

insert table 1 here

Telephone questionnaire.

The telephone interviews took approximately 10 to 20 minutes and asked questions regarding the type of referrals the participants took on, and the community resources for people who had experienced trauma in their area. They were also asked whether they had had any experiences which they feel were indicative of vicarious traumatisation which has not been picked up by the postal questionnaire. Additional details were also asked about the coping methods they used, details of any additional specific training, and finally the degree of supervision, personal support and therapy they received.

Statistics

Spearman rank correlation coefficients were carried out between non parametric interval and ratio data. Independent sample t-tests were carried out on parametric nominal and continuous data, and Mann-Whitney tests on non-parametric data. Chi-square tests were used with nominal data. One-way analysis of variance (ANOVA) was the statistical test of choice for parametric interval data and nominal data and the Kruskal-Wallis test was the non parametric equivalent. A stepwise linear multiple regression equation examined the possible contributing factors to the T.S.I. (Traumatic Stress Institute) Belief Scale, revision M and the Vicarious Traumatisation (V.T.) Behaviour Scale. A logistic regression equation looked at the predictors for scoring above or below the norm T.S.I. Belief Scale total score. Cohen's kappa correlation coefficient was used to assess inter rater reliability for qualitative data.

Results

Participants

Postal questionnaire respondents consisted of 81 (69.83%) female and 35 (30.17%) male qualified clinical psychologists, with details of their ages shown in graph 1 and table 2.

insert graph 1 here

insert table 2 here

Number of years since qualification is shown in graph 2 and table 3.

insert graph 2 here

insert table 3 here

30 (25.64%) of participants had experienced adverse life events in the last twelve months with 45 (38.46%) having experienced trauma in their life.

Within the last working week, psychologists reported having worked a mean of 3.71 hrs (SD = 3.67) with people whose main difficulties were trauma related. Whilst the mean of the average number of trauma hours worked per. week was 4.74 (SD = 5.23), and

participants having worked for a mean of 101.33 months (approximately 8 years, 5 months) (SD = 5.23) with trauma, with a range from 1 month to 27 years.

On average the participants rated themselves as having 48.96% (SD = 27.49) control over the number of people that they saw as part of their caseload who had experienced trauma. 19 (15.97%) reported avoiding working with certain types of problems due to personal reasons, and 38 (32.20%) said they tried to limit the number of people they saw with trauma related difficulties. 51 (43.22%) of psychologists worked within a multi disciplinary framework.

A mean of 1.57 hrs (SD = 1.88) of supervision per month was received, and 4.08 hrs per. month (SD = 4.43) given. 34 (28.57%) of participants had been or were in personal therapy. 45.4% had undergone additional training in working with people who had experienced trauma, with 37.8% having attended a trauma conference within the last two years.

With regards to theoretical orientation the majority of participants described theirs as being cognitive behavioural (80.34%), with the other main orientations being eclectic (18.80%), psychodynamic (9.40%) and cognitive analytical (5.13%).

Postal questionnaire

33 (29.46%) out of a total of 119 participants scored above the norm value for the T.S.I Belief Scale, Revision M total score. This was a mean total score of 173.45 (SD = 48.36). This is in comparison to the higher T.S.I. Belief Scale, Revision L total mean score of 184 (SD = 36) in Pearlman and MacIan's study (1995). This latter study surveyed 188 self-identified trauma therapists. The average V.T. Behaviour Scale score was 2.10 (SD = 2.01).

With regards to gender, differences were found with the two T.S.I. Belief Scale control schemas, with the other-control schema (the need to manage interpersonal situations) and self-control schema (the need to be in charge of one's own feelings and behaviours) scores being statistically significantly greater for women than men, therefore indicating greater disruption, table 4.

insert table 4 here

Female psychologists compared to male psychologists, reported to a statistically significant level that they had had a change in their attitudes and behaviours, since they had started to work with people who had experienced trauma, table 5.

insert table 5 here

Participants who had had an adverse life event in the last twelve months, compared to those who had not, reported to a statistically significant extent driving differently since working with people with trauma problems, table 5.

Whilst people who had had, or were having personal therapy scored significantly higher on the V.T. Behaviour Scale score, table 4. They also reported finding themselves being more agitated and becoming more concerned about their family and friends safety, since they had started working with people who had trauma related problems compared to psychologists who had not used personal therapy, table 5.

Those who worked within a multi disciplinary framework scored higher on disruption of the self-trust schema (the belief that one can trust one's judgement), and significantly lower on the other-intimacy schema (the belief that one is close and connected with others) than those not working with a multi disciplinary framework, table 4.

Psychologists who had undergone additional training were more likely to say that they had had a diminished interest in recreational activity, and had taken additional security measures since working with people who had experienced trauma than those with no additional training, table 5. Whilst participants who had attended a trauma related

conference in the last two years showed a significantly lower other-intimacy and other-trust schema scores, table 4.

Those who tried to limit the number of people who they saw with trauma related difficulties had significantly lower scores on the self-trust schema (the belief that one can trust one's judgement), and a greater V.T. Behaviour Scale score than their colleagues who did not limit their case loads, table 4. Those who placed limits also reported avoiding reports of trauma in the media, finding themselves being more aggressive, more agitated, had more problems with regards to scheduling appointments and having taken additional security measures, since they had started to work with people who had experienced trauma, table 5.

There was a statistically significant negative correlation between the number of hours worked in the last week with trauma and participants' self-esteem schema scores and a positive correlation with the V.T. Behaviour Scale score, table 6.

insert table 6 here

It was also found that people who reported avoiding reports of trauma in the media, said that they had a change in their attitudes and behaviours towards people, and had been conscious of checking things more often since working with trauma problems, reported

working significantly more hours in their last working week than those who did not report these changes. Table 4.

Psychologists who reported working statistically significant longer average hours per week with trauma, reported driving differently and changes in their attitudes and behaviour towards people, table 4.

Negative correlations were found between the length of time people had been working with people with trauma problems and the self-esteem schema (the belief one is valuable and worthy of respect), and the self-intimacy schema (the belief that time spent alone is enjoyable), table 6. It was also found that people who reported having had sleep problems since starting to work with trauma, because they were thinking about the trauma their clients had experienced, had worked for a significantly fewer number of months with this client group. The mean number of months they reported having worked with trauma was 67.79 months (approximately 5 years and 7 months), (SD = 60.15), whilst those who reported no sleep problems had worked with trauma for an average of 108.26 months (approximately 9 years), (SD = 78.20). Results also showed that people who reported avoiding travelling alone had worked for significantly fewer months with trauma. This group had worked for an average of 29.20 months with trauma (approximately 1 year and 9 months), (SD = 20.72). In contrast those participants who did not report avoiding travelling alone had worked an average of 104.74 months (approximately 8 years and 9 months (SD = 76.74), table 4.

Psychologists thought vicarious traumatisation came about in the following ways. 57.63% of the participants agreed that it could be due to schema changes, 72.65% because of the extreme emotional distress the person is communicating, and 50.43% because of the therapist's unresolved difficulties. 21.19% disagreed that it was due to schema change or unresolved difficulties, and 16.24% disagreed that it was due to extreme emotional distress being communicated. 21.19%, 11.11% and 27.35% of participants did not know whether schema change, extreme distress or unresolved difficulties respectively were the reasons vicarious traumatisation came about. The participants were allowed to agree, disagree or say they did not know with regard to more than one hypothesis.

The main ways in which people said they personally coped with the emotional impact of this kind of work were informal and social support, recreational activities and supervision, with further details shown in table 7 and graph 3. The level of inter rater reliability between the categorisation of this data by the author and the research assistant for these categories was 0.84, table 8.

insert table 7 here

insert graph 3 here

insert table 8 here

Telephone interview

20 randomly selected psychologists participated in the telephone interviews. They can be regarded as being representative of the postal questionnaire sample on a number of factors, with a similar percentage of people having used personal therapy, and receiving a similar amount of supervision. However the telephone questionnaire sample had had more additional training (telephone participants = 70%, postal participants = 45.5%) and used supervision to a greater extent as a way of coping with the emotional impact of working with people who have experienced trauma (telephone participants = 40%, postal participants = 27.27%).

The main types of trauma psychologists worked with were childhood sexual abuse, adult physical assault and road traffic accidents. These trauma types also made up the largest percentages of their trauma case loads. The different types of trauma are shown in table 9 and graph 4, while graph 5 shows the mean percentages of the different types of trauma in participants' case load.

insert table 9 here

insert graph 4 here

insert graph 5 here

A quarter (25%) of participants had utilised personal therapy, with an average duration of 3 years and 3 months (SD = 33.81) and frequency of 2.3 times a months (SD = 3.19). The majority (97.5%) of participants described their friends and family as being supportive of the work that they did. The aspects of trauma work they described as most rewarding were; there was a positive outcome and people moved on (75%), assisting people to make major changes in their lives (15%), seeing different areas of life (5%) and help identify positives within the individual and channel these (5%), There was 100% agreement between the raters on assignment of these categories to the qualitative data.

Participants reported receiving an average 1.69 hours of supervision a month (SD = 1.86), with an average of 22 minutes (SD = 34 minutes) of this spent specifically looking at trauma cases. 44.44% of trauma supervision was received from peers, 44.44% from managers and 11.11% from senior colleagues.

70% of the sample had had additional training, with 53.9% having attended conferences and workshops whilst the remainder's additional training consisted of specific approaches and therapeutic technique training. On average this training had been 2 years and 6 months ago (SD = 24.58).

The majority (75%) of participants had not had any experiences, thoughts or feelings that they thought were indicative of vicarious traumatisation which had not been expressed in the postal questionnaire. The remainder said that had become more aware of the dangers of driving, had had nightmares or found the work very draining.

The main ways of coping with particularly difficult cases cited were supervision (40%), having a separate stable personal life (15%), being more cautious and sensitive during the sessions (15%) and is shown in greater detail in table 10 and graph 6.

insert table 10 here

insert graph 6 here

Only 25% of participants felt that there was a specific type of trauma that they found it particularly difficult to work with, with the majority of these people saying it was

childhood sexual abuse. Instead they described it in terms of individual characteristics of the case, with the main difficulties being the problems were chronic and they thought the therapy process had become stuck (40%) and the content of the traumatic event. (15%). These are shown in table 11 and graph 7.

insert table 11 here

insert graph 7 here

Model

Variables, based on the author's model of vicarious traumatisation, figure 1 were entered into two linear stepwise regression equations.

insert figure 1 here

In one equation the dependent variable was the T.S.I. Belief Scale total score and in the other the V.T. Behaviour Scale total score.

In the first regression equation it was found that the average number of hours spent working with people who had experienced trauma was found to be predictive of the T.S.I. Belief Scale, table 12.

insert table 12 here

In the second regression equation it was found that the greater the number of hours spent in the last week working with trauma, the higher the other-esteem schema score, if limits were placed upon the number of people seen with trauma related difficulties, then the higher the V.T. Behaviour Scale score and vice versa, table 13.

insert table 13 here

The T.S.I. Belief Scale total score was transformed into a dichotomous variable by distinguishing between participants' scores above or below the norm score. A logistic stepwise regression equation was then found to predict the presence or absence of a T.S.I. Belief Scale total score, above or below the norm score. It was found that there was a negative correlation between the number of months worked with trauma and scoring above the norm score. Table 14.

insert table 14 here

In summary, participants in this sample reported greater cognitive disruptions if they were female, did not limit their case load, had not attended a trauma conference in the last two years, had only worked a few hours in last week with trauma and had worked a short time with trauma. The greatest behavioural disruptions were reported by female therapists who had had an adverse life event in the last year, had undergone additional training, had utilised personal therapy, limited their trauma case load, worked a large number of hours with trauma per. week, and had worked a long time with trauma.

Discussion

With regards to the main hypotheses the study set out to test, it was found that the more trauma hours worked per. week, the greater the number of reported behavioural changes but the less disruption in the self-esteem schema (the belief one is valuable and worthy of respect). This finding is similar to that of Pearlman and Mac Ian (1995), who found that the greater the proportion of the therapist's clinical work devoted to trauma work, the fewer disruptions there were in the therapist's self-trust schema, (the belief that one can trust one's judgement). It can therefore be hypothesised that exposure to trauma

effects behavioural changes, but that trauma work results in therapists having greater self esteem as measured by the T.S.I. Belief Scale.

The second hypothesis that this study set out to test, was that the effects of working with trauma is cumulative. With regards to schema changes the hypothesis was rejected, as those newer to trauma work reported more schema disruptions, and vice versa. In terms of behavioural changes the hypothesis was neither proved or rejected, as psychologists who had worked a long time with trauma reporting more sleep problems, but unlike less experienced therapists, did not report avoiding travelling alone. These schema findings are similar to those of Pearlman and Mac Ian (1995), who found that therapists who had the least trauma work experience had the greatest schema disruptions. This result is also consistent with the burnout literature, which showed that being younger or newer to trauma work is correlated with the highest levels of burnout (Ackerley, Burnell, Holder and Kurdek, 1988; Deutsch, 1984).

These findings however may be compounded by a maturation effect, in that as people grow older they may experience these cognitive and behavioural changes. It is also possible that there is a filtering process that takes place, and that only psychologists who do not experience major cognitive and behavioural changes due to trauma work, continue to work with these types of difficulties. This area could be clarified further by carrying out a longitudinal study of research, or by asking detailed questions of experienced psychologists about their career paths. It is also possible that there is an inoculation effect, whereby a gradual exposure to trauma work allows the person to

gradually adapt to the effects of working with this particular type of difficulty. This finding may also be explained by the possibility that as the psychologist's experience in this area increases, including continued professional development, education, teaching and consultation work their schemas may evolve, adapt and be less disrupted.

The third and final hypothesis is that the level of controllability that a psychologist has over the number of people they see who have experienced trauma is related to the level of vicarious traumatisation they experience, but this can be rejected as there was no significant association between these variables.

In this study female participants had the greatest schema disruptions. This is a similar finding to that of Kassam-Adams (1994), who found that gender (female) contributed significantly to the prediction of P.T.S.D. symptoms in her survey of psychotherapists. This may be because female members of staff are requested to be seen by people who have been sexually abused, (the most common type of trauma seen) because the majority of people sexually abused are women.

This study's results also showed that having a trauma history is not as significant in terms of cognitive and behavioural changes as it is in other studies, (Pearlman and Mac Ian 1995; Follette, Polusny and Milbeck 1994). The only behavioural change reported was driving differently and this may be attributable to the participants' traumatic event being a road traffic accidents. This finding supports that the concept that the cognitive and behavioural changes reported in the study are of a vicarious nature, and not related

to the psychologist's trauma history. This finding is of particular relevance, as there have been efforts within the legal system in America to involve therapist's own trauma histories in determining professional competency (Follette, Polusny and Milbeck 1994).

Psychologists who had either utilised personal therapy or limited their caseload reported a larger number of behavioural changes, than those psychologists who did not utilise these strategies. However due to causality not being predicable from this study it is difficult to be sure whether these strategies were adopted because of the participant's recognition of the behavioural changes, or whether they are effects of working with trauma.

With regards to the clarification of the concept of vicarious traumatisation the largest percentage of participants thought that it came about due to the emotional distress that the individual was communicating which best fits the Figley (1995) model of compassion fatigue, rather than the changed schema model of McCann and Pearlman (1990).

Positive ways were cited to cope with the emotional impact of working with people who had experienced trauma, which are similar to the findings of Scauben and Frazier's (1995) survey of female counselors of working with people who had experienced sexual violence, and Follette et al.'s (1994) survey of mental health professionals.

The results of the telephone interviews showed that childhood sexual abuse was the type of trauma worked with the most, that it made up the greatest percentage of people's trauma case load and was cited as the type of trauma that was most difficult to work with. This group described themselves as being very well supported by their family and friends, with the majority finding that the person was able to move on and there was a positive outcome as being the most rewarding aspect of working with trauma. Similar to the postal participants a number of very positive coping mechanisms were given. The most difficult aspects of trauma work were described by the majority of psychologists, as being that the patient's problems were chronic and that therapy had become stuck, and not the content of the trauma being described, which is hypothisised to bring about changes according to the models of McCann and Pealman (1990) and Figley (1995).

Although this research provides important empirical documentation on vicarious traumatisation, these findings need to be interpreted with care due to the methodological limitations of this study. These include the fact that the study is of a cross sectional design and therefore no causal inferences can be made. A limitation of the study is that to protect the anonymity of the participants the data from the postal questionnaire and telephone interview could not be matched up. There is also a possibility that a number of Type 1 errors may have been made by carrying out a large number of comparisons, but this is due to the exploratory nature of this research. As with any survey the participants were self selecting and it would therefore be difficult to generalise the findings.

Another possible limitation is that it may have been difficult for people to gauge retrospectively whether they had experienced a change in their behaviour since starting to work with trauma. This could be looked at in more detail by carrying out a longitudinal study which examined cognitive and behavioural changes over time. It is also worth noting that all the data is self reported, and it would be important to know if a observer or significant other would evaluate their schemas or behaviours similarly, as it is possible that they are unaware of changes that have taken place since working with trauma. This therefore emphasises the importance of addressing possible difficulties in training, consultation with colleagues and self supervision.

Another important aspect of the study is that due to the eclectic nature of most of British clinical psychologists' jobs, the mean number of hours spent working with trauma is just over one tenth of a working week. It could therefore be argued that this degree of exposure to trauma is not enough to cause cognitive and behavioural changes. However the results demonstrated that a substantial degree of cognitive and behavioural changes were reported, with almost a third of participants scoring higher than the norm for the T.S.I. Belief Scale total score.

It is important to consider the limitations of the main measures used within the study. The V.T. Behaviour Scale was in it's first draft having been developed specifically for the purpose of the study, using the author's clinical knowledge and the relevant literature. The mean total score for this measure was low, and within this scale there are a number of behavioural changes which were not acknowledged by any participants.

This measure is naturally open to refinement, but the results of this study does raise questions about it's validity, and how to measure the behavioural impact of vicarious traumatisation. Ultimately the concept of the behavioural impact of vicarious traumatisation could be re-examined.

The correlations between the V.T. Behaviour Scale and a number of the individual sub scales of the T.S.I. Belief Scale, although statistically significant are low in value. This may be due to the underdevelopment of the V.T. Behaviour Scale, but it also raises questions regarding the validity and reliability of the T.S.I. Belief Scale. Criticism of the T.S.I. Belief Scale, Revision M's validity could also be levelled in terms of the small number of participants it has been standardised and that it was a mixed clinical and non clinical group.) However it could be argued that it is simply a slightly shorter and better worded version of a measure that has been standardised on a far larger population. The T.S.I. Belief Scale also has the greatest construct validity in terms of vicarious traumatisation, in comparison to the alternative measures considered. These included the World Assumptions Scale (Janoff-Bulman, 1996) and the Secondary Traumatic Stress Disorder Scale (Figley, 1996).

It can therefore be concluded that there are a number of cognitive and behavioural changes which are associated with working with people who main difficulties are trauma related. This study indicates that cognitive changes are more prevalent in less experienced female therapists working with only a few people who have experienced trauma. Whilst behavioural changes were reported most frequently by female therapists

who had a large amount of exposure to trauma in terms of hours per week and length of time working in this area. The results clearly show that there are a number of contradictions between the factors which seem to contribute towards cognitive and behavioural changes, although this may be explained in part by hypothesising that cognitive changes happen, are noticed or reported first.

The study's participants work with a wide variety of trauma, and it is possible that different types of trauma affect therapists in different ways. Therefore in terms of future research it would be pertinent if different types of trauma and their effects were examined, for example therapists working predominantly with childhood sexual abuse or victims of torture. Research could also be carried out which isolates aspects of working with trauma which have the greatest effect on the therapist, and why this might be. This would be of particular relevance to the treatment of therapists with vicarious traumatisation. Future research could also examine whether there are any transitory effects of trauma which therapists experience and which have not been highlighted by this study. This would naturally require a very different methodology to the one used in this study.

It can be concluded from this research that the model of vicarious traumatisation developed by the author, figure 1, has support in terms of a number of factors being statistically significantly associated with cognitive and behavioural changes. It can further be concluded that the V.T. Behaviour Scale has proved to be a useful initial tool for measuring a number of hypothesised behavioural changes, which can take place as a

result of vicarious traumatisation, with further refinement possible in terms of reliability and validity.

Both cognitive and behavioural of changes have implications for the individual's personal and professional well being and the wider systems of their patients, family, colleagues and the National Health Service. A first step would be to make therapists in training, their supervisors and qualified therapists more aware of the potential effects of working with trauma. Preventative guidelines based on the empirical research which has been carried out could be incorporated in management policy, and specialist help provided for individuals who find the effects of working with trauma overwhelming.

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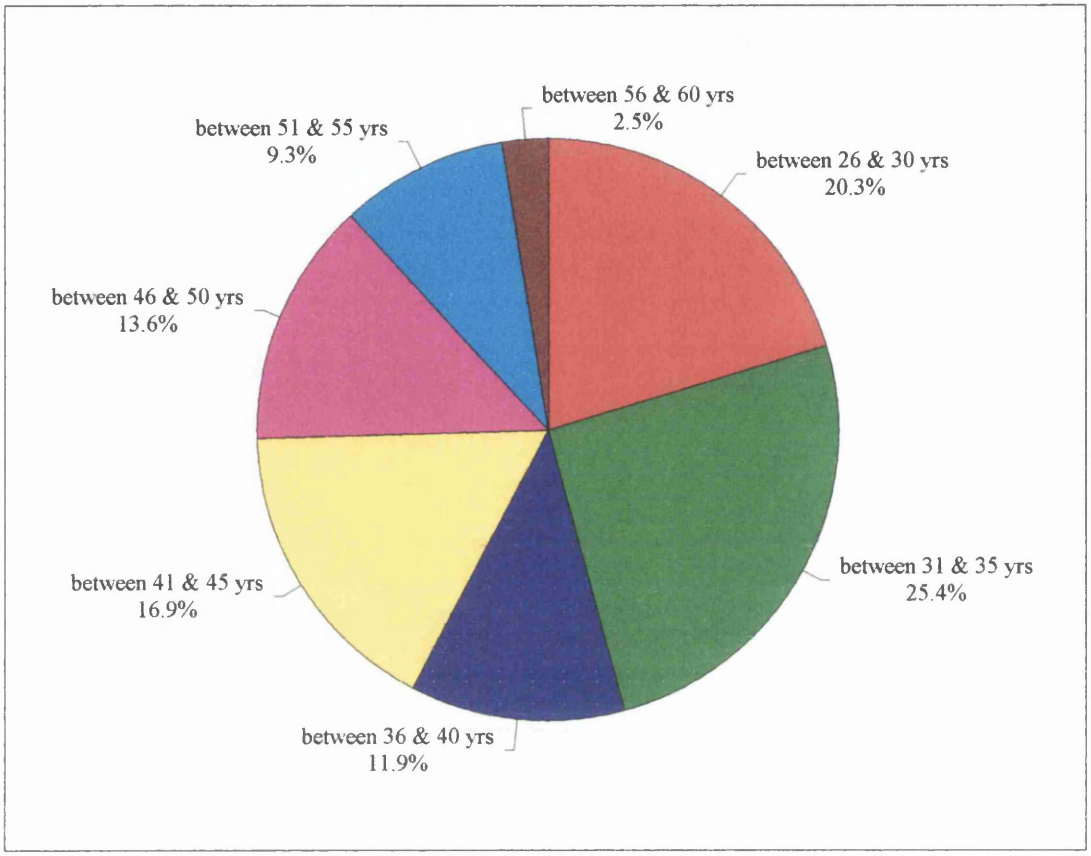
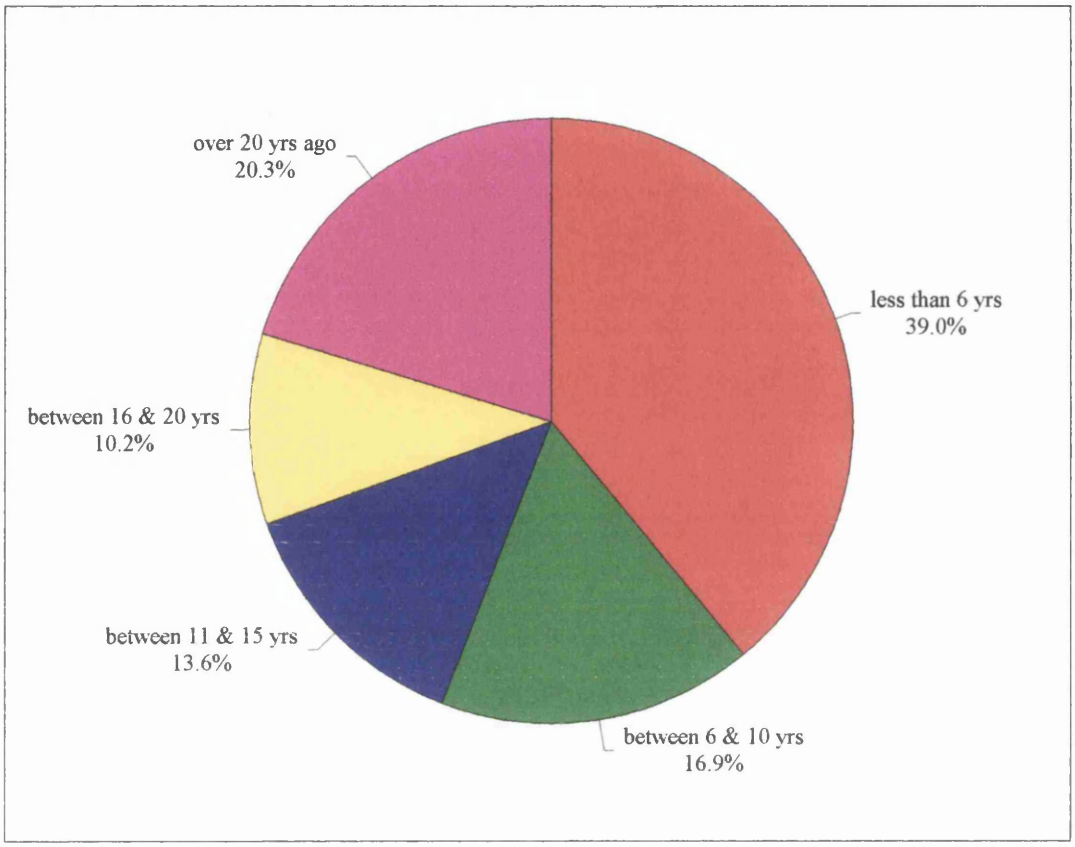
Graphs

Prepared in accordance with guidelines for submission to The Journal of Traumatic Stress (Appendix 4.5)

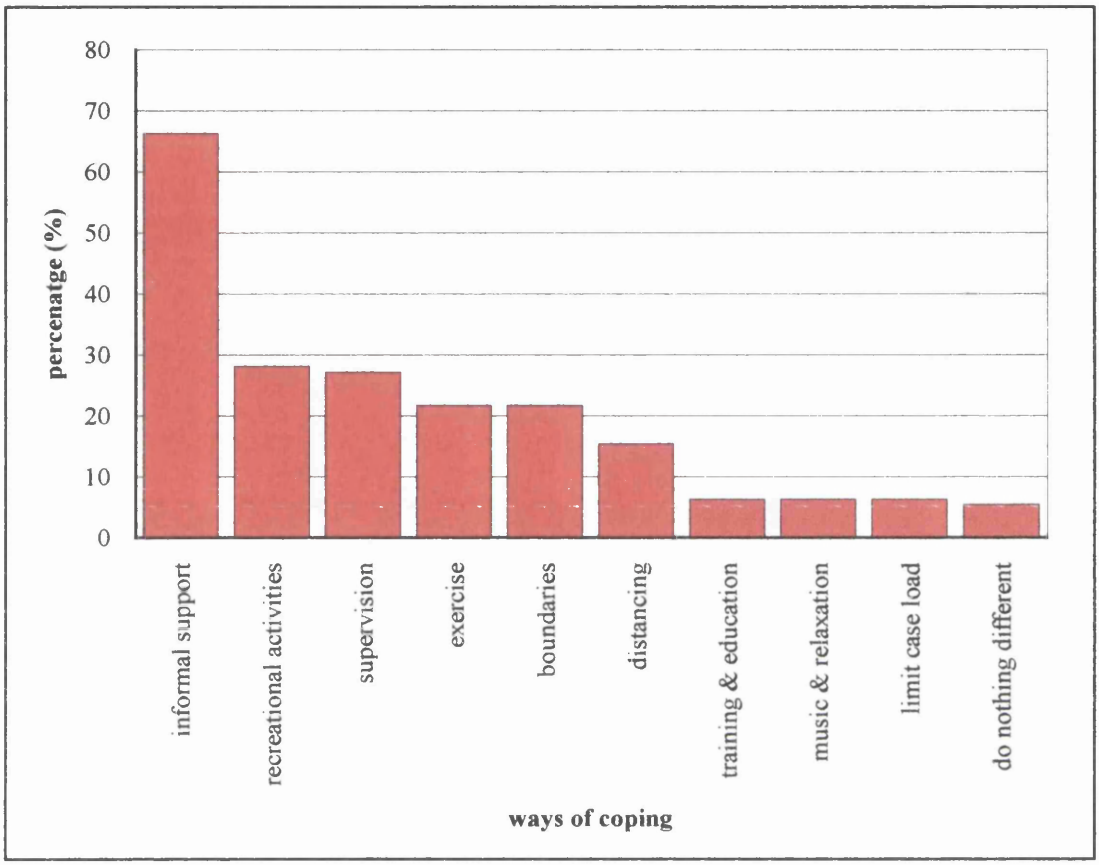
Graph 1. Age groups of participants.



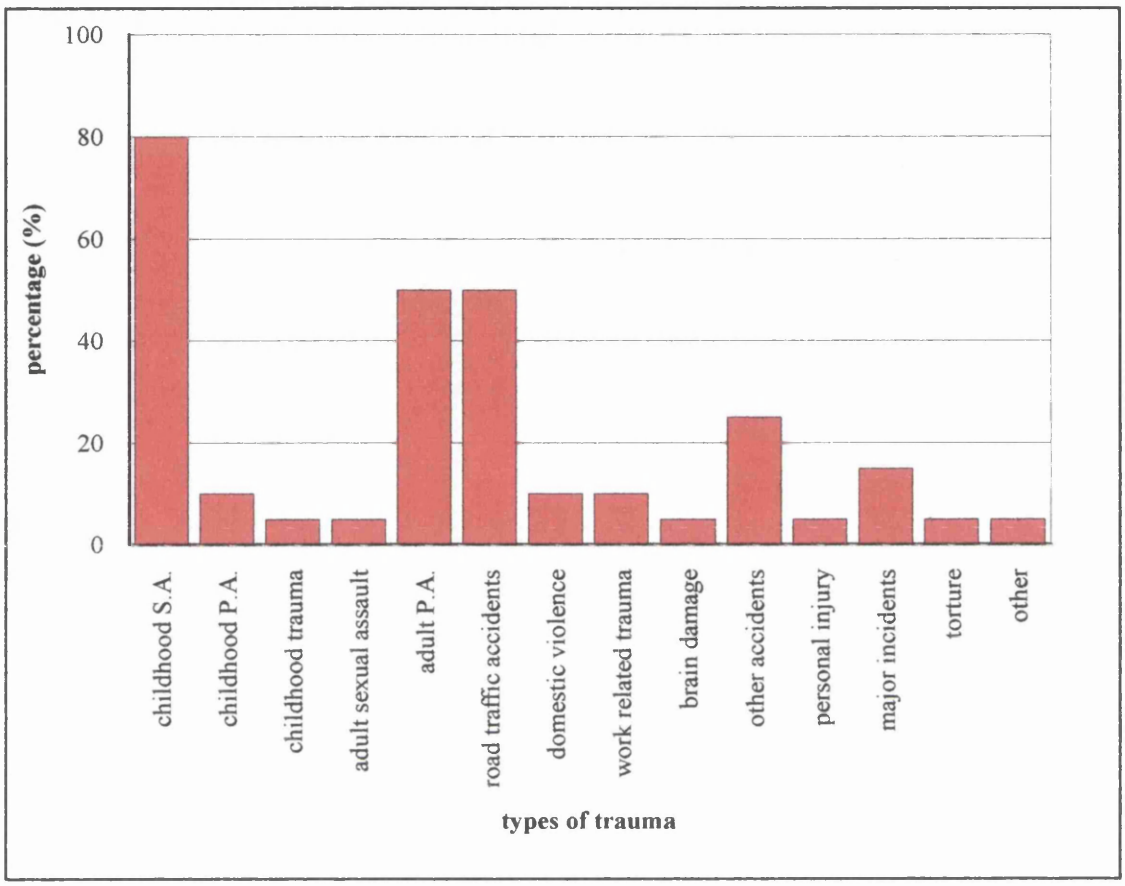
Graph 2. Number of years since qualification.



Graph 3. Ways of coping with the emotional impact of working with people who experience trauma.

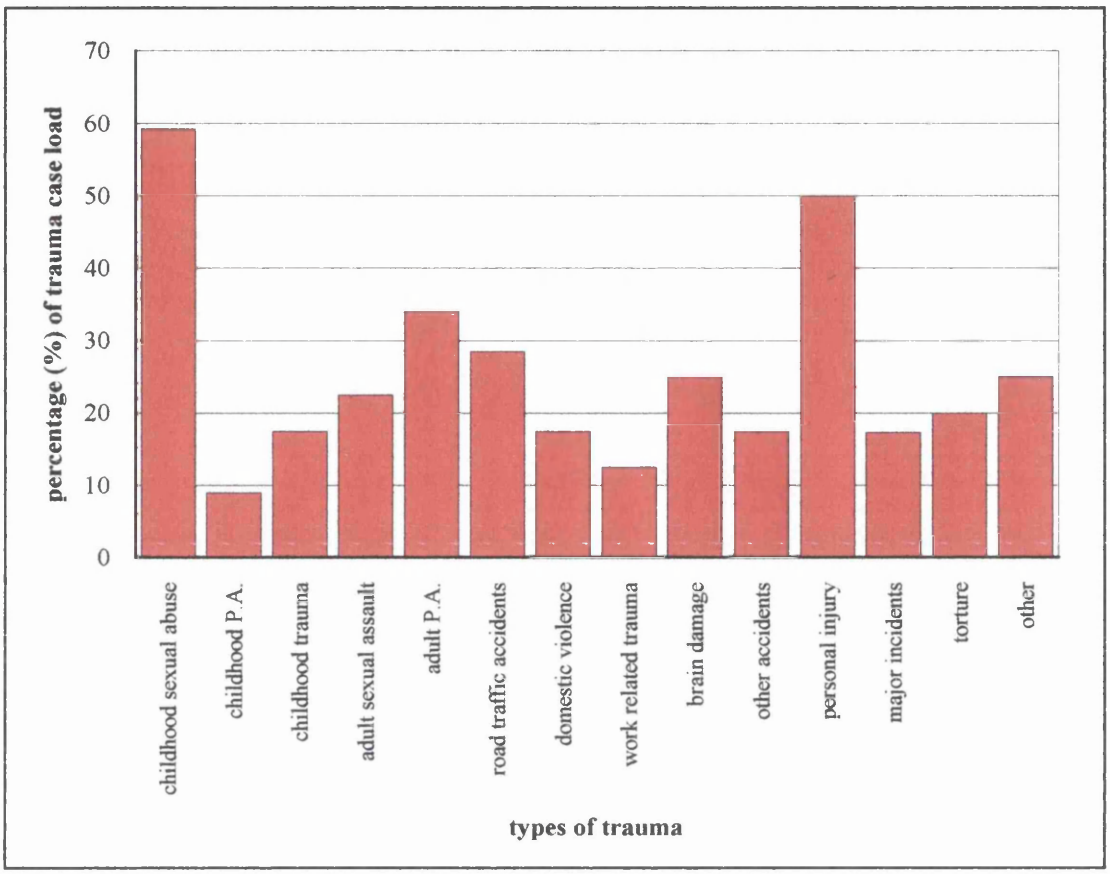


Graph 4. The main types of trauma that the participants work with.



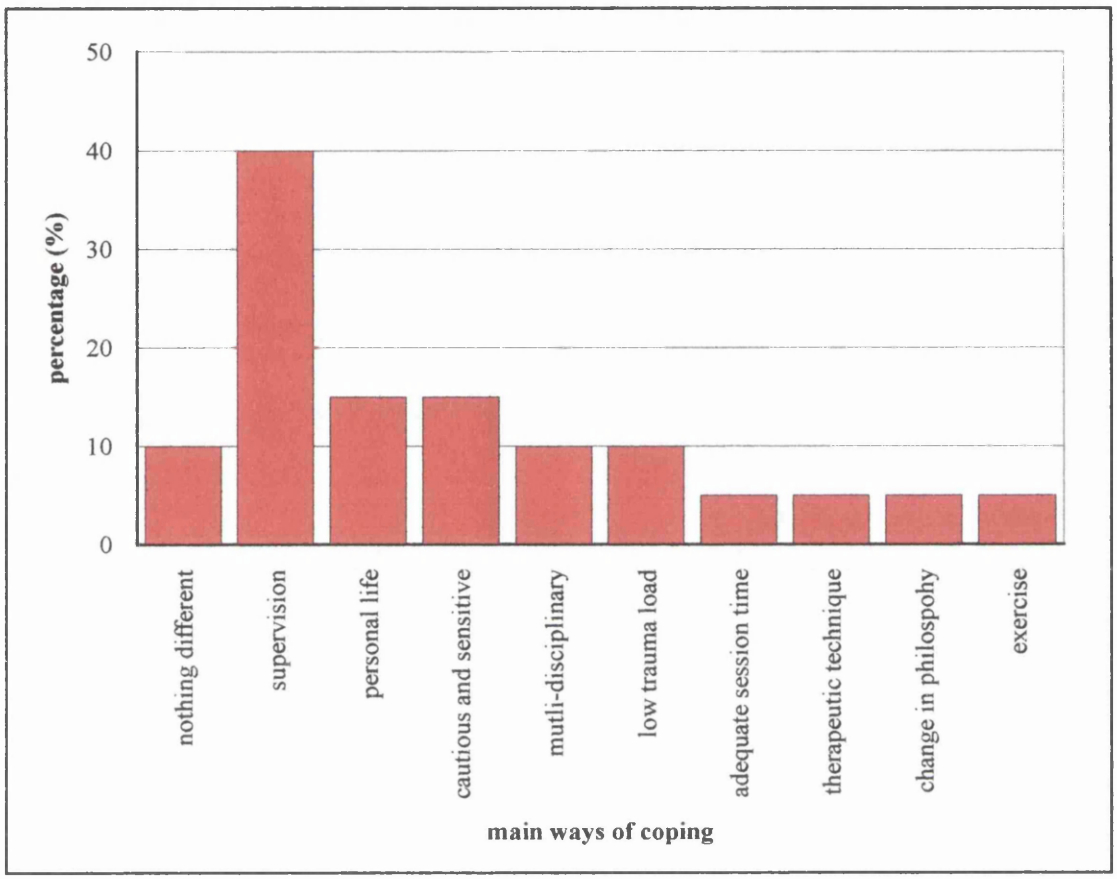
Note.
childhood S.A. = childhood sexual abuse
childhood P.A. = childhood physical abuse
childhood trauma = other childhood trauma
adult P.A. = adult physical abuse

Graph 5. Mean percentage of different types of trauma in participants' case loads.

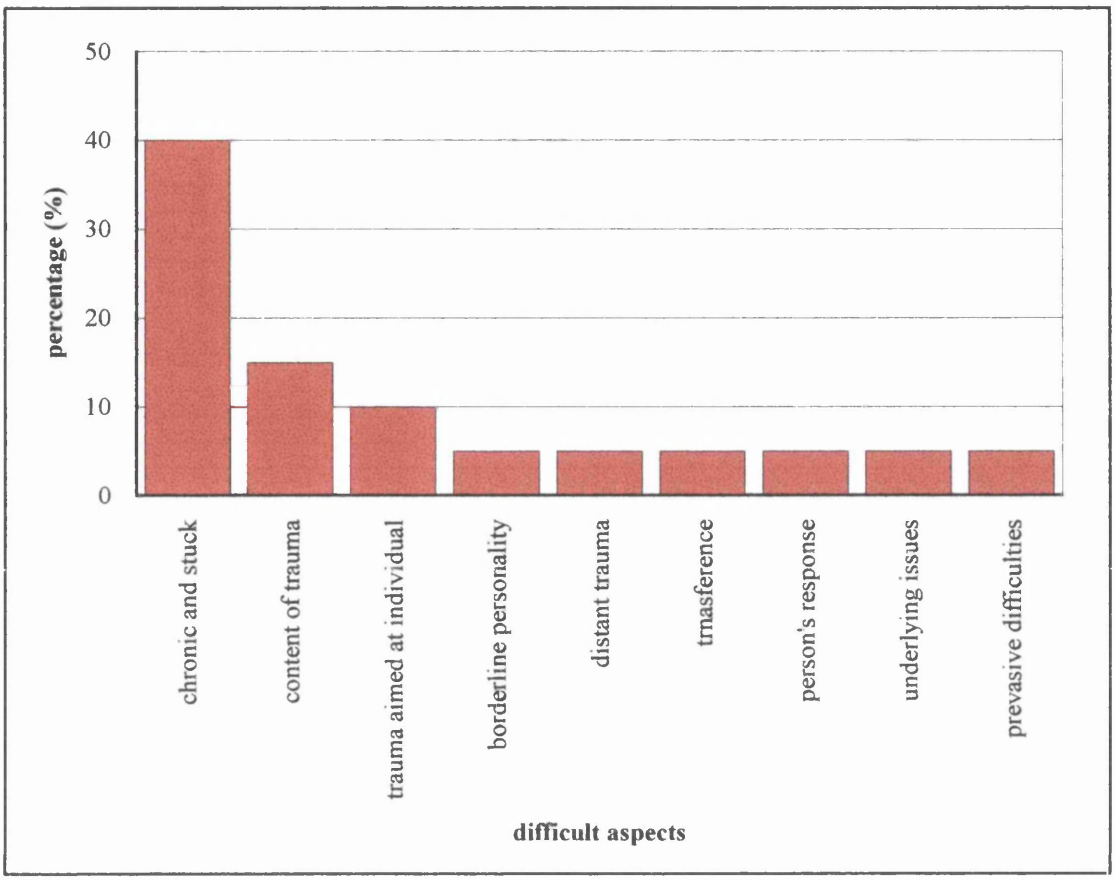


Note.
childhood P.A. = childhood physical abuse
childhood trauma = other childhood trauma
adult P.A. = adult physical assault

Graph 6. Main ways of coping with difficult trauma cases.



Graph 7. Difficult aspects of working with people who have experience trauma.



Tables

Prepared in accordance with guidelines for submission to The Journal of Traumatic Stress (Appendix 4.5)

Table 1. Spearman rank correlation coefficients between the V.T. Behaviour Scale and T.S.I. Belief Scale schemas.

Variable	V.T. Behaviour Scale
T.S.I. Belief Scale	0.20*
other-control	0.19*
other-esteem	0.29**
self-control	0.23*
self-safety	0.26**

Note.
*$p < 0.05$. **$p < 0.01$.

Table 2. Age groups of participants.

Age group	Percentage (%)
Between 26 and 30 years old	20.3
Between 31 and 35 years old	25.4
Between 36 and 40 years old	11.9
Between 41 and 45 years old	16.9
Between 46 and 50 years old	13.6
Between 51 and 55 years old	9.3
Between 56 and 60 years old	2.5

Table 3. Number of years since qualification.

Number of years qualified	Percentage (%)
Less than 6 years	39
Between 6 and 10 years	16.9
Between 11 and 15 years	13.6
Between 16 and 20 years	10.2

Table 4. Comparison of means by independent sample t tests and Mann Whitney tests, of a number of variables and vicarious traumatisation measures.

Variable	female	limiting trauma	not multi-dis. wk.	personal therapy	no trauma confs.
T.S.I. Belief Scale					
other-control	t = 2.22*				
self-control	t = 2.17*				
self-trust		t = -2.24*	t = 3.33**		
other-trust					t = 2.04*
other-intimacy			t= 2.44*		t = 2.04*
V.T. Behaviour Scale		z = 3.58***		t = 2.54*	

Variable	media avoid	change in att. & beh.	checking more	driving differently	sleep problems	not avoiding travelling alone
no. of trauma hrs.	t = 2.55*	z = 3.14**	t = 2.08*			
av. no. of trauma hrs.		z = 4.05***		z = 2.01*		
no. of trauma months					t = 2.13*	z = 2.55*

Note.
limiting trauma = limiting the number of people seen with trauma related difficulties.
not multi-dis. wk. = not working within a multidisciplinary framework.
personal therapy = having used personal therapy.
no trauma confs. = not having attended a trauma conference within the last two years.
media avoid = avoided reports of trauma in the media since working with people who have trauma related problems.
change in att. & beh. = having had a change in attitudes and behaviour towards people since working with people who have trauma related problems.
checking more = conscious of checking things more often since working with people who have trauma related problems.
driving differently = driving differently since working with people who have trauma related problems.
sleep problems = had trouble falling asleep, or staying asleep because of thoughts about the trauma that your clients have experienced since working with people who have trauma related problems.
not avoiding travelling alone = have not avoided travelling alone since working with people who have trauma related problems.

Table 5. Comparison of a number of variables and changes in behaviour by chi squares.

Variable	female	personal therapy	adverse life events	add. training	trauma limits
V.T. Behaviour Scale					
avoid media					$\chi^2 = 7.78^{**}$
diminished rec. activity				$\chi^2 = 4.98^{*}$	
more aggressive					$\chi^2 = 7.57^{**}$
more agitated		$\chi^2 = 8.31^{**}$			$\chi^2 = 6.08^{*}$
apt. problems					$\chi^2 = 5.49^{*}$
change in att. & beh.	$\chi^2 = 10.61^{**}$				
additional security				$\chi^2 = 4.27^{*}$	$\chi^2 = 5.56^{*}$
concerns re. fam. & fri		$\chi^2 = 4.28^{*}$			
driving differently			$\chi^2 = 4.78^{*}$		

Note.
personal therapy = having used personal therapy.
adverse life events = having experienced adverse life events in the last twelve months.
add. training = having undergone additional training in working with people who have experienced trauma.
trauma limits = limiting the number of people seen with trauma related difficulties.
avoid media = having avoided reports of trauma in the media since working with people who have trauma related problems.
diminished rec. activity = a diminished interest in recreational activities since working with people who have trauma related problems.
more aggressive = being more aggressive since working with people who have trauma related problems.
more agitated = being more agitated since working with people who have trauma related problems.
apt. problems = more problems with regards to scheduling appointments since working with people who have trauma related problems.
change in att. & beh. = had a change in attitudes and behaviour towards people since working with people who have trauma related problems.
additional security = taken additional security measures since working with people who have trauma related problems.
concerns re. fam. & fri. = become more concerned about family and friends' safety since working with people who have trauma related problems.
driving differently = driving differently since working with people who have trauma related problems.
$^{*}p < 0.05$. $^{**}p < 0.01$.

Table 6. Spearman rank correlation coefficients between trauma work variables and vicarious traumatisation measures.

Variable	number of trauma hours in last working week	number of months worked with trauma
T.S.I. Belief Scale		
self-esteem	-0.163*	-0.26**
self-intimacy		-0.23*
V.T. Behavioural Scale	0.30*	

Note.
*p < 0.05. **p < 0.01.

Table 7. Participants' ways of coping with the emotional impact of working with people who have experienced trauma.

Way of coping	Percentage (%)
Informal and social support	66.36
Recreational activities	28.18
Supervision	27.27
Exercise	21.81
Boundaries	21.81
Distancing	15.45
Training and education	6.36
Music and relaxation	6.36
Limit case load	6.36
Do nothing different	5.45

Table 8. Inter rater reliability for qualitative data.

Variable	Kappa
Postal questionnaire	
Coping with emotional impact of working with trauma	0.84***
Telephone interview	
Most difficult aspects of trauma work	0.87***
Coping working with particularly difficult cases	0.84***

Note. ***$p < 0.001$.

Table 9. The main types of trauma that the participants worked with and the mean percentage of these different types in their trauma caseload.

Type of trauma	% of psychologists who work with type of trauma	Mean % of caseload
Childhood sexual abuse	80	59.25
Adult physical assault	50	34.14
Road traffic accidents	50	28.5
Other accidents	25	17.5
Major incidents	15	17.33
Childhood physical abuse	10	9
Domestic violence	10	17.5
Work related trauma	10	12.5
Other childhood trauma	5	17.5
Adult sexual assault	5	22.5
Acquired brain damage	5	25
Other	5	25
Personal injury	5	50
Torture	5	20

Table 10. Main ways of coping with difficult trauma cases.

Ways of coping	Percentage (%)
Supervision	40
Separate stable personal life	15
Being more cautious and sensitive	15
Nothing different	10
Multi disciplinary work	10
Low trauma workload	10
Enough session time for resolution	5
Therapeutic technique	5
Change in philosophy, world view	5
Exercise	5

Table 11. Difficult aspects of working with people who have experienced trauma.

Difficult aspects of working with trauma	Percentage (%)
Chronic and stuck	40
Content of trauma	15
Trauma directed specifically at the individual	10
Was preventable	10
Borderline personality disorder	5
Distant trauma	5
Transference	5
Person's response	5
Complex underlying issues	5
Pervasive difficulties	5

Table 12. Stepwise linear regression analysis 1.

dependent variable and predictor variable	F	R	Beta
T.S.I. Belief Scale			
average hours of trauma	8.43***	0.34	-0.21

Table 13. Stepwise linear regression analysis 2.

dependent variable and predictor variable	F	R	Beta
V.T. Behaviour Scale			
hours of trauma	27.33***	0.49	0.38
other-esteem	26.97***	0.62	0.33
limits on trauma	22.89***	0.67	0.21

Note.
hours of trauma = number of hours during the last working week spent working with patients whose main difficulties were trauma related.
limits on trauma = "Do you try to limit the number of people you see with trauma related difficulties?"
***$p < 0.001$.

Table 14. Logistic regression analysis.

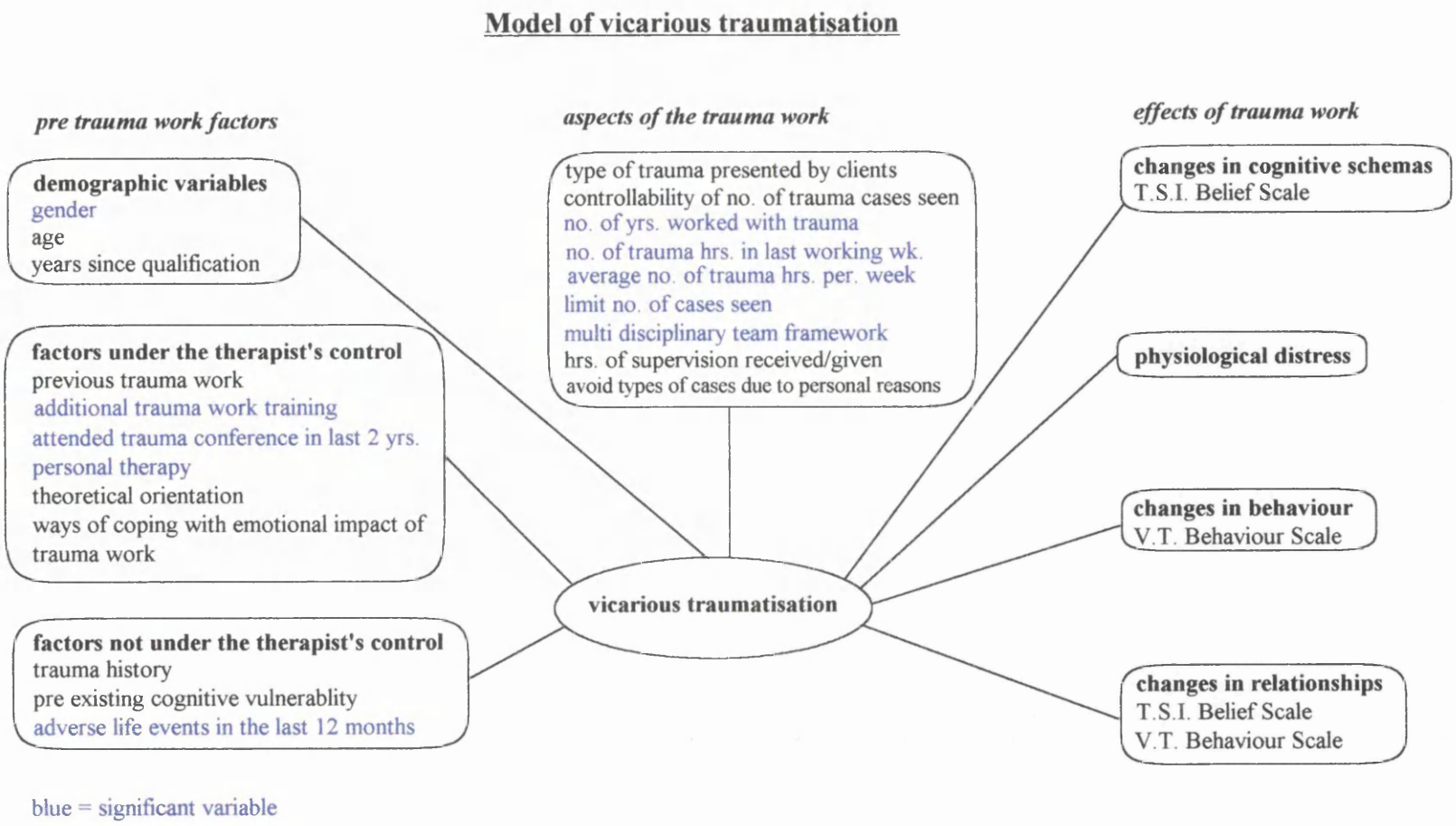
Dependent variable and predictor variable	R
T.S.I. Belief Scale	
Months of trauma	-0.19*

Note.
Months of trauma = number of months spent working with people whose main difficulties have been trauma related.
*$p < 0.05$.

Figures

Prepared in accordance with guidelines for submission to The Journal of Traumatic Stress (Appendix 4.5)

Figure 1. A model of vicarious traumatisation.



Clinical Case Research Study 1

The Role of Control in an Older Adult with Diabetes and Generalised Anxiety Disorder: A Case Study

The Role of Control in an Older Adult with Diabetes and Generalised Anxiety Disorder: A Case Study

Abstract

A research clinical case study of a women in her late sixties, who after more than twenty years of well controlled type 1 diabetes, started to experience behavioural and cognitive symptoms of generalised anxiety disorder (G.A.D.), after having fainted due to a number of hypoglycaemic episodes. Assessment was carried out by clinical interview using the Hospital Anxiety and Depression Scale (H.A.D.S.), (Zigmond and Snaith, 1983), the Perceived Control of Diabetes Measure, (Bradley, 1994a) and the Well-Being Questionnaire (Bradley, 1994b). Formulation was within a cognitive behavioural and systemic framework. Resolution of the women's difficulties was achieved using anxiety management techniques, via the restoration of a sense of control regarding her diabetic condition. However, at a six months follow up there had been a decrease in her sense of control and an increase in her anxiety symptoms, possibly attributable to the development of glaucoma. Statistically significant associations were found between her estimation of control and a number of standardised measures. Implications for clinical work are considered.

Clinical Case Research Study 2

The Contribution of Neuropsychology to the Differential Diagnosis of Organophosphate Exposure and Myalgic Encephalomyelitis: A Case Study

The Contribution of Neuropsychology to the Differential Diagnosis of Organophosphate Exposure and Myalgic Encephalomyelitis: A Case Study

Abstract

This research clinical case study reviews the literature on the neuropsychological effects of organophosphate exposure and myalgic encephalomyelitis (M.E.), and applies this to the case of a fifty year old farmer with a five year history of excessive fatigue, anxiety, feeling low and bouts of hypersomnia. Conclusions are drawn regarding the difficulties of differential diagnosis regarding organophosphate exposure and M.E.

Clinical Case Research Study 3

Working with "Inappropriate Sexual Behaviour" in Learning Disabilities:

A Case Study

Working with "Inappropriate Sexual Behaviour" in Learning Disabilities: A Case Study

Summary

This article details a number of alternative hypotheses with regards to one type of challenging behaviour, "inappropriate sexual behaviour", and demonstrates their application in the assessment, formulation and intervention with a man in his late thirties who presented this type of challenge to services. During the treatment phase there was a decrease in the occurrence of this behaviour from baseline measures, but an increase at a two months follow up compared to the treatment phase. Reasons for these changes are explored.

APPENDICES

Appendix 1

Small Scale Service Evaluation Project

What do people think and feel about being neuropsychometrically assessed?

Appendix 1.1

Dear ,

As part of an ongoing programme to improve our services I am writing to find out if you are willing to be interviewed as part of a research project, on how you found being tested by a psychologist from our department.

The interview will take a maximum of half an hour and will be confidential. This means that the psychologist you saw will not see the results of the interview.

If you do **not** wish to be contacted by telephone or post in a weeks time to arrange a mutually convenient time and place, please fill in the tear-off slip and return it in the enclosed stamped addressed envelope.

Yours sincerely,

Laura Toplis, psychologist.

— — — — — — — — — — — — — — — — — — — —

I do NOT wish to part in the research study.
Name:

Signature:

Appendix 1.2

Explain that the information given will be confidential and will not be disclosed to the psychologist or any other mental health professionals that they have had contact with.

A. Had anyone told you that you were being referred to a Clinical Psychologist?

B. What was the explanation given?

C. Who gave you the explanation?

D. What were the worries or concerns that you had before you did the tests?

<u>During the test:</u>

E. How much did you feel your problems were being taken seriously?

0% 100%

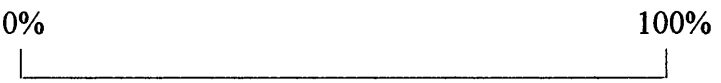
F. How much was doing the tests a relief for you?

0% 100%

G. How much was this a trauma for you?

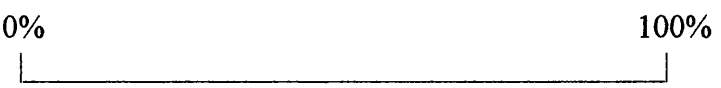
0% 100%

H. How much were the tests a waste of time?



I. How valuable did you find the tests?

J. How much relevance did you think the tests had to your everyday life?



K. What were your fears about the testing?

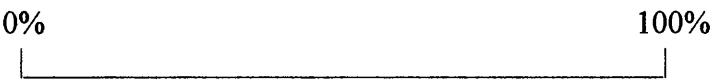
L. What was it like being tested? **Tick as many of these boxes as apply**

enjoyable	pointless	felt stupid
embarrassing	challenging	frustrating
interesting	frightening	humiliating
easy	absorbing	difficult
boring	worrying	puzzling
disappointing	reassuring	degrading
calming	confusing	demanding
satisfying	irritating	leisurely
pleasant	peculiar	realistic
relaxing	serious	dissatisfying
tiring	invigorating	helpful
revealing	surprising	exhausting
too long	too quick	stimulating
fun	anxiety-provoking	enlightening
depressing	distressing	intimidating
daunting	frivolous	thorough

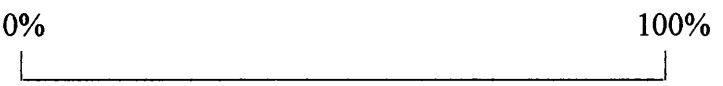
M. What information did you receive after the testing from the psychologist?

N. Who else gave you information on how you had done on the testing?

O. How much did you understand this?



P. To what extent did the information cover all your questions?



Q. Do you think that this questionnaire should be a regular feature for people being tested?

R. What changes would you make to it?

S. Are there any questions you would like to have been asked and weren't?

T. Are there any questions that you found difficult to answer?

U. or would rather have not answered?

Appendix 1.3

Clinical Psychology Forum

Clinical Psychology Forum is produced by the Division of Clinical Psychology of The British Psychological Society. It is edited by Steve Baldwin, Lorraine Bell, Jonathan Calder, Lesley Cohen, Simon Gelsthorpe, Laura Golding, Helen Jones, Craig Newnes, Mark Rapley and Arlene Vetere, and circulated to all members of the Division monthly. It is designed to serve as a discussion forum for any issues of relevance to clinical psychologists. The editorial collective welcomes brief articles, reports of events, correspondence, book reviews and announcements.

Notes for contributors

Articles of 1000-2000 words are welcomed. Send two
Contributors are asked to keep tables to a minimum, to ensure that all references are complete and accurate, and to give a word count. Please indicate the author's employers, to appear at the head of the article, and include an address for correspondence, with e-mail if possible. News of Branches and Special Groups is especially welcome.
Language: contributors are asked to use language which is psychologically descriptive rather than medical and to avoid using devaluing terminology; I.e. avoid clustering terminology like "the elderly" or medical jargon like "person with schizophrenia". If you find yourself using quotation marks around words of dubious meaning, please use a different word.
Articles submitted to Forum will be sent to members of the Editorial Collective for referring. They will then communicate directly with authors.
We reserve the right to shorten, amend and hold back copy if needed.

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Appendix 2

Major Research Project Literature Review

A Review of the Literature on Helping Induced Trauma

Appendix 2.1

NOTES FOR CONTRIBUTORS

1. The *British Journal of Clinical Psychology* publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour, e.g. neuropsychology, age associated C.N.S. changes and pharmacological (in the later case an explicit psychological analysis also required), through studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicity social and psychological levels of analysis. The general focus of studies in an abnormal behaviour such as that described and classified by current diagnosis systems (I.C.D.-10, D.S.M.-IV) but it is not bound by the exclusive use of such diagnostic systems. The Journal is catholic with respect to the range of theories and methods used to answer substantive scientific problems. Studies of samples with only be considered if they have a direct bearing on clinical theory or practice.
2. The following types of paper are invited:
(a) Papers reporting original empirical investigations.
(b) Theoretical papers, provided that these are sufficiently related to empirical.
(c) Review articles which need not be exhaustive, but which should give an interpretation of the state of the research in a given field and where appropriate, identify its clinical implications.
(d) Brief Reports and Comments (see paragraph 6).
Case studies are normally published only as Brief Reports. Papers are evaluated in terms of their theoretical importance, contributions to knowledge, relevance to the concerns of practising clinical psychologists, and readability. Papers generally appear in order o f acceptance, except for the priority given to Brief Reports and Comments.
3. The circulation of the Journal is worldwide, and papers are reviewed by colleagues in many countries. There is no restriction to British authors, and papers are invited from authors throughout the world.
4. The editors will reject papers which evidence discriminatory, unethical or unprofessional practices.
5. Papers should be prepared in accordance with The British Psychological Society's Style Guide, available at £3.50 per copy from The British Psychological Society, St. Andrew's House, 48 Princess Road East, Leicester LE1 7DR, England. Contributions should be kept as concise as clarity permits, and illustrations kept as few as possible. Papers should not normally exceed 5000 words. A structured abstract of up to 250 words should be provided (see Volume 35(2), pp. 323 (1996), for details. The title should indicate exactly but as exactly but as briefly as possible the subject of the article, bearing in mind its use in abstracting and indexing systems.

(a) Contributions should be typed in double spacing with wide margins and only on one side of each sheet. Sheets should be numbered. The top copy and at least three good duplicates should be submitted and a copy should be retained by the author.

(b) This journal operates a policy of blind peer review. Papers will normally be scrutinized and commented on by at least two independent expert referees as well as by the editor or by an associate editor. The referees will not be made aware of the identity of the author. All information about the authorship including personal acknowledgments and institutional affiliations should be confined to a removable from page and the text should be free of such clues as identifiable self-citations ('In our earlier work...') The paper's tittle should be repeated on the first page of the text.

(c) Tables should be typed in double spacing on separate sheets. Each should have a self-explanatory title and should be comprehensible without reference to the text. They should be referred to in the text by arabic numerals. Data given should be checked for accuracy and must agree with mentions in the text.

(d) Figures, i.e. diagrams, graphs or other illustrations, should be on separate sheets numbered sequentially 'Fig. 1', etc., and each identified on the back with the title of the paper. They should be carefully drawn, larger than their intended size, suitable for photographic reproduction and clear when reproduced in size. Special care is needed with symbols: correction at proof stage may not be

possible. Lettering must not be put on the original drawing but upon a copy to guide the printer. Captions should be listed on a separate sheet.

(e) Bibliographical references in the text should quote the author's name and date of the publication thus: Hunt (1993). They should be listed alphabetically by the author at the end of the article according to the following format:

Moore, R. G. & Blackburn, I.-M. (1993). Sociothrophy, autonomy and personal memories in depression. *British Journal of Clinical Psychology, 32*, 460-462.

Steptoe, A. & Wardle, J. (1992). Cognitive predictors of health behaviour in contrasting regions of Europe. In C. R. Brewin, A. Steptoe, & J. Wardle (Eds), European Perspectives in Clinical and Health Psychology, (pp. 101-118). Leicester: The British Psychological Society.

Particular care should be taken to ensure that references are accurate and complete. Give all the journal titles in full.

(f) SI units must be used for all measurements, rounded off to practical values if appropriate, with the Imperial equivalent in parentheses (*see BPS Style Guide*).

(g) Authors are requested to avoid the use of sexist language.

(h) Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies of experimental techniques. The materials should be submitted to the Editor together with the article, for simultaneous referring.

6. Brief Reports and Comments are limited to two printed pages. These are subject to accelerated review process to afford rapid review process to afford rapid publication of research studies, and theoretical, critical or review comments whose essential contribution can be made within a small space. They also include research studies whose importance or breadth of interest is insufficient to warrant publication as full articles, and case reports making a distinctive contribution to theory or method. Authors are encourages to append an extended report to assist in the evaluation of the submission and to be made available to interested readers on request to the author. To ensure that the two-page limit is not exceeded, set typewriter margins to 66 characters maximum per line and limit the test, including references and a 100 word abstract, to 150 lines. Figures and tables should be avoided. Title, author and name and address for reprints and data of receipt are not included in the allowance. However deduct three lines from the text each and every time any of the following occur:

(a) title longer than 70 characters,

(b) author names longer than 70 characters,

(c) each address after the first address,

(d) each text heading (these should normally be avoided).

A character is a letter or space. A punctuation mark counts as two characters (character plus space) and a space must be allowed on each side of a mathematical operator.

7. Proofs are sent to authors for correction of print, but not for introduction of new or different material. They should be returned to the Journals Manager as soon as possible. Fifty complimentary copies of each paper are supplied to the senior author on request: further copies may be ordered on a form supplied with the proofs.

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Appendix 3

Major Research Project Application for Ethical Approval

A Survey of Qualified Clinical Psychologists working in Britain with People who have experienced Trauma

Appendix 3.1

3920

Dear ,

Re: A survey of qualified clinical psychologists working in Britain with people who have experienced trauma.

I am carrying out research into the above area as part of my Doctorate in Clinical Psychology at the University of Glasgow. This project is designed to look at how the direct clinical work that clinical psychologists do, with people who have experienced trauma, effects their behaviour, and the way they think and feel. Naturally the results of this research has consequences for training and the working environment of clinical psychologists.

I would therefore be most grateful if you could complete the attached questionnaire, which will only take approximately twenty minutes.

If you become distressed whilst completing this questionnaire then please stop filling it in. There are a number of agencies which you may find useful to contact should you find yourself becoming distressed. (Details of these can be found at the end of the questionnaire).

This questionnaire is confidential and anonymous.

There is also a form attached which you can fill in, if you consent to be contacted by telephone to be asked a further set of questions about the possible affects of working with people who have been traumatised. You would be initially contacted by a research assistant by telephone, and then transferred to myself to protect your anonymity. The interview would take a maximum of twenty minutes.

There is also a form attached if you wish to receive the results of this research project, which will be available in October 1999.

Please return the questionnaire and forms in the attached envelope.

If you have any questions regarding this questionnaire then please feel free to contact me at the above address or telephone number.

Yours sincerely,

Laura Toplis, Trainee Clinical Psychologist, under the supervision of Dr. Elizabeth Campbell, Senior Lecturer.

Appendix 3.2

A survey of qualified clinical psychologists working in Britain with people who have experienced trauma.

Please indicate that you have read and understood the content and aims of this study as explained in the covering letter, and whether you do or do not wish to consent to participate in this study, by placing a tick in the appropriate box below.

I consent to participate in this study ☐

I do not consent to participate in this study ☐

1. Which year were you born? _____

2. Please indicate your gender (*delete as appropriate). ***female/ male**

3. Which year did you qualify as a clinical psychologist? _____

4. Have you experienced any adverse life events in the last twelve months? **__ yes, __ no**

5. Have you experienced any trauma (trauma being defined as experiencing, witnessing, or being confronted with an event(s) that involved actual or threatened death, or serious injury, or a threat to the physical integrity of self or others, and your response involving intense fear, helplessness, or horror), in your life?

__ yes, __ no

6. Within the last working week, how many hours did you spend working with patients whose **main** difficulties were trauma related?

_____ hours

7. How long have you worked with people whose **main** difficulties have been trauma related?

____ months

8. On average how many hours a week do you spend working with this particular group?

_____ hours

9. How much control do you have over the number of people you see who have experienced trauma? (please place a mark on the line to indicate your level of control).

no control_____**total control**

10. Are there certain types of problems that you avoid working with, due to personal reasons, i.e. not working sexual abuse perpetrators because you have children.

__ yes, __ no

11. Do you try to limit the number of people you see with trauma related difficulties?

__ yes, __ no

12. Do you work within a multidisciplinary team framework? **__ yes, __ no**

13. Do you receive regular supervision? **__ yes, __ no**

14. How many hours a month do you spend in supervision? **_____ hours**

15. Are you/or have you ever been in personal therapy? **__ yes, __ no**

16. Have you undergone additional training in working with people who have experienced trauma?

__ yes, __ no

17. Have you attended a trauma related conference in the last two years? **__ yes, __ no**

18. What would you describe your theoretical orientation as being?

Since working people with trauma related problems have you...

19. ...avoided reports of trauma in the media? **__ yes, __ no**

20. ....taken a greater interest in media reports of trauma? **__ yes, __ no**

21. ....had a diminished interest in recreational activities? **__ yes, __ no**

22. ....had a diminished interest in social activities? **__ yes, __ no**

23. ....found yourself being more aggressive? **__ yes, __ no**

24. ....found yourself being more agitated? **__ yes, __ no**

25. ....found yourself with more problems with regards to scheduling appointments, i.e. forgetting appointments, double scheduling, rescheduling or cancelling appointments? **__ yes, __ no**

26. ....had a change in your attitudes and behaviour towards men? **__ yes, __ no**

27. ....taken any additional security measures? **__ yes, __ no**

28. ....had trouble falling asleep, or staying asleep because you are thinking about the trauma that your clients have experienced? **__ yes, __ no**

29. ....stopped discussing your work with colleagues? **__ yes, __ no**

30. ....become more concerned about your family and friends' safety? **__ yes, __ no**

31. ....avoided travelling alone? **__ yes, __ no**

32. ....been conscious of checking things more often? **__ yes, __ no**

33. ....found yourself driving differently? **__ yes, __ no**

TSI BELIEF SCALE Revision L (c)

This questionnaire is used to learn how individuals view themselves and others. As people differ from one another in many ways, there are no right or wrong answers. Please place next to each item the number from the scale below which you feel most closely matches your own beliefs about yourself and your world. Try to complete every item.

1	2	3	4	5	6
disagree strongly	disagree	disagree somewhat	agree somewhat	agree	agree strongly

1. I generally feel safe from danger. _____
2. People are wonderful. _____
3. I can comfort myself when I'm in pain. _____
4. I find myself worrying a lot about my safety. _____
5. I don't feel like I deserve much. _____
6. I can usually trust my own judgment. _____
7. I feel empty when I am alone. _____
8. I have a lot of bad feelings about myself. _____
9. I'm reasonably comfortable about the safety of those I care about. _____
10. Most people destroy what they build. _____
11. I have a difficult time being myself around other people. _____
12. I enjoy my own company. _____
13. I don't trust my own instincts. _____
14. I often think the worst of others. _____
15. I believe I can protect myself if my thoughts become self-destructive. _____
16. You can't trust anyone. _____
17. I'm uncomfortable when someone else is leading the group. _____
18. I feel good about myself most days. _____
19. Sometimes I think I'm more concerned about the safety of others than they are. _____
20. Other people are no good. _____
21. Sometimes when I'm with people, I feel disconnected. _____
22. People shouldn't place too much trust in their friends. _____
23. Mostly, I don't feel like I'm worth much. _____
24. I don't have much control in my relationships. _____
25. My capacity to harm myself scares me sometimes. _____
26. For the most part, I like other people. _____
27. I deserve to have good things happen to me. _____
28. I usually feel safe when I'm alone. _____
29. If I really need them, people come through for me. _____
30. I can't stand to be alone. _____
31. This world is filled with emotionally disturbed people. _____
32. I am basically a good person. _____
33. For the most part, I can protect myself from harm. _____
34. Bad things happen to me because I'm bad. _____
35. Some of my happiest experiences involve other people. _____
36. There are many people to whom I feel close and connected. _____
37. Sometimes I'm afraid of what I might do to myself. _____
38. I am often involved in conflicts with other people. _____
39. I often feel cut off and distant from other people. _____
40. I worry a lot about the safety of loved ones. _____
41. I don't experience much love from anyone. _____
42. Even when I'm with other people, I feel alone. _____
43. There is an evil force inside of me. _____
44. I feel uncertain about my ability to make decisions. _____
45. When I'm alone, I don't feel safe. _____

1	2	3	4	5	6
disagree strongly	disagree	disagree somewhat	agree somewhat	agree	agree strongly

46. When I'm alone, it's like there's no one there. _____
47. I can depend on my friends to be there when I need them. _____
48. Sometimes I feel like I can't control myself. _____
49. I feel out of touch with people. _____
50. Most people are basically good at heart. _____
51. I sometimes wish I didn't have any feelings. _____
52. I'm often afraid I will harm myself. _____
53. I am my own best friend. _____
54. I feel able to control whether I harm others. _____
55. I often feel helpless in my relationships with others. _____
56. I don't have a lot of respect for the people closest to me. _____
57. I enjoy feeling like part of my community. _____
58. I look forward to time I spend alone. _____
59. I often feel others are trying to control me. _____
60. I envy people who are always in control. _____
61. The important people in my life are relatively safe from danger. _____
62. The most uncomfortable feeling for me is losing control over myself. _____
63. If people really knew me, they wouldn't like me. _____
64. Most people don't keep the promises they make. _____
65. Strong people don't need to ask for help. _____
66. Trusting other people is generally not very smart. _____
67. I fear my capacity to harm others. _____
68. I feel bad about myself when I need others' help. _____
69. To feel at ease, I need to be in charge. _____
70. I have sound judgment. _____
71. People who trust too much are foolish. _____
72. When my loved ones aren't with me, I fear they may be in danger. _____
73. At times my actions pose a danger to others. _____
74. I feel confident in my decision-making ability. _____
75. I can't work effectively unless I'm the leader. _____
76. I often doubt myself. _____
77. I can usually size up situations pretty well. _____
78. I generally don't believe the things people tell me. _____
79. Sometimes I really want to hurt someone. _____
80. When someone suggests I relax, I feel anxious. _____

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34. Could you please list below the ways you personally cope with the emotional impact of working with people who have experienced trauma?

---

35. Vicarious traumatisation is defined as "the transformation that occurs within the therapist (or other trauma worker) as a result of the empathic engagement with client's trauma experiences and their sequelae". How do you think vicarious traumatisation comes about? (Please put a tick in the box next to the statement(s) that you agree with).

	agree	disagree	do not know
a) because the therapist is hearing the details of the person's traumatic experience and this is changing their own thoughts about themselves, others and the world?	☐	☐	☐
b) because of the degree of extreme emotional distress the person is communicating?	☐	☐	☐
c) because of the therapist's unresolved difficulties?	☐	☐	☐

d) some other reason, please specify

THANK YOU FOR HAVING TAKEN THE TIME AND THOUGHT TO FILL OUT THIS QUESTIONNAIRE

It would be most helpful, even if you feel that you are totally unaffected in a negative way by your work with people who have experienced trauma, if you would consent to be contacted by telephone by myself. The purpose of this would be to answer a number of additional questions either over the telephone, or in a person to person interview. This would take a maximum of fifteen minutes. If you consent to this, please fill out the details below.

Name:

Work telephone number:

Most convenient times to be called:

If you like to receive details of the results of this research then please fill out the section below.

Name: Title:

Address:

Number of copies required:

Details of organisations to contact if you find yourself becoming distressed whilst completing this questionnaire:

your general practitioner.
your local occupational health department.

Appendix 3.3

Telephone Questionnaire Consent Form

It would be most helpful, even if you feel that you are totally unaffected in a negative way by your work with people who have experienced trauma, if you would consent to participate in a telephone interview. This would involve answering additional questions as to the possible affects of working with traumatised people. You would be initially contacted by a research assistant by telephone, and then transferred to myself to protect your anonymity. The interview would take a maximum of twenty minutes. If you consent to this, please fill out the details below.

Name: _____

Work telephone number: _____

Most convenient days and times to be telephoned:_____

_____

_____

Appendix 3.4

Telephone interview

1. With regards to the people that you see who have experienced trauma, what are the main types of trauma that they have experienced?

---

b. Could say roughly what the percentages are?

Type of trauma	percentage of cases currently seen with this type of trauma
---	---
---	---
---	---
---	---
---	---

2. What type of trauma do you find it most difficult to work with?

---

b. Do you have any idea why this is?

---

3. How do you cope working with particularly difficult cases?

---

4. What type of community based resources do you have in the area who work with people who have experienced trauma?

---

5. Have you had any experiences, thoughts or feelings that you are indicative of vicarious traumatisation which you did not express in the postal questionnaire?

---

9. Have you had any additional specific training in working with people who have experienced trauma?

yes_____ no_____

b. If yes, what was it?

---

c. How long ago was that? **_____months**

10. How much supervision do you receive per month? **_____hours**

b. How much specific supervision for working with people who have experienced trauma do you receive per month? **_____hours**

c. Who is this from?

---

11. Are your family and friends supportive of the work you do?

---

12. Have you, or are having personal therapy? **yes**_____ **no**_____

b) How often is this?

c) How long have you had this for?

13. What would you say are the most rewarding aspects of working with people who have experienced trauma?

Appendix 3.5

Request for Details of Completed Research

If you would like to receive details of the results of this research after its completion in October 1999, then please complete the section below.

Name: _____

Title: _____

Address:

_____

_____

_____

Appendix 3.6

GREATER GLASGOW COMMUNITY AND MENTAL HEALTH SERVICES N.H.S. TRUST

SUBMISSION OF RESEARCH PROTOCOLS TO THE RESEARCH ETHICS COMMITTEE

All research protocols for consideration by the Research Ethics Committee of Greater Glasgow Community and Mental Health Services N.H.S. Trust must be submitted on the standard application form, a copy of which is enclosed. Your attention is drawn to the guidance notes to researchers, and it is suggested that you read these prior to completing your application.

The application must be completed even when a separate protocol (for example, prepared by a pharmaceutical company) exists.

If you wish advice on completing your application, or any aspect of the study you are proposing to undertake please contact Mrs Anne McMahon, Medical Director's Office, Trust Headquarters, Gartnavel Royal Hospital.
Tel: 0141-211-3824.

Appendix 4

Major Research Project

A Survey of Qualified Clinical Psychologists working in Britain with People who have experienced Trauma

Appendix 4.1

3920

Dear ,

Re: A survey of qualified clinical psychologists working in Britain with people who have experienced trauma.

I am carrying out research into the above area as part of my Doctorate in Clinical Psychology at the University of Glasgow. This project is designed to look at how the direct clinical work that clinical psychologists do, with people who have experienced trauma, effects their behaviour, and the way they think and feel. Naturally the results of this research has consequences for training and the working environment of clinical psychologists.

I would therefore be most grateful if you could complete the attached questionnaire, which will only take approximately twenty minutes.

If you become distressed whilst completing this questionnaire then please stop filling it in. There are a number of agencies which you may find useful to contact should you find yourself becoming distressed. (Details of these can be found at the end of the questionnaire).

This questionnaire is confidential and anonymous.

There is also a form attached which you can fill in, if you consent to be contacted by telephone to be asked a further set of questions about the possible affects of working with people who have been traumatised. You would be initially contacted by a research assistant by telephone, and then transferred to myself to protect your anonymity. The interview would take a maximum of twenty minutes.

There is also a form attached if you wish to receive the results of this research project, which will be available in October 1999.

Please return the questionnaire and forms in the attached envelope.

If you have any questions regarding this questionnaire then please feel free to contact me at the above address or telephone number.

Yours sincerely,

Laura Toplis, Trainee Clinical Psychologist, under the supervision of Dr. Elizabeth Campbell, Senior Lecturer.

Appendix 4.2

A survey of qualified clinical psychologists working in Britain with people who have experienced trauma.

Please indicate that you have read and understood the content and aims of this study as explained in the covering letter, and whether you do or do not wish to consent to participate in this study, by placing a tick in the appropriate box below.

I consent to participate in this study ☐

I do not consent to participate in this study ☐

1. How old are you? (please tick the appropriate box)

- **under 26 years old** ☐
- **between 26 and 30 years old** ☐
- **between 31 and 35 years old** ☐
- **between 36 and 40 years old** ☐
- **between 41 and 45 years old** ☐
- **between 46 and 50 years old** ☐
- **between 51 and 55 years old** ☐
- **between 56 and 60 years old** ☐
- **over 60 years old** ☐

2. Please indicate your gender (*delete as appropriate) ***female/ male**

3. How many years have you been qualified as a clinical psychologist? (please tick the appropriate box)

- **less than 6 years** ☐
- **between 6 and 10 years** ☐
- **between 11 and 15 years** ☐
- **between 16 and 20 years** ☐
- **over 20 years** ☐

4. Have you experienced any adverse life events in the last twelve months? (please tick the appropriate box)

☐ **yes** ☐ **no**

5. Have you experienced any trauma (trauma being defined as experiencing, witnessing, or being confronted with an event(s) that involved actual or threatened death, or serious injury, or a threat to the physical integrity of self or others, and your response involving intense fear, helplessness, or horror), in your life?

☐ **yes** ☐ **no**

6. Within the last working week, how many hours did you spend working with patients whose **main** difficulties were trauma related? _____ **hours**

7. How long have you worked with people whose **main** difficulties have been trauma related? _____ **year/s,** _____ **months**

8. On average how many hours a week do you spend working with this particular group? _____ **hours**

9. How much control do you have over the number of people you see who have experienced trauma? (please place a mark on the line to indicate your level of control).

no control_____**total control**

10. Are there certain types of problems that you avoid working with, due to personal reasons, i.e. not working sexual abuse perpetrators because you have children?

☐ **yes** ☐ **no**

11. Do you try to limit the number of people you see with trauma related difficulties?

☐ **yes** ☐ **no**

12. Do you work within a multidisciplinary team framework? ☐ **yes** ☐ **no**

13. How many hours of supervision do you receive a month? _____ **hours**

14. How many hours of supervision do you give a month? _____ **hours**

15. Are you/or have you ever been in personal therapy? ☐ **yes** ☐ **no**

16. Have you undergone additional training in working with people who have experienced trauma? ☐ **yes** ☐ **no**

17. Have you attended a trauma related conference in the last two years?

☐ **yes** ☐ **no**

18. What would you describe your theoretical orientation as being?

Since working with people who have trauma related problems have you...

19. ...avoided reports of trauma in the media? ☐ **yes** ☐ **no**

20. ....taken a greater interest in media reports of trauma? ☐ **yes** ☐ **no**

21. ....had a diminished interest in recreational activities? ☐ **yes** ☐ **no**

22. ....had a diminished interest in social activities? ☐ **yes** ☐ **no**

23. ....found yourself being more aggressive? ☐ **yes** ☐ **no**

24. ....found yourself being more agitated? ☐ **yes** ☐ **no**

25. ....found yourself with more problems with regards to scheduling appointments, i.e. forgetting appointments, double scheduling, rescheduling or cancelling appointments? ☐ **yes** ☐ **no**

26. ....had a change in your attitudes and behaviour towards people? ☐ **yes** ☐ **no**

27. ....taken any additional security measures? ☐ **yes** ☐ **no**

28. ....had trouble falling asleep, or staying asleep because you are thinking about the trauma that your clients have experienced? ☐ **yes** ☐ **no**

29. ....stopped discussing your work with colleagues? ☐ **yes** ☐ **no**

30. ....become more concerned about your family and friends' safety? ☐ **yes** ☐ **no**

31. ....avoided travelling alone? ☐ **yes** ☐ **no**

32. ....been conscious of checking things more often? ☐ **yes** ☐ **no**

33. ....found yourself driving differently? ☐ **yes** ☐ **no**

TSI BELIEF SCALE Revision M (c)

This questionnaire is used to learn how individuals view themselves and others. As people differ from one another in many ways, there are no right or wrong answers. Please place next to each item the number from the scale below which you feel most closely matches your own beliefs about yourself and your world. Try to complete every item.

1	2	3	4	5	6
disagree strongly	disagree	disagree somewhat	agree somewhat	agree	agree strongly

1. People are wonderful....._____
2. I can comfort myself when I'm in pain....._____
3. I don't deserve anything good....._____

1	2	3	4	5	6
disagree strongly	disagree	disagree somewhat	agree somewhat	agree	agree strongly

4. I don't trust my own instincts....._____
5. I can protect myself if my thoughts become self-destructive....._____
6. You can't trust anyone....._____
7. I'm uncomfortable when someone else is leading the group....._____
8. I enjoy feeling like part of a community....._____
9. The most uncomfortable feeling for me is losing control over myself ....._____
10. I worry about the safety of loved ones....._____
11. I don't have control in my relationships....._____
12. I feel empty when I am alone....._____
13. I think the worse of others....._____
14. I feel good about myself most days....._____
15. My capacity to harm myself scares me....._____
16. I feel able to control whether I harm others....._____
17. I often doubt myself....._____
18. I can't be myself around others....._____
19. If I need them, people will come through for me....._____
20. Some of my happiest times are with other people....._____
21. I don't feel like I'm worth much....._____
22. I enjoy my own company....._____
23. I feel helpless in my relationships with others....._____
24. I fear my capacity to harm others....._____
25. People are always hurting my feelings....._____
26. I can size up situations pretty well....._____
27. I don't believe what people tell me....._____
28. People are no good....._____
29. I feel cut off from people....._____
30. I feel like I can't control myself....._____
31. I deserve to have good things happen to me....._____
32. I can't stand to be alone....._____
33. Sometimes I really want to hurt someone....._____
34. I can trust my own judgment....._____
35. I wish I didn't have feelings....._____
36. My friends don't listen to my opinion....._____
37. I would never hurt myself....._____
38. Bad things happen to me because I'm bad....._____
39. When I'm alone, it's like there's no one there....._____
40. I can't stop worrying about others' safety....._____
41. I need to be in control of myself at all times....._____
42. I am often in conflict with other people....._____
43. I have a hard time making decisions....._____
44. If people really knew me, they wouldn't like me....._____
45. I can control whether I harm others....._____
46. I feel jealous of people who are always in control of themselves....._____
47. I worry about what other people will do to me....._____
48. I have bad feelings about myself....._____
49. I look forward to time I spend alone....._____

1	2	3	4	5	6
disagree strongly	disagree	disagree somewhat	agree somewhat	agree	agree strongly

50. People shouldn't trust their friends....._____
51. I feel helpless around others....._____
52. The important people in my life are in danger....._____
53. Even if I think about hurting myself, I won't do it....._____
54. I don't feel love from anyone....._____
55. Strong people don't need to ask for help....._____
56. The world is full of people with mental problems....._____
57. I have good judgment....._____
58. I feel hollow inside when I'm alone....._____
59. I'm not worth much....._____
60. I could do serious damage to someone....._____
61. I feel threatened by others....._____
62. When I'm with people, I feel alone....._____
63. I am good at figuring out what's going on with people....._____
64. I often feel people are trying to control me....._____
65. People who trust others are stupid....._____
66. I feel bad about myself when I need help....._____
67. I don't respect the people that I know best....._____
68. I am a good person....._____
69. I believe that someone is going to hurt me....._____
70. To feel okay, I need to be in charge....._____
71. I do things that put other people in danger....._____
72. No one really knows me....._____
73. When I'm alone, it's as if there's no one there, not even me....._____
74. I can't let go....._____
75. I trust too many people....._____
76. People are good at heart....._____
77. I can make good decisions....._____

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34. Could you please list below the ways you personally cope with the emotional impact of working with people who have experienced trauma?

_____

_____

_____

35. Are there any other ways that you feel you have been affected by working with people who have experienced trauma?

---

36. How have you coped with this?

---

37. Vicarious traumatisation is defined as, "...the transformation that occurs within the therapist (or other trauma worker) as a result of the empathic engagement with client's trauma experiences and their sequelae". How do you think vicarious traumatisation comes about? (Please tick the appropriate box(es), you may agree with more than one idea).

	agree	**disagree**	**do not know**
a) because the therapist is hearing the details of the person's traumatic experience and this is changing their own thoughts about themselves, the world and others?	☐	☐	☐
b) because of the degree of extreme emotional distress the person is communicating?	☐	☐	☐
c) because of the therapist's unresolved difficulties?	☐	☐	☐

d) some other reason, please specify,

Details of organisations to contact if you find yourself becoming distressed whilst completing this questionnaire:

your general practitioner.

your local occupational health department.

THANK YOU FOR HAVING TAKEN THE TIME AND THOUGHT TO FILL OUT THIS QUESTIONNAIRE

Appendix 4.3

Telephone Questionnaire Consent Form

It would be most helpful, even if you feel that you are totally unaffected in a negative way by your work with people who have experienced trauma, if you would consent to participate in a telephone interview. This would involve answering additional questions as to the possible affects of working with traumatised people. You would be initially contacted by a research assistant by telephone, and then transferred to myself to protect your anonymity. The interview would take a maximum of twenty minutes. If you consent to this, please fill out the details below.

Name: _____

Work telephone number: _____

Most convenient days and times to be telephoned:_____

_____

Appendix 4.4

Telephone interview

1. With regards to the people that you see who have experienced trauma, what are the main types of trauma that they have experienced?

---

b. Could say roughly what the percentages are?

Type of trauma	percentage of cases currently seen with this type of trauma
---	---
---	---
---	---
---	---
---	---

2. What type of trauma do you find it most difficult to work with?

---

b. Do you have any idea why this is?

---

3. How do you cope working with particularly difficult cases?

---

4. What type of community based resources do you have in the area who work with people who have experienced trauma?

---

5. Have you had any experiences, thoughts or feelings that you are indicative of vicarious traumatisation which you did not express in the postal questionnaire?

---

9. Have you had any additional specific training in working with people who have experienced trauma? **yes**_____ **no**_____

b. If yes, what was it?

---

c. How long ago was that? _____**months**

10. How much supervision do you receive per month? _____**hours**

b. How much specific supervision for working with people who have experienced trauma do you receive per month? _____**hours**

c. Who is this from?

---

11. Are your family and friends supportive of the work you do?

---

12. Have you, or are having personal therapy? **yes**_____ **no**_____

b) How often is this?

c) How long have you had this for?

13. What would you say are the most rewarding aspects of working with people who have experienced trauma?

Appendix 4.5

Instructions to Contributors

1. Manuscripts, in quadruplicate and in English, should be submitted to the editor-Elect:

Regular mail
Dr. Dean G. Kilpatrick
Medical University of South Carolina
National Crime Victims Research and
Treatment Center
Department of Psychiatry and Behavioural Sciences
171 Ashley Avenue
Charleston, South Carolina 29425-0742

Overnight mail
Dr. Dean G. Kilpatrick
Medical University of South Carolina
National Crime Victims Research and
Treatment Center
165 Cannon Street
Third floor, Room OC310
Charleston, South Carolina 29403-5713

Authors must submit manuscripts in a form appropriate to blind review (i.e. identifying information should appear *only* on the title page). Manuscripts should use nonsexist language. Three paper formats are accepted. *Regular articles* (usually no longer than 7,500 words, *including* references and tables) are theoretical articles, full research studies, and occasionally reviews. Purely descriptive articles are rarely accepted. Brief reports (2,500 words, including references and tables) are for case studies that cover a new area, preliminary data on a new problem or population, condensed findings from a study that does not merit a full article, or methodologically oriented papers that replicate findings in new populations or report preliminary data on new instruments. *Commentaries* (1,000 words or less) cover responses to previously published articles or, occasionally essays on a professional or scientific topic of general interest. Response commentaries, submitted no later than 8 weeks after the original article is published (12 weeks if outside the U.S.), must be content-directed and use tactful language. The original author is given the opportunity to respond to accepted commentaries. *Book/Media* reviews are solicited by the Book Review Editor.

2. Submission is a representation that the manuscript has not been published previously and is not currently under consideration for publication elsewhere. A statement transferring copyright from the authors (or their employers, if they hold the copyright) to the International Society for Traumatic Stress Studies will be required before the manuscript can be accepted for publication. The Editor will supply the necessary forms for this transfer. Such a written transfer of copyright, which previously was assumed to be implicit in the act of submitting a manuscript, is necessary under the U.S. Copyright Law in order for the publisher to carry through the dissemination of research results and reviews as widely and effectively as possible.

3. Type double-spaced on one side of 8 ½ x 11 inch or A4 white paper using generous margins on all sides and a font no smaller than 10-point, and submit the original and three copies (including copies of all illustrations and tables).

4. A title page is to be provided and should include the title of the article, author's name (no degrees), author's affiliation, acknowledgments, and suggested running head. The affiliation should comprise the department, institution (usually university or company), city, and state (or nation) and should be typed as a footnote to the author's name. The suggested running head should be less than 80 characters (including spaces) and should comprise the article title or an abbreviated version thereof. Also include the *word count*, the complete mailing address and telephone number for the corresponding author during the review process, and, if different, a name and address to appear in the article footnotes for correspondence after publication.

5. An abstract is to be provided, no longer than 120 words.

6. A list of 4-5 words is to be provided directly below the abstract. Key words should express the precise content of the manuscript, as they are used for indexing purposes.

7. Illustrations (photographs, drawings, diagrams, and charts) are to be numbered in one consecutive series of Arabic numerals. The captions for illustrations should be typed on a separate sheet of paper. Photographs should be large, glossy prints, showing high contrast. Drawings should be prepared with india ink. Either the original drawings or good-quality photographic pints are acceptable. Identify figures on the back with author's name and number of the illustration.

8. Tables should be numbered (with Arabic numerals) and referred to by number in the text. Each table should be typed on a separate sheet of paper. Center the title above the table, and type explanatory footnotes (indicated by superscript lowercase letters) below the table.

9. List references alphabetically at the end of the paper and refer to them in the text by name and year in parentheses. In the text, all author's' names must be given for the first citation (unless six or more authors), while the first author's name, followed by et al., can be used in subsequent citations. References should include (in this order): last names and initials of *all* authors, year published, title of article, name of publication, volume number and inclusive pages. The style and punctuation of the references should conform to the strict APA style-illustrated by the following examples (however, use indentation below):

Journal Article
Friedrich, W. N., Urquiza, A. J., and Beilke, R. L. (1986). Behaviour problems in sexually abused young children. *Journal of Pediatric Psychology, 11*, 47-57.

Book
Kelly, J. A. (1983). *Treating child-abusive families: Intervention based on skills-training principles.* New York: Plenum Press.

Contribution to a Book
Feindler, E. L. & Fremouw, W. J. (1983). Stress inoculation training for adolescent problems. In D. Meichenbaum and M. E. Jaremko (Eds.), *Stress reduction and prevention* (pp. 451-485). New York: Plenum Press.

10. Footnotes should be avoided. When their use is absolutely necessary, footnotes should be numbered consecutively using Arabic numerals and should be typed at the bottom of the page to which they refer. Place a line above the footnote, so that it is set off from the text. Use the appropriate superscript for citation in the text.

11. **The journals follows the recommendations of the 1994 *Publication Manual* of the American Psychological Association (Fourth Edition)**, and it is suggested that contributors refer to this publication.

12. After a manuscript has been accepted for publication and after all revisions have been incorporated, manuscripts may be submitted to the Editor's Office on **personal-computer disks**. Label the disk with identifying information-kind of computer used, kind of software and version number, disk format and file name of article, as well as abbreviated journal name, authors' last names, and (if room) paper title. Package the disk in a disk mailer or protective cardboard. **The disk must be the one from which the accompanying manuscript (finalized version) was printed out.** The Editor's Office cannot accept a disk without its accompanying, matching hard-copy manuscript. Disks will be used on a case-by-case basis-where efficient and feasible.

13. The journals makes no page charges. Reprints are available to authors, and order forms with the current price schedule are sent with proofs.