TRAUMA THERAPY AND THE EFFECTS ON THE THERAPIST

by

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My thanks also go to our course administrator, Catherine Beattie for her patience and assistance in producing and collecting the questionnaires and dealing with enquiries from interested participants.

DECLARATION

This thesis was conducted under the academic and clinical supervision of Kay Garvey and Delia Cushway. David Giles advised me on the statistical analysis in chapters two and three. I recruited the participants through the West Midlands DCP and via psychology departments in the West Midlands. Apart from the collaboration of the above people the thesis is my own work. This thesis has not been submitted to any other university.

The authorship of papers from the study will be shared with the above people. The literature review is being prepared for publication in the Journal of Traumatic Stress (see Appendix 1). The main paper is being prepared for publication in the British Journal of Clinical Psychology (see Appendix 2). The brief paper is being prepared for publication in Clinical Psychology and Psychotherapy (see Appendix 3).

SUMMARY

The aim of this thesis was to explore the psychological impact of trauma work on clinical psychologists. The literature review considers the plethora of terms used to describe this phenomenon in order to inform future research and clarify previous studies' findings. It draws out the key symptoms, variables, criteria and underlying concepts of these terms. The main study reviews the empirical literature in order to inform the design of the study and explores a range of personal and professional factors that might be associated with trauma symptomatology in clinical psychologists. It was found that few clinical psychologists experienced significant trauma symptoms and that higher trauma symptoms were connected with higher caseloads of trauma clients, higher personal trauma history and, to a lesser extent, more disrupted cognitive schema. However, the assessment of the effects of trauma work as trauma symptoms might have contributed to these findings. Therefore, the brief paper explored participants' descriptions of emotional and cognitive reactions to a distressing or traumatic event. Participants described a wide variety of reactions and that these appeared to change over time. The study concluded that more inclusive measures should be used to assess the psychological effects of working with trauma. A variety of issues arose during the course of this research concerning the research process and the choice of methodology. These are discussed in the research review along with an account of the personal impact and wider issues that this study provoked.

CHAPTER ONE: LITERATURE REVIEW

What can we call the impact of trauma work? A review of the concepts describing the effects of trauma work on the therapist

This paper has been prepared for submission to the Journal of Traumatic Stress (See Appendix 1)

ABSTRACT

Countertransference, burnout, vicarious traumatisation, secondary trauma and compassion fatigue are various terms that have been put forward to describe the psychological impact of working therapeutically with individuals who have experienced traumatic events. This plethora of terms has led to difficulties in researching this phenomena and conflicting results with research that is undertaken. Leading researchers in the field have identified that the most important debate in this field is the variety of ideas that are put forward to account for the difficulties faced by therapists. The various terms will be discussed, compared and contrasted. Finally these ideas will be amalgamated to give a shared understanding and suggestions for future work will be made.

Keywords: Vicarious; Secondary; Traumatisation; Compassion Fatigue

INTRODUCTION

Following the inclusion of posttraumatic stress disorder (PTSD) into the Diagnostic and Statistical Manual [DSM, American Psychiatric Association (APA), 1980] there has been an increase of interest into the psychological impact of traumatic life events. The majority of this research has focused on direct victims of traumatic experiences (Figley, 1995). Recently, research has also described the effects on secondary or indirect victims, i.e. those who support the primary victim (Ilife and Steed, 2000). The literature on secondary victims originated from research about emergency service personnel (Stamm, 1999). Interest in other specialist professional groups has developed, including the effects of working with trauma on the therapist (Pearlman and Maclan, 1995; Schauben & Frazier, 1995; Brady, Guy, Poelstra & Brokaw, 1999).

The literature is unanimously agreed that it is possible for a therapist who works with people that have experienced traumatic life events to become distressed and/or traumatised. The psychological impact of working with this client group varies from mirroring the symptoms of a client to a more global impact on the therapist (Sexton, 1999). Dutton and Rubinstein (1995) theorised that there were three categories of reactions to working with trauma survivors:

1. Psychological distress or dysfunction e.g. distressing emotions, intrusive imagery, somatic complaints, physiological arousal,

numbing, avoidance, dissociation, addictive or compulsive behaviours, impairment in daily professional and personal functioning

2. Cognitive changes e.g. changes in schema (beliefs about self, others and world), victim blaming and clinician guilt
3. Impairments in relationships e.g. personal and professional including labelling, distancing, judging and overidentification

A number of terms to describe the distress related to working with trauma have been proposed. The most commonly used terms are burnout (Schaufeli, 1999), countertransference (Wilson and Lindy, 1994), compassion fatigue (Figley, 1995), secondary traumatic stress (Stamm, 1999) and vicarious traumatisation (McCann and Pearlman, 1990a). (To avoid confusion these terms will be used only when referring to that particular idea.) These terms can be broadly categorised into three areas: therapeutic processes (countertransference), stress/burnout and traumatisation.

Stamm (1997) described the abundance of terms and the lack of consensus or satisfying language to describe this phenomenon as a challenge for future researchers. However, the challenge may rest with the underlying content of these concepts and the processes they describe rather than simply the name of them.

This lack of clarity regarding definition and operationalisation of these concepts has presented a problem for previous research as inappropriate methodologies are used to research each concept (e.g. Pearlman and Maclan, 1995; Schauben & Frazier, 1995; Brady et al., 1999). For instance, researchers may claim to investigate long term reactions to a series of events but their methodology is suited to investigating the short-term reactions to a single event. This mismatch of methodology and concepts may have resulted in a discrepancy in the findings over the rate of traumatisation in therapists and the variables related to it e.g. schema change, personal therapy, trauma history etc (a full discussion into the discrepancy in empirical papers can be found in Hancock, Garvey, Cushway & Giles, 2002).

The confusion over the definition of and use of specific terms used within the literature means there is uncertainty over what the impact of working with trauma is, how it is caused and the nature of risk and vulnerability factors. A therapist concerned about their potential for becoming traumatised could not consult this literature and identify the steps they may take to alleviate the risk. It is therefore important to have a clear understanding of these terms in order that research findings can be clarified and future research is unambiguous about the phenomena under exploration.

The aim of this review is to give an account of the concepts associated to trauma-related distress in therapists. The terms will be defined,

symptoms and factors that contribute to the development of the phenomena will be described and the theoretical basis for each concept will be critically evaluated. Finally, the review will produce some broad conclusions about the nature of distress in therapists who work with people who have experienced trauma and the ways in which this field can be advanced.

THERAPEUTIC PROCESSES (Countertransference)

The definition of countertransference has been a source of debate within the psychoanalytic movement. Originally, countertransference was regarded as a hindrance to therapy and an indicator that the therapist required further analysis (Freud, 1910). Contemporarily, countertransference is regarded as an integral part of psychoanalytic technique (Bateman & Holmes, 1995) and the definition is now wider and more integrative:

> Those thoughts and feelings experienced by the analyst which are relevant to the patients' internal world and which may be used by the analyst to understand the meaning of the patient's communications to help rather than hinder treatment (Bateman & Holmes, 1995, p109)

Whilst this definition focuses on the patient's communication, other definitions have proposed that countertransference can represent a combination of aspects of the patient and of the therapist (Gabbard & Wilkinson, 2000).

One of the first articles to think about the impact on the therapist of working with survivors of traumatic experiences was Haley (1974). She reported on the intense and overwhelming fear experienced by therapists of Vietnam veterans. Other authors have noted the mirroring of symptoms from client to therapist, particularly PTSD-like symptoms (Wilson and Lindy, 1994). These symptoms were thought to be a temporary countertransference reaction to an individual client.

Observable or reportable signs of countertransference include affective, ideational and physical responses (Sexton, 1999). These can include sadness, rage, fear, shame, anxiety, horror, self-doubt, confusion, intrusive images, nightmares, somatic reactions, sleep disturbance, agitation and drowsiness. Wilson and Lindy (1994) divided these signs into four broad areas:

1. Physiological reactions e.g. arousal, somatic reactions, sleep difficulties, agitation, inattention
2. Emotional reactions e.g. anxiety, depression, hostility, denial, horror, confusion, shame
3. Psychological reactions e.g. detachment, overidentification

4. Behavioural reactions e.g. forgetting, numbing, self-medication, loss of boundaries, relief over missed appointments

The majority of the literature written about countertransference takes up the contemporary view that countertransference represents a communication about the patient. Surprisingly, little present-day literature has been written about the reactions of the therapist and the therapists' personal characteristics that contribute to this reaction. There are exceptions to this, most notably the text by Wilson and Lindy (1994), which concentrates exclusively on the effects of countertransference on the therapist who works with truama.

Wilson and Lindy (1994) identify several factors that are important in determining the countertransference reaction:

- The nature of the stressor e.g. complexity, type (death, injury, abuse) duration, severity, frequency
- Personal factors in the therapist e.g. beliefs/values, defensive styles, personal experiences, training, motivation
- Factors in the client e.g. age, culture, gender, personality, defensive/coping styles, level of traumatisation, pre-morbidity
- Organisational factors e.g. attitudes towards clients, resources, support

Therapists were thought to be particularly vulnerable to countertransference reactions where they touched on issues for the therapist (Astin, 1997). The degree to which a therapist cannot work

through a countertransference reaction is related to the therapists' unresolved trauma and personal characteristics.

Countertransference is conceptualised in relation to specific models of psychotherapy. It can only be understood in relation to the premises and assumptions of these models. Depending on the definition, countertransference places the emphases on patient or therapist, or both rather than an interaction between the two. Countertransference explains the mechanism by which therapists can experience similar symptoms to their clients and it may be that it is an aspect of trauma–related distress in therapists. However it does not easily explain potential longer-term effects, except in reference to the therapists' own issues, or capture why therapists working with trauma clients may be particularly vulnerable to countertransference reactions over and above any other population.

BURNOUT/STRESS

BURNOUT

The most commonly cited definition of burnout (Shaufeli, 1999) is derived from the Maslach Burnout Inventory (Maslach, Jackson & Leiter, 1996), a widely used assessment measure of burnout. This definition describes burnout as:

> a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment that can occur among individuals who work with people in some capacity (Maslach *et al.*, 1996, p4)

Schaufeli (1999) states that the most comprehensive definition has been synthesised from a review of the definitions of burnout.

> Burnout is a persistent, negative, work related state of mind in "normal" individuals that is primarily characterized by exhaustion, which is accompanied by distress, a sense of reduced effectiveness, decreased motivation, and the development of dysfunctional attitudes and behaviours at work. This psychological condition develops gradually but may remain unnoticed for a long time for the individual involved. It results from a misfit between intentions and reality at the job. Often burnout is self-perpetuating because of inadequate coping strategies that are associated with the syndrome (Schaufeli & Enzmann, 1998, p36)

This definition is an attempt to bring together the central indicator, associated symptoms, onset or course, preconditions and maintaining factors. The course of burnout is commonly agreed to be gradual and it becomes progressively worse without intervention (Figley, 1995). Other authors have also identified the precursors to burnout as chronic

exposure to needy clients, excessive job demands and a disparity between environmental demands and coping (Farber, 2000; Fox and Cooper, 1998; Schaufeli, 1999).

Over a hundred symptoms have been associated with burnout (Schaufeli & Enzmann, 1998). Kahill (1988) has narrowed this vast range of symptoms to five symptom clusters:

- Physical: fatigue, exhaustion, sleep difficulties, somatic problems
- Emotional: anxiety, depression, guilt, helplessness
- Behavioural: aggression, callousness, substance abuse
- Work related: resigning, poor performance, absenteeism, tardiness, misuse of breaks, theft
- Interpersonal: poor communication, inability to concentrate, withdrawal, dehumanise/intellectualise

A different approach to reduce this overwhelming list of symptoms to constructs relating specifically to burnout has been achieved by categorising the main components. These attempts have identified between one and three main components:

- Exhaustion (Schaufeli and Enzmann, 1998)
- Emotional exhaustion, personal accomplishment and depersonalisation. Depersonalisation has recently been reconceptualised as cynicism (Maslach & Jackson, 1981)
- Physical fatigue, emotional exhaustion and cognitive weariness (Shirom, 1989)

- Physical, emotional and mental exhaustion (Pines and Aronson, 1988)

Farber and Heifetz (1982) have identified several vulnerability factors including professional isolation, emotional drain of being empathic, ambiguous successes and non-reciprocated giving and attentiveness. Deutsch (1984) has considered the role of failing to live up to expectations and feelings of inadequacy and incompetence. Fox and Cooper (1998) add reduced sense of accomplishment and give a central place to one's own unrealistic expectations. Newman and Gamble (1995) include social distance due to confidentiality and difficulty in explaining work to others. Miller (1998) also states that being younger, less experienced in trauma work, working in a hospital setting and less frequent supervision are additional factors. Factors that are protective against the development of burnout are therapists' personal lives e.g. personal accomplishments, activities and social support (Farber, 1983; Fox & Cooper, 1998).

A variety of theoretical approaches have been put forward to account for the development of burnout. A description of these approaches can be found in Schaufeli, Maslach & Marek (1993). These approaches have looked at burnout from a multitude of perspectives within interpersonal, individual and organisational models. Views of burnout have ranged from a state of failure to a syndrome to a process (Deutsch, 1984; Maslach & Jackson, 1981). Contemporary thinking would suggest that

burnout is best viewed as a process (Schaufeli, 1999; Schaufeli, Maslach & Marek, 1993).

Therapists working with trauma are at additional risk of burnout compared to non-trauma therapists as their clients present with chronic symptoms, may be keen to avoid the focus of therapeutic work i.e. the traumatic event and therefore may not make progress (McCann & Pearlman, 1990a). It is suggested that burnout in therapists who work with victims of trauma is the final common pathway of continual exposure to traumatic material that cannot be worked through (McCann & Pearlman, 1990a).

One of the strengths of burnout is that it has a variety of theoretical models put forward to account for the development of burnout in individuals, unlike many other terms. Burnout shares simliarities with countertransference, they both include work-related symptoms e.g. missed/cancelled appointments, lateness. McCann and Pearlman (1990a) also suggest that the symptoms of burnout are similar to the numbing and avoidance experienced by survivors of traumatic experiences. One limitation of burnout is that is not specific to trauma work and cannot easily account for the PTSD-like symptoms that have been observed in therapists working with trauma. Burnout is a concept that has been used with any human service professional and therefore, not only is not specific to trauma but it is not specific to the unique relationship formed between therapist and client.

COMPASSION STRESS/FATIGUE

Compassion fatigue/stress are widely used although imprecisely defined terms. Figley (1995) states that compassion fatigue is equivalent to secondary traumatic stress and therefore uses the same definition:

> Natural behaviours and emotions that arise from knowing about a traumatising event experienced by a significant other – stress from helping or wanting to help

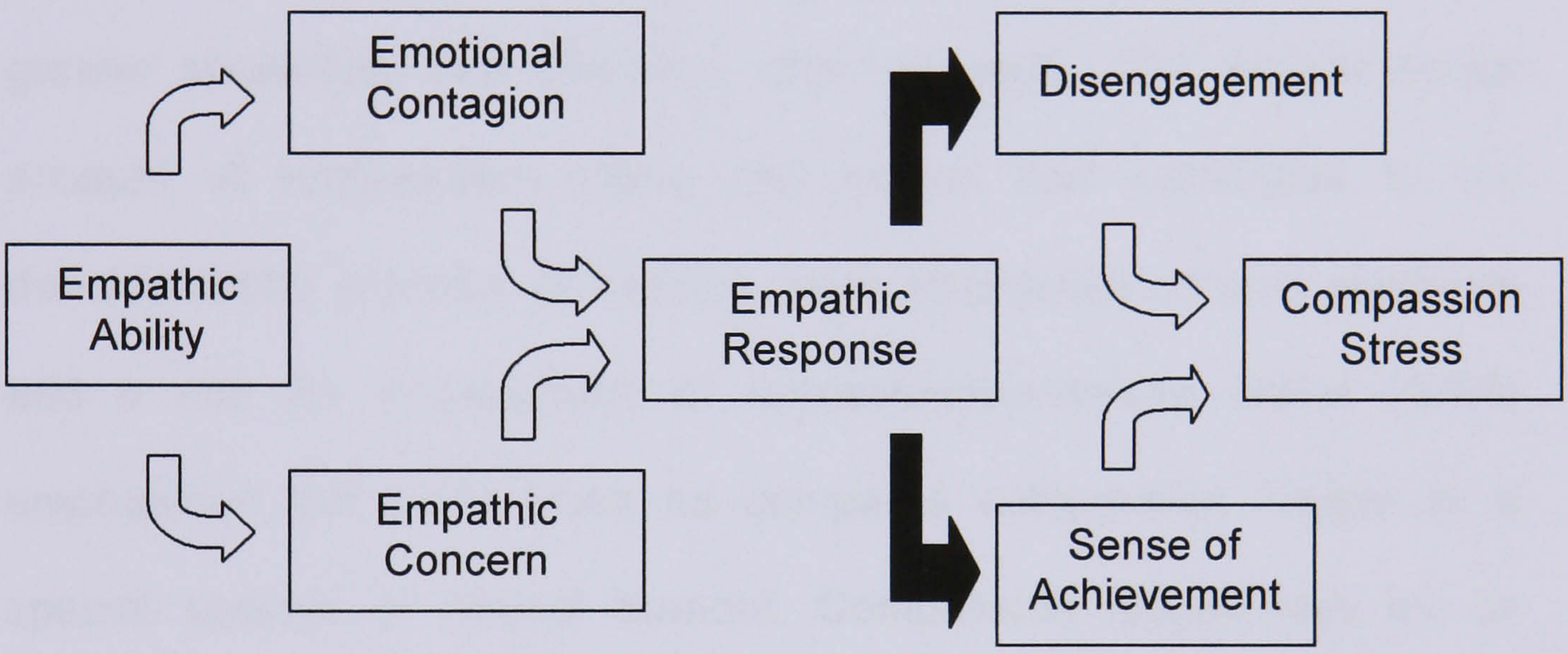
Authors have proposed significant overlaps between secondary traumatic stress and compassion fatigue (Figley, 1995; Stamm, 1995). However, they are sufficiently different to warrant a separate account within this review.

Research on compassion fatigue has focused on populations other than trauma survivors or those who work with them e.g. crisis line staff, AIDS, nurses, professionals who work with the terminally ill (Stamm, 1999). This suggests that compassion fatigue may contain elements not unique to working with trauma survivors and that it may contain aspects of stress and burnout.

It is not possible to report on the specific symptoms and factors that may mediate the relationship between offering therapy and compassion fatigue due to the lack of research specific to compassion fatigue.

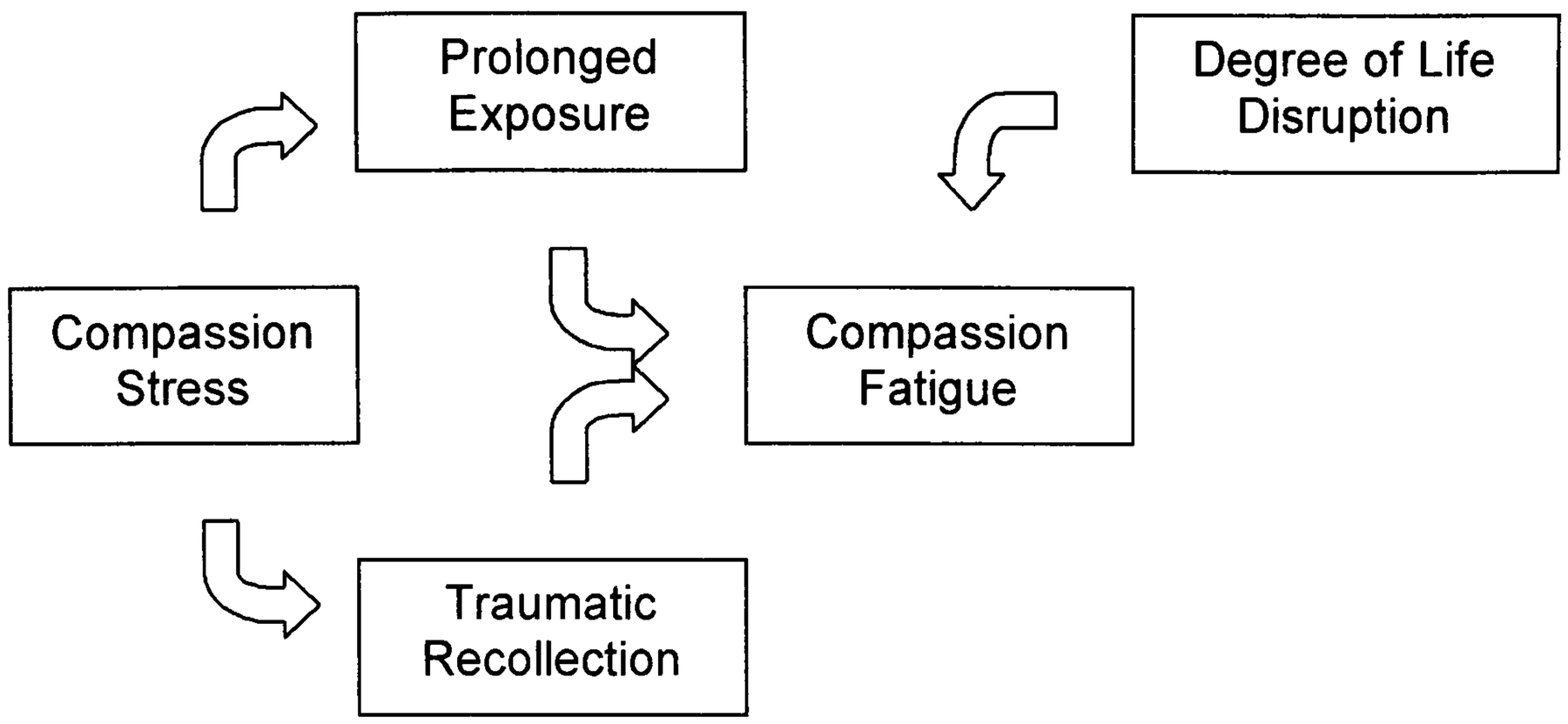
Figley (1995) put forward a theory suggesting that compassion stress is connected with exposure to suffering. The therapists' capacity for empathy is mediated by the therapists' empathic ability, identification with client and susceptibility to emotional contagion. This leads to the therapist to make efforts to reduce the persons' suffering. The degree of compassion stress experienced is mediated by the therapist ability to disengage and to maintain a sense of achievement. (See figure 1).

Figure 1: Compassion Stress



Compassion fatigue is seen as a state of exhaustion as a result of prolonged exposure to compassion stress and recollections of the trauma. This is mediated by life disruptions experienced by the therapist. (See figure 2).

Figure 2: Compassion Fatigue



Compassion fatigue was included in the section with burnout as it has greater similarities with this than other concepts. The developmental account of compassion stress and fatigue has similarities to the developmental process of burnout, both emphasise chronic exposure and a role for expectations of success/achievement. Miller (1998) emphasises this point when he compares compassion fatigue to a special species of clinical burnout. Compassion fatigue may be an analogue of burnout in therapists working with trauma survivors. However, this is likely to be a debateable point in the literature as leading authors propose compassion fatigue is equivalent to secondary traumatic stress and is therefore different to burnout (Figley, 1995).

Compassion fatigue, unlike burnout, is specific to the therapeutic relationship and Figley's model can account for the trauma symptoms found in therapists. Researchers have tried to spread compassion fatigue too wide in trying to account for symptoms in populations where burnout or stress concepts may be more relevant and focusing on

populations where trauma –related distress is relevant. This may in part be due to the infancy of this concepts and also, because some researchers may not have used the term in its original sense.

CONCEPTS OF TRAUMATISATION

Viewing the consequences of working with individuals who experienced traumatic events as traumatic for the therapist began following the introduction of PTSD in the DSM (APA, 1980). Several authors considered the responses of therapists in this way and new concepts were introduced.

POSTTRAUMATIC STRESS DISORDER (PTSD) AND SECONDARY TRAUMATIC STRESS DISORDER (STSD)

There have been attempts to conceptualise the effects of working with individuals who have experienced traumatic events as PTSD. PTSD includes a set of characteristics e.g. persistent re-experiencing, avoidance, numbing of responsiveness and increased arousal following the person experiencing witnessing or confronting and event that involves actual or threatened death or serious injury, or threat to the physical integrity of self or others. The persons' response involved fear, helplessness or horror (APA, 1994).

Conceptualising the impact of working with individuals who experience traumatic events as PTSD has followed two closely related strands. Figley (1995) has argued that the impact of working with trauma can be seen to be PTSD without any revision to these criteria. The DSM-IV (APA, 1994) quotes that PTSD can follow 'learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate'. The second strand involves adapting the PTSD criteria for secondary victims including families and professionals (Figley, 1995). The adapted criteria relate the event to the client. They state that re-experiencing criteria can be about the client or the client's event and the hypervigilancy is about the client not the self.

At first it may seem that research into the impact of trauma work has used the concept of PTSD. However, it is only that studies have used measures of PTSD to assess the extent the effects of working with trauma. Some studies have reported participants who meet the criteria for PTSD. It is not clear whether the subgroup who meet the PTSD criteria are different from those who do not. It may be that different vulnerability factors come into effect at this level of severity.

Within the literature exploring the effects of working with trauma, comparisons are drawn to the experiences of clients. A major theme in this has been the characterisation of the clients' difficulties as PTSD. Whilst there have been various attempts to suggest theoretical models for the development and maintenance of PTSD within clients (e.g. Foa,

Steketee & Rothbaum, 1989; Horowiz, 1986; Janoff-Bulman, 1992). This literature has yet to be applied to therapists. It is outside the scope of this review to give an account of the theories of PTSD. However it may be worth looking to these models, and indeed other developments within the theory of PTSD, to give theoretical strength to exploring the psychological impact of working with trauma and to provide further understanding of the effects of trauma work.

PTSD places the emphasis on the traumatising event rather than the individuals' pathology. PTSD is an insufficient term for describing trauma-induced distress in therapists due to the narrowness of the concept and the findings that responses to trauma therapy are much broader than PTSD. Due to its diagnostic status PTSD also underestimates the amount of distress in therapists, as particular criteria have to be met. This is generally reflected within the literature where other terms are used in preference.

SECONDARY TRAUMATIC STRESS

The definition given for secondary traumatic stress is identical to that of compassion fatigue.

Natural behaviours and emotions that arise from knowing about a traumatising event experienced by a significant other – stress from helping or wanting to help (Stamm, 1995)

Symptoms of secondary traumatic stress can include posttraumatic symptoms e.g. intrusive, avoidance and arousal symptoms as well as feelings of helplessness, confusion and isolation (Sexton, 1999). Chrestman (1995) reports symptoms of secondary traumatic stress also include somatic symptoms, distressing emotions, addictive/compulsive behaviours, and functional impairment. These symptoms are disconnected from the therapist's own lives.

The onset is often rapid unlike the gradual onset of burnout/stress related symptoms and there can also be a much faster recovery than in burnout (Sexton, 1999). Rather than a state change directly tied to a patient, as in countertransference, secondary traumatic stress looks at how patients affect therapists' lives, inner worlds and relationships i.e. trait changes (Stamm, 1997).

Researchers have found that secondary traumatic stress is associated with a range of factors including therapist's personal characteristics, characteristics of the client, characteristics of the trauma, coping style and the environment which therapy takes place (Chrestman, 1995; Dutton and Rubinstein, 1995).

Stamm (1999) suggested a much broader conceptualisation of secondary traumatic stress which proposed that other terms e.g. compassion fatigue, PTSD and vicarious traumatisation are subspecies of secondary traumatic stress.

As with compassion fatigue, one of these difficulties with secondary traumatic stress is its lack of a clear definition. This imprecise finding makes research on the concept difficult to carry out, as one cannot be sure how to operationalise the syndrome, its symptoms and therefore research any related variables. The factors associated with secondary traumatic stress are strikingly similar to those proposed by Wilson and Lindy (1994) for countertransference. Unlike other concepts, there is no information on whether secondary traumatic stress is a cumulative process or thought of as a reaction to a one-off event. Stamm's (1997) proposal to bring together these various terms under the umbrella of secondary traumatic stress may a starting point from which to create a more cohesive theory of traumatisation in therapists. This proposition also clearly delineates compassion stress from secondary traumatic stress.

VICARIOUS TRAUMATISATION

McCann and Pearlman (1990b) defined vicarious trauma as:

> The cumulative transformation in the inner experience of the therapist that comes about as a result of empathic engagement with the with the clients' traumatic material

There are several key aspects to these vicarious traumatisation. The first is that vicarious traumatisation is a normal reaction to working with victims rather than symptoms of therapists' pathology and it also does

not reflect any intentionality on the part of the survivor (Pearlman & Saakvitne, 1995). The second is that vicarious traumatisation places the emphasis on the interaction between the therapist and the stressor. The interaction occurs between characteristics of the situation (aspects of traumatic events, social and cultural variables) and the therapist (psychological needs, cognitive schema, coping style) (McCann & Pearlman, 1990a, 1990b, Pearlman & Saakvitne, 1995). It refers to cumulative effects on therapists. Vicarious traumatisation continues to intensify with repeated exposure to graphic details of abuse (McCann & Pearlman, 1990a, 1990b, Pearlman & Saakvine, 1995). Therapists working with trauma will experience lasting alterations in the cognitive schema that will significantly impact on feelings, relationships and life (McCann & Pearlman, 1990a, 1990b, Pearlman & Saakvine, 1995).

Therapists can experience symptoms including PTSD-like symptoms e.g. intrusive thoughts/imagery, numbing; emotional reactions e.g. anxiety/anger/depression; somatic symptoms; feelings of vulnerability and difficulty in trusting others (Neuman & Gamble, 1995). Sexton (1999) also states that symptoms can manifest as cynicism, despair and loss of hope. Within the therapeutic relationship vicarious traumatisation can result in loss of empathy, victim blaming, loss of energy and idealism and boundary violations (McCann & Pearlman, 1990b, Pearlman & Saakvitne, 1995). Vicarious traumatisation can, if unacknowledged, lead to burnout (McCann & Pearlman, 1990a).

Brady et al., (1999) and Pearlman and Maclan (1995) summarise the relevant variables that are associated with vicarious traumatisation. Relevant situational characteristics are exposure to graphic details, re-enactments of the trauma between client and therapist, consecutive sessions, exposure to children's trauma. Aspects of the client that may be relevant are difficult relational experiences and client behaviours e.g. acting out, self-destructive actions, dissociation. Aspects of the therapist include personal trauma history, meaning of traumatic life events, psychological style, interpersonal style, professional development, current stressors and support. Work characteristics may include work setting and socio-cultural context.

The theoretical model used to explain vicarious traumatisation is constructivist self developmental theory (CSDT – McCann & Pearlman, 1990b). The theory rests on the hypothesis that trauma disrupts schema. They define schema as beliefs, assumptions or expectations. They reviewed the literature and identified several schemas about self and others that are disrupted in trauma including safety, dependency/trust, esteem, power, intimacy. The extent of the disruption to the therapist depends on the salience of the schema to the individual. The greater the disruption the more the therapist is likely to experiences changes in their worldview and emotional and behavioural changes.

Vicarious trauma accounts for individual differences within this theory. The variables found to be associated with vicarious traumatisation

overlap considerably with countertransference and secondary traumatic stress. However the theory, in its application to therapist, has focused on disturbance in memory, imagery and cognitive schema. There has been no real focus on affective components. CSDT also claims to be the only theory that accounts for cognitive changes. However theories of PTSD (e.g. Foa, Steketee & Rothbaum, 1989; Horowitz, 1986; Janoff-Bulman, 1992), which have not been applied to trauma work, also account for cognitive changes.

DISCUSSION

The aim of this review was to define each concept, describe the associated symptoms and related variables and give an account of the theoretical underpinnings. Several aspects limited how adequately these aims could be achieved. Due to difficulties with definition the literature was difficult to interpret and clear distinctions between each concept could not be made as satisfactorily as one would like. Particular terms e.g. compassion fatigue, secondary traumatic stress have been interpreted in a number of different ways.

The concepts appraised in this review are summarised in Table 1. The main differences between the models seem to be in their view of whether each concept is looking at short (e.g. countertransference), medium (compassion stress, secondary traumatic stress, STSD/PTSD) or long-term effects of trauma (burnout, vicarious trauma, compassion

fatigue). There are also differences in whether concepts consider the cumulative effects of trauma, e.g. compassion fatigue, vicarious trauma. Symptoms and vulnerability and protective factors are not clearly delineated between each concept. Indeed, it is surprising that virtually identical lists of associated factors exist within the literature for countertransference, secondary traumatic stress and vicarious traumatisation. The theoretical background behind some concepts is weak; the weaker theoretical concepts also tend to be the least well defined and the most confused and misused within the literature.

Table 1: A Summary of Concepts Related to the Effects of Trauma Work

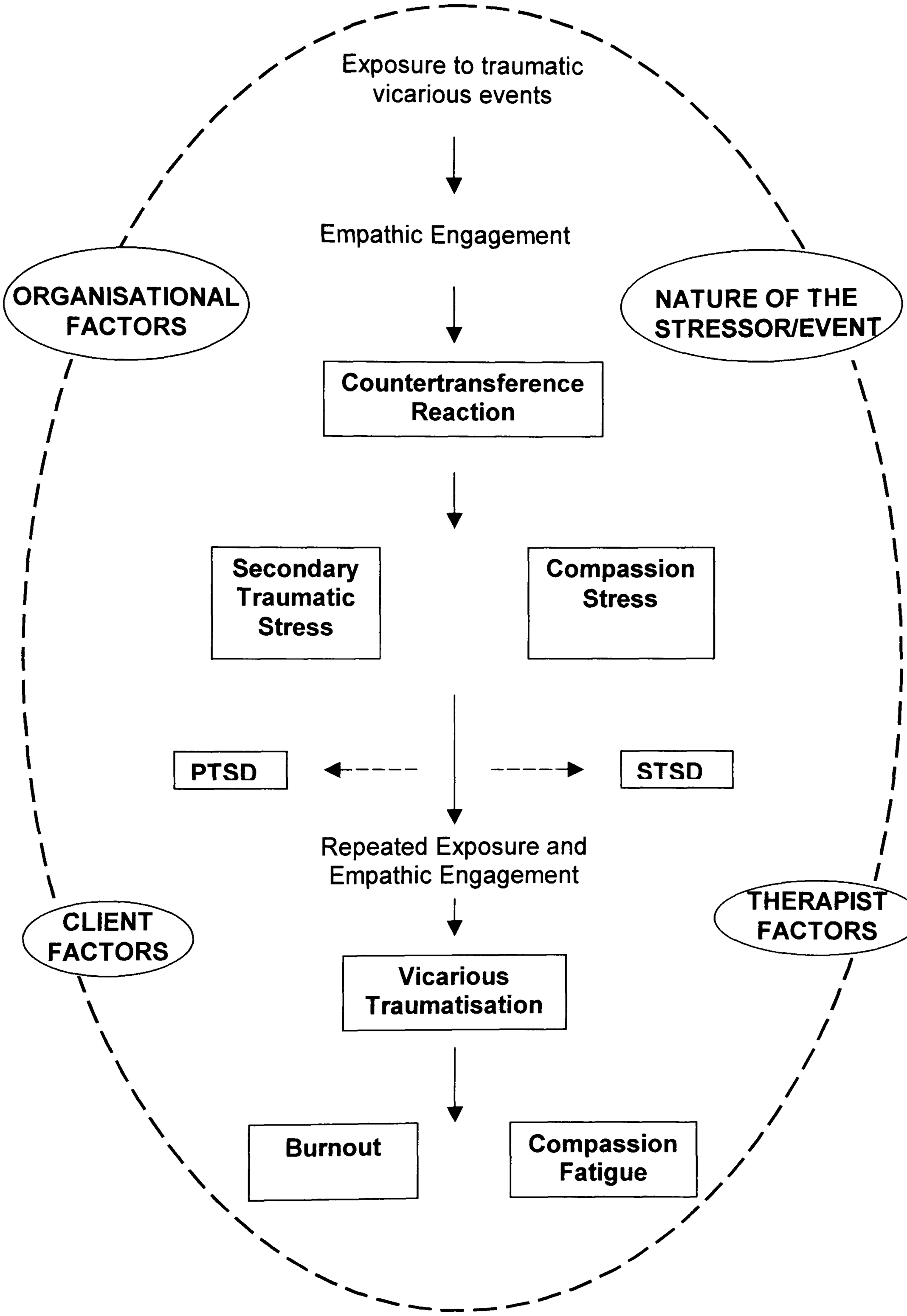
CONCEPT	KEY ASPECTS		MAIN ADVANTAGES	MAIN DISADVANTAGES
	Course	Cumulative Effects		
Counter-transference	Short term	No	Explains the process by which therapists mirror clients symptoms	Not specific to trauma work Specific to therapeutic model
Burnout	Long term	Yes	Theoretical models	Not specific to (trauma) therapy Does not account for PTSD-like symptoms
Compassion Stress/ Fatigue	Medium / Long term	No/Yes	Theoretical Model	Lack of definition Confusion of term with STS & burnout Lack of research re symptoms and associated variables Lack of theoretical model
PTSD/STSD	Medium term	No	Clearly delineated symptoms Clear definition	Diagnostic Criteria Limits response to PTSD symptoms Lack of theoretical model
STS	Medium term	-	Umbrella term	Lack of definition Confusion of term with STS & burnout Lack of theoretical model
Vicarious Trauma	Long term	Yes	Theoretical Model Accounts for individual differences	Lack of concentration on affective symptoms

CONCLUSIONS

The field concerning the psychological effects on therapists working with trauma is still in its infancy. It is, therefore not surprising to find inconsistencies within the literature describing the effects of such work. The concepts mentioned are attempting to capture a broad range of responses to different situations, of different severities and of different durations.

The inclusion of several terms under the umbrella term of secondary traumatic stress appears to be a productive solution to beginning to organise these reactions into a coherent body. The further division of these reactions under the aspects mentioned (short/medium/long-term, cumulative vs. single) may add an extra dimension. The initial reaction may be characterised by countertransference. If not resolved, this may go on to develop into an acute stress reaction from there, depending on the level of severity of symptoms, compassion stress or STSD/PTSD may develop. With repeated exposure the effects may be conceptualised as vicarious traumatisation and left untreated this may develop into burnout/compassion fatigue. This process may resemble that portrayed in figure 3. Throughout this process organisational factors, factors relating to the event, characteristics of the client and characteristics of the therapists will either protect against or increase the risk of the reaction to trauma work developing further.

Figure 3: A Developmental Model of the Reactions to Trauma Work



The differentiation in concepts according to the major differences identified (short/medium/long-term, cumulative vs. single) seems to be important. The inclusion of these aspects in future empirical or theoretical papers may help the differentiation of each of the concepts reviewed. Clarifying these aspects of the concept under investigation would hopefully allow for appropriate research methodologies to be utilised and ultimately clear research findings regarding symptoms, risk/protective factors and the course or duration of the various types of effects resulting from working with trauma.

The field of trauma-related distress in therapists may benefit from the application of other fields of literature. Given the research into the impact on therapists in still in its infancy compared to other concepts e.g. PTSD this may prove a worthwhile avenue for theoretical ideas. The broader trauma literature, for example, complex trauma, cumulative trauma, acute stress may also provide useful insights into this phenomenon.

This review has attempted to clarify the terms that have been used to describe the impact of working with trauma. It has attempted to give a tentative suggestion for the comparative development of each of the terms linking this to the differences found beteen the concepts. As a result of this review it is hoped that future research can reach more definitive conclusions and that this will lead to a better understanding of the area of the psychological effects of working with trauma.

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CHAPTER TWO: MAIN PAPER

Traumatisation in Clinical Psychologists: The roles of exposure, trauma history, cognitive schema, therapy and gender

This paper has been prepared for submission to the British Journal of Clinical Psychology (See Appendix 2)

This study has received ethical approval from Coventry University Ethics Committee (See Appendix 4)

ABSTRACT

Objectives: This study explored the phenomena of traumatisation in clinical psychologists. Specifically, it explored whether a range of professional and personal variables mediated the relationship between exposure to vicarious events and trauma symptomatology and explored schema disruption, caseloads of trauma clients and personal trauma history across various groups.

Design: The study was a cross-sectional questionnaire survey of all clinical psychologists in the West Midlands. Statistical analyses tested associations between variables and differences between males and females, participants with little/no or several posttraumatic symptoms and those who had experienced therapy or not.

Method: 136 participants completed questionnaires including personal and professional factors, a trauma history measure, the Traumatic Stress Institute Belief Scale (Pearlman & Maclan, 1994) and the Posttraumatic Stress Diagnostic Scale (Foa, 1995).

Results: The vast majority of clinical psychologists experienced no or mild posttraumatic symptoms. No significant correlations were found between professional and personal variables and both, exposure to vicarious events and posttraumatic symptoms. Significant differences were found between participants with several posttraumatic symptoms

compared to participants with little or no posttraumatic symptoms. No significant differences were found for gender or therapy.

Conclusion: This study indicated that traumatisation is not as universal as previous research suggests. It found no evidence of a mediating role for professional and personal variables. It found support for previous conclusions regarding the significance of exposure and trauma history in relation to traumatisation but not for disruptions in cognitive schema.

INTRODUCTION

Over the last two decades there has been an abundance of literature surrounding the study and treatment of psychological effects of trauma (Yule, 1999). This was precipitated by the inclusion of the diagnosis of Posttraumatic Stress Disorder (PTSD) in the Diagnostic and Statistical Manual of Mental Disorders [DSM – American Psychiatric Association (APA), 1980]. Whilst the majority of this literature has focused on individuals who have been directly affected by traumatic events (Figley, 1995), interest has also turned to secondary victims of trauma including family members and emergency services personnel (Stamm, 1999). A recent development within the literature on secondary victims has been the focus on professionals who work therapeutically with survivors of trauma (Chrestman, 1995; Kassam-Adams, 1995; Pearlman and Maclan, 1995; Schauben and Frazier, 1995).

Early anecdotal reports suggested that therapists mirrored the symptoms of their clients (e.g. Haley, 1974). Symptoms such as intrusive imagery and cognitions (Pearlman and Maclan, 1995), avoidant responses, physiological arousal, somatic complaints and distressing emotional experiences have been observed in trauma therapists (Chrestman, 1995).

There are a variety of terms that have been applied to the traumatisation of therapists, for example, burnout (Schaufeli, 1999),

countertransference (Wilson and Lindy, 1994), compassion fatigue (Figley, 1995), secondary traumatic stress (Stamm, 1995) and vicarious traumatisation (McCann and Pearlman, 1990a). Each of these terms is derived from different perspectives. Four broad perspectives can be identified; firstly, Wilson and Lindy (1994) state that reports of the impact of trauma work were confined to the countertransference literature. With the advent of terms such as stress and burnout, these concepts were then used to explain the impact of trauma work (Figley, 1995). Clinicians and researchers who were informed by the development of PTSD subsequently considered therapists' responses as their own traumatic reactions to traumatic material (Neuman & Gamble, 1995; Pearlman & Saakvitne, 1995). Terms that consider the impact or working with trauma as PTSD include PTSD itself and secondary traumatic stress disorder (Figley, 1995). Finally, the last group of terms considers a broader definition of trauma responses than the concept of PTSD allows, these terms include secondary traumatic stress (Stamm, 1995) and vicarious traumatisation (McCann & Pearlman, 1990a).

These terms have often been used interchangeably despite subtle differences. Differences between the terms include whether terms are specific to trauma therapy, whether they consider the impact as a reaction to a one-off or a series of events or whether the reaction is considered a cumulative process. Different terms cover some common symptoms yet other symptoms are unique to particular terms. In addition, the terms often lack an operational definition. Theoretical

accounts of each term can lack the power to explain how therapists become effected and to predict which therapists may be at risk for developing traumatic reactions and why. See Hancock, Garvey and Cushway (2002) for a discussion of the differences between the terms used to describe the impact of working with trauma.

Empirical studies have largely adopted the term vicarious traumatisation (McCann and Pearlman, 1990a, 1990b). This is probably due to the fact that vicarious traumatisation has the clearest definition and the most coherent theoretical explanation, for example, Brady Guy, Poelstra & Brokaw (1999) state that vicarious traumatisation goes beyond other concepts and Sexton (1999) views it as the most comprehensive account.

Vicarious traumatisation is described as a normal reaction to working with victims rather than indicating therapists' pathology. It places the emphases on the interaction between the characteristics of the situation (aspects of traumatic events, social and cultural variables) and the therapists' unique personality (psychological needs, cognitive schema, coping style). The theory rests on the hypothesis that trauma disrupts schema, the extent of this disruption is dependent on the salience of the schema to the individual. Vicarious traumatisation may continue to intensify with repeated exposure to graphic details of the traumatic event, gradually reinforcing changing schema. Pearlman and McCann (1990a) state that all therapists working with trauma will experience

lasting alterations in the cognitive schema that will significantly impact on their feelings, relationships and life.

There is limited empirical research into vicarious traumatisation or other related concepts. The majority of this research has claimed to use the concept of vicarious traumatisation to inform methodology, for example, the inclusion of schema measures. The research to date has focused on the variables that may predict traumatisation in therapists (Table 1 describes these papers).

In summary, these studies conclude that it is possible that therapists can be traumatised by their work. However, reports of the amount of distress reported by therapists vary from no clinical symptoms (Van Minnen & Keijsers, 2000) to mild (Chrestman, 1995) to 50% experiencing a 'clinical' degree of symptoms (Kassam-Adams, 1995).

All the research, with the exception of Brady *et al.*, (1999) and Van Minnen and Keijsers (2000) concluded that greater levels of exposure, defined by caseload or exposure to details of trauma, predicted greater trauma symptomatology.

Table 1: Summary of Empirical Papers on Vicarious Traumatisation

	Participants (client group)	Measures	Results
Van Minnen & Keijsers (2000)	39 (15 male (M), 24 female (F)) therapists (20 trauma and 19 non-trauma)	Traumatic Stress Institute (TSI) Beliefs Scale World Assumptions Scale (WAS) Symptom Checklist (SCL) 90-R Semi-Structured Interview	No scores outside norms No differences between objective measures Trauma therapists reported more subjective negative and positive cognitive changes
Iliffe & Steed (2000)	18 (13F, 5M) counsellors (domestic violence)	Semi-Structured Interview	Counsellors reported trauma symptomatology and changes in beliefs No sex differences found
Brady, Guy, Poelstra & Brokaw (1999)	446 female therapists (sexual abuse)	Impact of Events Scale (IES) TSI Beliefs Scale Spiritual Well Being Scale	Low level of trauma symptoms Higher percentage and number of current clients, higher number over time and greater exposure to graphic details predicted trauma symptomatology not disruptions in beliefs
Johnson & Hunter (1997)	73 female counsellors (41sexual assault and 32 non-sexual assault)	Maslach Burnout Inventory (MBI) Beliefs and Values Questionnaire Ways of Coping Scale Personal/Work Variables	More disrupted schema found in sexual assault counsellors
Pearlman & Maclan (1995)	188 (136F, 52M) therapists (trauma)	IES TSI Belief Scale SCL 90-R Personal/Work Variables	No. of trauma survivors, trauma experience & trauma history predicted trauma symptoms & disruption in schemas Other important variables included work setting, training therapy and supervision
Schauben & Frazier (1995)	148 female counsellors (sexual violence)	PTSD & Vicarious Trauma Measure TSI Beliefs Scale MBI Brief Symptom Inventory Personal/Work Variables	Percentage of survivors is predictive of PTSD, vicarious traumatisation and belief change Prior trauma history did not predict symptoms or beliefs
Kassam-Adams (1995)	100 (75% F) therapists (sexual trauma)	IES Personal Strain Index Personal/Work Variables	50% scored in clinical range of IES Exposure to sexually traumatised clients, gender and trauma history predicted PTSD
Chrestman (1995)	Trauma Therapists	IES Trauma Symptom Checklist WAS Behaviour Checklist Personal/Work Variables	Therapists did not score in clinical range of IES Moderating variables include income, training, percentage of clients with trauma, clinical time

The effect of gender has received little attention as most research has focused on female participants. Two studies that included male participants made no reference to the effects of gender. However, Kassam-Adams (1995) found that gender predicted trauma symptomatology and female participants experienced more trauma symptoms than did male participants. A number of authors have recommended that the role of gender be further researched (Brady *et al.*, 1999; Schauben and Frazier, 1995).

Pearlman and Maclan's (1995) study found that therapy was an important variable in predicting trauma symptoms, with those therapists receiving therapy experiencing greater posttraumatic symptomatology. However, other studies have not included therapy in their analysis.

There are two variables, schema and trauma history, where findings have been the subject of particular debate. Schauben & Frazier (1995), Pearlman & Maclan, (1995) and Johnson & Hunter (1995) have found that schemas are disrupted in those who work with trauma whilst others found no disruptions (Chrestman, 1995; Brady *et al.*, 1999, Van Minnen & Keijsers, 2000). Kassam-Adams (1995) and Pearlman & Maclan (1995) reported that therapists' trauma history predicts traumatisation, higher trauma histories were associated with more trauma symptomatology. However, Schauben and Frazier (1995) found no links between trauma history and vicarious trauma. These inconsistent results may be due to methodological limitations of the studies.

A number of studies have failed to account for key variables e.g. gender (Schauben & Frazier, 1995; Brady *et al*, 1999), therapy (all studies with the exception of Pearlman & Maclan, 1995) and trauma history (Chrestman, 1995, Johnson & Hunter, 1997). Little or no effect has been found for a range of other variables including training, experience, supervision or number of hours worked. However, these variables have not been consistently included in analysis of previous studies.

One of the methodological concerns is the potential bias due to participant selection. Most studies were conducted in the USA with female participants. Comparing participants from separate studies, it appears that they were drawn from a wide variety of professional groups; these samples may have had substantial differences in terms of their professional training and knowledge about trauma. Therefore different findings regarding trauma history, gender, levels of trauma symptoms etc. may actually be attributable to differences in knowledge and training.

With the exception of Chrestman (1995), Pearlman and Maclan (1995) and Van Minnen and Keijsers (2000) research focused on therapists working with specific trauma populations e.g. abuse, sexual/domestic violence. Focusing on specific populations may have benefits for clarifying the effects of clinical work for that population but could also limit the generalisability of that study's conclusions.

Nearly all studies, with the exception of Van Minnen and Keijsers (2000) and Johnson and Hunter (1997) recruited only trauma therapists as participants. Therefore, it is difficult to conclude if the conclusions drawn from these studies are specific to working with trauma. No study has drawn a large number of participants from a single professional group that includes a range of different specialties and different degrees of interest or experience in trauma work.

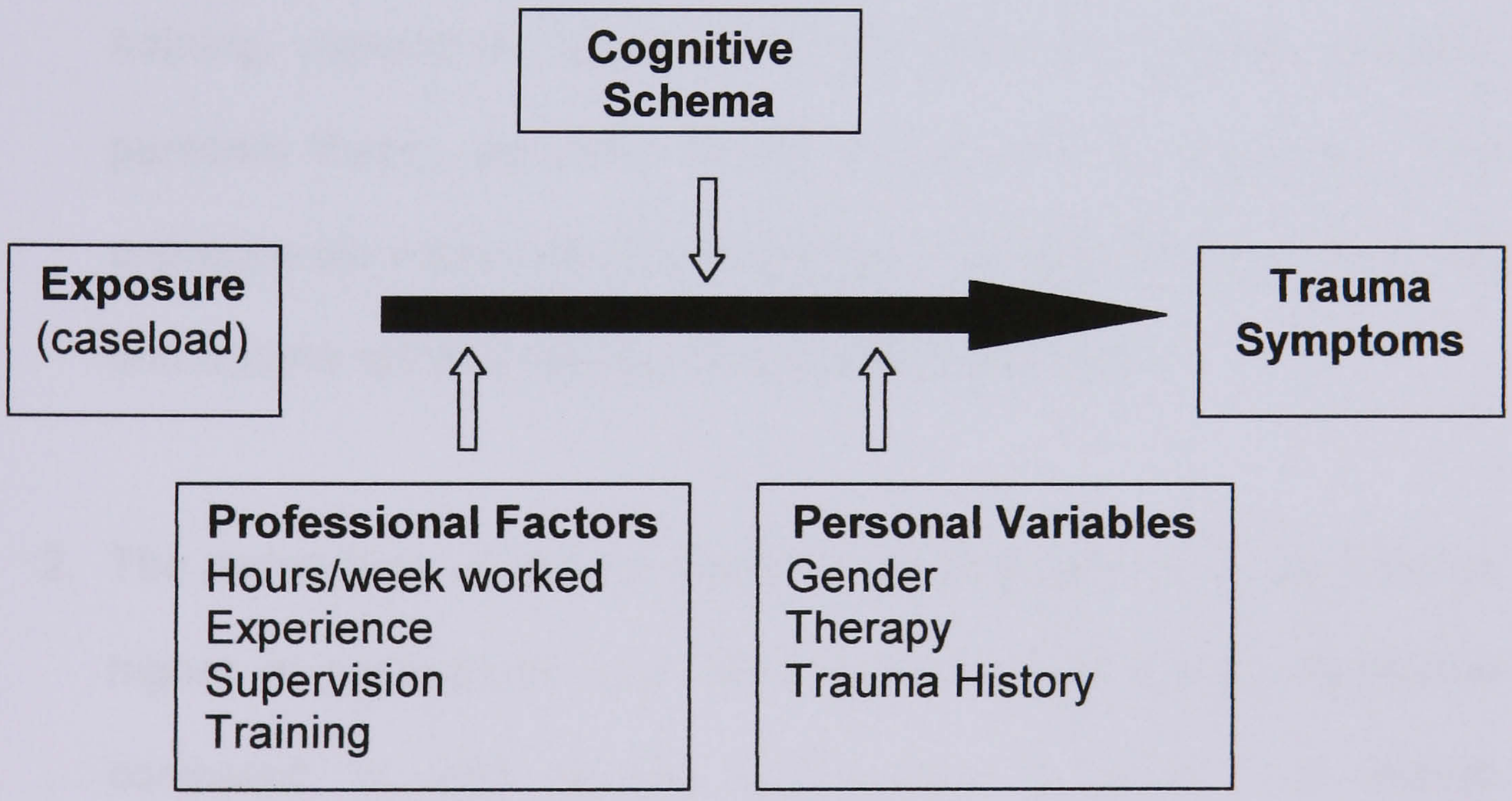
Schauben and Frazier (1995) used measures of PTSD and vicarious traumatisation that had no reliability or validity data. Johnson and Hunter (1997) also developed their own measure of beliefs that had no validity of reliability data. The use of measures with no reported reliability or validity calls into question the validity of their findings. Most studies contained measures e.g. Impact of Events Scale, Trauma Symptom Checklist, Traumatic Stress Institute Belief Scale, with adequate psychometric properties, lending to the validity of the findings of the studies that used these measures.

Studies have generally used measures of PTSD or trauma symptomatology to assess vicarious traumatisation. The sensitivity of these measures to symptoms of vicarious traumatisation has been called into question (Chrestman, 1995; Brady *et al*, 1999). Therefore, studies reporting participants who are vicariously traumatised may be finding participants with PTSD or trauma symptoms as a result of their own trauma history. Also, low reports of trauma symptoms within

participants may be due to the insensitivity of these measures.

Whilst conflicting results exist, a picture is emerging that that personal variables (e.g. gender, trauma history, personal therapy), professional factors (e.g. training, experience, hours worked, supervision) and cognitive schema might mediate the relationship between exposure to vicarious events and levels of posttraumatic symptoms. Figure 1 demonstrates this relationship.

Figure 1: The Mediating Role of Cognitive Schema, Professional Factors and Personal Variables between Exposure (caseload) and Trauma Symptomatology



AIMS OF THE PRESENT STUDY

The present study aims to explore the relationship between personal variables, professional factors and cognitive schema and symptoms of vicarious trauma. The study also aims to provide confirmatory evidence for previous findings regarding the significance between trauma history, caseload, disruption in schema, therapy, gender and levels of trauma symptomatology.

HYPOTHESES

1. Beliefs, professional factors (hours per week worked, trauma-related training, experience, supervision) and personal variables (gender, personal theory, personal trauma history) will be associated with exposure (as measured by percentage of trauma clients in caseload) and trauma symptomatology (as measured by PDS).

2. The percentage of trauma clients in a caseload will be significantly higher in participants who have several posttraumatic symptoms compared to little or no posttraumatic symptoms, in female participants compared to male participants and in participants who have received therapy compared to those who have not received therapy. Professional factors (hours per week worked, trauma-related training, experience, supervision) will not contribute significantly to these differences.

3. The number of personal traumatic events will be significantly higher in participants who have several posttraumatic symptoms compared to little or no posttraumatic symptoms, in female participants compared to male participants and in participants who have received therapy compared to those who have not received therapy. Professional factors (hours per week worked, trauma-related training, experience, supervision) will not contribute significantly to these differences.

4. Disruptions in cognitive schema will be significantly greater in participants who have several posttraumatic symptoms compared to little or no posttraumatic symptoms, in female participants compared to male participants and in participants who have received therapy compared to those who have not received therapy. Professional factors (hours per week worked, trauma-related training, experience, supervision) will not contribute significantly to these differences.

METHOD

DESIGN

The design of the study is cross-sectional survey exploring levels of posttraumatic symptomatology/vicarious traumatisation and related factors in a sample of clinical psychologists working in the West Midlands with postal questionnaires. Associations between factors were

measured using correlations and differences between sub-groups within the survey were tested using ANOVA.

MEASURES

Participants were asked to complete several questionnaires that were presented in the following order:

- DEMOGRAPHIC (see appendix 5)

Participants were asked to provide personal information about their age, gender, marital status and ethnic origin

- PROFESSIONAL AND PERSONAL FACTORS (see appendix 6)

Participants were asked to provide information about their work environment including client group, work setting, experience, hours worked, training received, supervision and personal therapy.

- TRAUMA HISTORY QUESTIONNAIRE (see appendix 7)

The trauma history questionnaire was adapted from the Posttraumatic Stress Diagnostic Scale (PDS – Foa, 1995). The PDS assesses 12 traumatic events. Participants were asked to indicate how many clients with each traumatic experience they were currently working with and estimate the percentage of these clients on their caseload.

Participants were also asked to fill an identical questionnaire about their own traumatic experiences.

- POSTTRAUMATIC DIAGNOSTIC SCALE (PDS - Foa, 1995; see appendix 8)

The scale used to assess the severity of PTSD symptoms in this study is taken from the 49 item PDS. The scale has 17 items that assess re-experiencing, avoidance and arousal symptoms over the past month. Items are scored on a 4-point scale ranging from not at all/only one time to almost always/five or more times a week. Severity is established by summing the scores for these items, a higher score indicates greater severity. The scale has been used with clinical and non-clinical samples. Foa, Cashman, Jaycox and Perry (1997) and Foa, Riggs, Dancu and Rothbaum (1993) report the scale has good test-retest reliability (0.77-0.81), good internal consistency (0.78-0.92) and convergent validity with the structured clinical interview for diagnosis (0.65) and IES-R (0.78).

- TRAUMATIC STRESS INSTITUTE (TSI) BELIEF SCALE (Pearlman & Maclan, 1994 – see appendix 9)

The scale measures disruptions in cognitive schema. It is an 80-item questionnaire. Items are scored on a 6-point scale ranging from 1 - disagree strongly to 6 - agree strongly. A higher score indicates greater disruption in cognitive schema. It has been used with clinical populations and with therapists to diagnose the existence of vicarious

traumatisation. Pearlman and Maclan (1994) report good internal consistency (0.7 – 0.96).

PARTICIPANTS

Questionnaires were distributed to 360 clinical psychologists in the West Midlands. Participants were identified through the West Midlands DCP or the clinical psychology doctorate courses of Coventry and Warwick and Birmingham universities (via course handbooks). Participants were included in the study if they were currently seeing clients, participants were not excluded if they did not have clients with trauma histories, 136 (38%) participants returned questionnaires. Blank questionnaires were returned by 6 participants and 8 participants completed demographic or professional details as requested if participants did not want to take part. Therefore, a return rate of 34% was achieved. This is comparable to similar studies of the impact of working with individuals who have experienced trauma. These studies have reported return rates of between 24-58% (Kassam-Adams, 1995; Pearlman & Maclan, 1995; Pope & Feldman-Summers, 1992).

Participants were aged between 27-66 (mean = 42.24, s.d. = 8.42). 44 (36%) of the participants were male and 77 (64%) were female. The majority of participants were married (55%) and of Caucasian origin (92%), further details can be found in table 2.

Table 2: Demographic Data

Marital Status	Number (%)	Ethnic Background	Number (%)
Married	67 (55%)	White	110 (92%)
Single	21 (17%)	Afro-Caribbean	0 (0%)
Divorced	9 (7%)	Asian	1 (1%)
Widowed	2 (2%)	European	6 (5%)
Separated	4 (3%)	Other	3 (2%)
Co-habiting	19 (16%)		

This sample is very similar to Cushway, Tyler and Nolan's (1996) survey of West Midlands clinical psychologists and Norcross, Brust and Dryden's (1992) national survey in terms of gender, age and marital status. Comparisons were not possible between the participants who completed the questionnaire measures and those who completed only the demographic, personal and professional factors as the latter group was too small (n = 8).

PROCEDURE

Participants were sent the questionnaires (see appendices 4-9), a covering letter (see appendix 10) and information leaflet (see appendix 11) explaining the purpose of the study. They were invited to take part in the study and return the questionnaire measures. Participants who did not want to take part were asked to complete brief questions regarding demographic data and return their questionnaire to the researcher. A pre-paid envelope was enclosed for the return of the questionnaires.

RESULTS

The majority of participants worked in adult services (45%) and in multidisciplinary teams (52%). The most common frequency of supervision was monthly (40%). 65 (54%) had undertaken personal therapy and 55 (46%) had not. Further details can be found in Table 3.

Table 3: Details of Clinical Psychologists' Client Groups, Work Settings and Supervision Arrangements

Client Group	No. (%)	Work Setting	No. (%)	Frequency of supervision	No. (%)
Adults	54 (45%)	Psychology	27 (23%)	Weekly	26 (22%)
Children	17 (14%)	MDT	62 (52%)	Fortnightly	34 (28%)
Learning Disabilities	12 (10%)	Both	14 (12%)	Monthly	48 (40%)
Older Adults	9 (7%)	Primary Care	2 (2%)	Other	12 (10%)
Neuro psychology	3 (3%)	Private	5 (4%)		
Forensic	6 (5%	Other	9 (7%)		
Physical Health	6 (5%)				
Other	14 (12%)				

Participants had worked as qualified clinical psychologists for between 1-38 years (mean = 13.55, s.d. = 12.00). They worked between 15-75 hours per week (mean 36.37, s.d. = 8.87). The participants had received between 0-40 days (mean = 0.83, s.d. = 3.71) of trauma related training. The number of clients with a trauma history that each participant saw was between 0-39 (mean = 12.88, s.d. 7.57). The percentage of trauma

clients on their caseload was between 0-100% (mean = 47.47, s.d. = 28.82). The number of traumatic events the participants had personally experienced ranged from 0-9 (mean = 2.00, s.d. = 1.73).

Scores for participants on the PTDS ranged from 0-23 (mean = 4.51, mode = 0, s.d. = 4.92). 105 (86%) participants scored within the 'mild' range, 16 (13%) scored within the 'moderate' range and 1 (1%) participant scored with the 'moderate to severe' range. The ranges were defined by Foa (1995). Internal consistency was established, (cronbach's alpha = .83). Scores ranged from 98-280 (mean = 172.65, s.d = 36.11) on the TSI Belief Scale. Internal consistency was established (cronbach's alpha = .95).

Due to the sample size, the number of hypotheses made in this study, and therefore the number of statistical procedures carried out, and following recommendations made in previous studies (Brady *et al.*, 1999; Pearlman and Maclan, 1995) a significance level of $p < 0.01$ was used for analyses in this study. This reduces the risk of type I errors.

In order to help establish the characteristics of the participants to enable comparisons with previous and future studies, a profile of the characteristics of the participants exploring the correlations between the variables, which were not entered into further analysis, was investigated (See table 4).

Table 4: Profile of Characteristics of Participants

	1.	2.	3.	4.	5.	6.	7.
1. Hours per week worked	–						
2. No. of days trauma-related training	-.007[a] (.941)[b]	–					
3. No. of years since qualification	.026 (.779)	-.114 (.212)	–				
4. Frequency of supervision	.099 (.285)	-.125 (.175)	.382** (.000)	–			
5. Gender	-.342** (.000)	.041 (.657)	-.209* (.022)	-.068 (.463)	–		
6. Received personal therapy	-.006 (.952)	-.048 (.604)	.184* (.044)	.211* (.021)	-.029 (.754)	–	
7. Personal trauma history	.167 (.069)	.043 (.637)	.135 (.141)	-.043 (.644)	-.113 (.217)	-.115 (.209)	–
8. TSI Belief Scale total	-.184* (.044)	.046 (.618)	-.007 (.940)	-.138 (.133)	.029 (.753)	-.215* (.018)	-.094 (.305)

[a] Pearson's r, [b] p, * $p < 0.05$, ** $p < 0.01$

In summary, male participants were more likely to work longer hours and participants who had been qualified longer were more likely to receive less supervision.

Several correlations demonstrated a trend towards significance, male participants were more likely to have been qualified for longer. Participants who had received personal therapy were more likely to have more frequent supervision and to have been qualified for a shorter time. Participants who experienced more disruptions in their cognitive schema were more likely to have received personal therapy and work longer hours.

HYPOTHESIS 1

The mediating role of schemas, professional factors and personal variables between exposure and trauma symptomatology

As the first step in establishing whether there was a mediating relationship, the correlations between the variables were determined. These are reported in Table 5.

Table 5: Correlations between Schemas, Professional Factors, Personal Variables and both Caseload and Trauma Symptoms

		Caseload (% trauma clients)	Trauma Symptoms (Total PDS score)
Caseload		—	.321** (.001)
Schema		-.005[a] (.959)[b]	.288** (.001)
Professional	Hours per week worked	-.069 (.481)	-.208* (.022)
	No. of days trauma-related training	.212* (.028)	-.025 (.787)
	No. of years qualified	.098 (.314)	-.067 (.464)
	Frequency of supervision	.047 (.635)	-.091 (.325)
Personal	Gender	.049 (.615)	.098 (.286)
	Received personal therapy	-.147 (.131)	-.294** (.001)
	Trauma history	.186 (.054)	.333** (.001)

[a] Spearman's rho, [b] p, * $p < 0.05$, ** $p < 0.01$

In summary, participants with a higher percentage of trauma clients in their caseload, who experienced greater disruption in their cognitive

schema, who had received personal therapy or who reported a higher number of traumatic events in their personal history were more likely to experience posttraumatic symptoms.

Two correlations demonstrated a trend towards significance; participants who worked longer hours were more likely to experience posttraumatic symptoms and participants who had received more trauma-related training were likely to have a higher percentage of trauma clients in their caseload.

There were no significant correlations between gender, supervision, training, experience and posttraumatic symptoms. No significant correlations were found with caseload.

None of the variables were correlated with both exposure and trauma symptomatology. In the case of a mediating relationship correlations between each mediating variable and both the predictor (caseload) and outcome variable (trauma symptomatology) should be significant (Baron & Kenny, 1986). Therefore, it can be concluded that neither schema nor any of the professional factors or personal variables played a significant role in mediating the relationships between exposure and trauma symptomatology. Thus, hypothesis one was not supported

The measure for trauma symptomatology (PDS) demonstrated floor effects that were a considerable concern. Consequently, it was decided

to reduce the PDS score to a dichotomous variable. The PDS was divided at, approximately, the median. As a result the participants were split into two groups, the first showing little or no trauma symptomatology and the second showing evidence of several trauma symptoms. 57 (47.5%) participants were included in this first group, the PDS scores ranged between 0-2 (median = 1). The latter group consisted of 63 (52.5%) participants, PDS scores ranged between 3-23 (median = 6).

HYPOTHESIS 2

Differences in exposure (percentage of trauma clients in caseload) between participants divided by gender, therapy and level of posttraumatic symptoms

The percentage of trauma clients in the caseload was analysed using an analysis of variance with three between-groups variables of gender (male *vs.* female), therapy (received personal therapy *vs.* no personal therapy) and trauma symptoms (little or no symptoms *vs.* several symptoms). A similar 2x2x2 ANCOVA was then executed to ascertain the effects of the covariates (hours, training, experience supervision). The results of the ANOVA and ANCOVA are reported in table 6.

Table 6: Results of ANOVA and ANCOVA for Percentage of Trauma Clients in caseload

	ANOVA		ANCOVA	
	F (1,98)	Sig (p)	F (1,98)	Sig (p)
MAIN EFFECTS				
Trauma Symptoms	10.301	.002	11.561	.001
Gender	0.003	.958	0.328	.568
Personal Therapy	0.961	.147	2.718	.103
INTERACTIONS				
Trauma Symptoms * Gender	0.147	.702	0.528	.469
Therapy * Trauma Symptoms	0.620	.433	0.455	.502
Gender * Therapy	0.455	.501	0.246	.621
Trauma Symptoms * Gender * Therapy	1.219	.589	0.259	.612
COVARIATES				
Hours/week			0.126	.724
Training			4.084	.046
Experience			0.828	.365
Supervision			0.290	.592

The ANOVA revealed a significant main effect for trauma symptoms. The results of the ANCOVA suggests that when covariates were controlled the main effect for trauma is more significant compared to the ANOVA. This suggests that participants with a higher percentage of trauma clients experienced several trauma symptoms and participants with a lower percentage of trauma clients experienced little or few trauma symptoms.

The ANCOVA revealed a trend towards significance for training, which suggest that there are differences between the groups in the amount of training experienced.

The results of the ANOVA and ANCOVA do not fully support hypothesis two, the percentage of trauma clients was only significantly different between participants with several trauma symptoms and participants with little or no trauma symptoms and this was still significant when professional factors were controlled for. No significant differences were found between males and females and between participants who had received therapy and those who had not.

HYPOTHESIS 3

Differences in Trauma History between participants divided by gender, therapy and level of posttraumatic symptoms

The number of personal traumatic events was analysed using an analysis of variance with three between-groups variables of gender (male *vs.* female), therapy (received personal therapy *vs.* no personal therapy) and trauma symptoms (little or no symptoms *vs.* several symptoms). A similar 2x2x2 ANCOVA was then executed to ascertain the effects of the covariates (hours, training, experience supervision). The results can be found in Table 7.

Table 7: Results of ANOVA and ANCOVA for Number of Personal Traumatic Events

	ANOVA		ANCOVA	
	F (1,98)	Sig (p)	F (1,90)	Sig (p)
MAIN EFFECTS				
Trauma Symptoms	10.605	.001	10.979	.001
Gender	4.344	.039	1.449	.231
Personal Therapy	0.000	.997	0.103	.749
INTERACTIONS				
Trauma Symptoms * Gender	0.380	.539	0.424	.516
Trauma Symptoms * Therapy	0.773	.381	0.712	.401
Gender * Therapy	3.576	.061	4.501	.036
Trauma Symptoms * Gender * Therapy	3.714	.056	2.255	.136
COVARIATES				
Hours/week			3.457	.066
Training			0.064	.801
Experience			4.284	.041
Supervision			2.436	.122

The ANOVA revealed a significant main effect for trauma symptoms. The results of the ANCOVA suggests that when covariates were controlled the main effect for trauma is greater although not more significant compared to the ANOVA. This suggests that participants with greater number of personal traumatic events experienced several trauma symptoms and participants with fewer personal traumatic events experienced little or few trauma symptoms.

The ANOVA revealed a trend towards significance for a main effect for gender, suggesting that participants with greater number of personal traumatic events were male and participants with fewer personal traumatic events were female. However, the ANCOVA revealed no significant effects of gender when covariates were controlled for.

The ANCOVA revealed a trend towards significance for an interaction effect of sex and therapy when the covariates were controlled for. This suggests that trauma history is greater for males that have not received therapy and females that have received therapy and lower for males that have received therapy and females that have not received therapy.

The ANCOVA also revealed a trend towards significance for experience, which suggest that there are differences between the groups in the length of experience as a clinical psychologist.

The results of the ANOVA and ANCOVA do not fully support hypothesis three, the number of personal traumatic events was only significantly different between participants with several trauma symptoms and participants with little or no trauma symptoms and this was still significant when professional factors were controlled for. No significant differences were found between males and females and between participants who had received therapy and those who had not.

HYPOTHESIS 4:

Differences in cognitive schema between participants divided by gender, therapy and level of posttraumatic symptoms

The degree of disruption in cognitive schema was analysed using an analysis of variance with three between-groups variables of gender (male *vs.* female), therapy (received personal therapy *vs.* no personal therapy) and trauma symptoms (little or no symptoms *vs.* several

symptoms). A similar 2x2x2 ANCOVA was then executed to ascertain the effects of the covariates (hours, training, experience supervision). The results of the ANOVA and ANCOVA are reported in table 8.

Table 8: Results of ANOVA and ANCOVA for Disruptions in Cognitive Schema

	ANOVA		ANCOVA	
	F (1,98)	Sig (p)	F (1,90)	Sig (p)
MAIN EFFECTS				
Trauma Symptoms	6.781	.010	6.887	.010
Gender	0.004	.949	0.096	.758
Personal Therapy	4.565	.035	3.260	.074
INTERACTIONS				
Trauma Symptoms * Gender	0.066	.798	0.028	.868
Trauma Symptoms * Therapy	1.829	.179	2.116	.149
Gender * Therapy	1.863	.175	1.008	.318
Trauma Symptoms * Gender * Therapy	0.187	.666	0.258	.612
COVARIATES				
Hours/week			0.306	.581
Training			0.027	.870
Experience			0.853	.358
Supervision			1.818	.181

There were no significant effects below the 1% level. The ANOVA revealed trend towards a significant main effect for trauma symptoms. The results of the ANCOVA suggests that when covariates were controlled the main effect for trauma is greater although not more significant compared to the ANOVA. This suggests that participants with more disrupted cognitive schema experienced several trauma symptoms and participants with less disrupted cognitive schema experienced little or few trauma symptoms.

The ANOVA also revealed a trend towards significance for therapy, suggesting that participants with more disrupted schema undertake personal therapy and participants with less disrupted schema do not undertake personal therapy. However, the ANCOVA revealed no significant effects of therapy when covariates were controlled for.

The results of the ANOVA and ANCOVA do not support hypothesis four. Schema disruption was not significantly higher for participants with several posttraumatic symptoms compared with little or no posttraumatic symptoms (although this was a very strong trend towards significance), males compared with females and between participants who had received therapy compared with those who had not.

DISCUSSION

The low prevalence of trauma symptoms within this sample supports Van Minnen (2000) and Mahoney's (1997) findings that distress has been over represented in studies of therapists' psychological health. However this could have also been affected by the low return rate.

The results of this study do not confirm the mediating role for variables as suggested in figure 1. However, disruption in cognitive schemas, exposure, trauma history and therapy were associated with trauma symptomatology.

This study clarified aspects of findings from previous studies. Greater exposure and trauma history were linked to experiencing several trauma symptoms; this relationship was significant even when hours, training, experience and supervision were controlled for. There was also supporting evidence for greater disruption in cognitive schema and experiencing several trauma symptoms even after hours, training, experience and supervision were controlled for. Gender was not found to be a significant factor with trauma history and therapy was not found to be a significant factor with disruption in cognitive schema when hours, training, experience and supervision were controlled for.

In summary, this study found support for previous conclusions regarding the significance of exposure, trauma history and to a lesser extent disruptions in cognitive schema. Gender, therapy and professional factors were not generally significant factors. These results have to be tempered with caution as there was a high percentage of non-responders. However, it seemed that the clinical psychologists in this sample were representative of regional and national clinical psychologists (Cushway, *et al*, 1996; Norcross *et al*., 1992).

This study tried to counter methodological flaws of other studies, the study included a range of professional and personal variables. Participants were recruited from a sample of clinical psychologists across a wide range of specialties and experience. Participants were not excluded from analysis if they did not regularly offer therapeutic

intervention to individuals who have experienced traumatic events. The representativeness of the participants was addressed and the study used validated measures.

However, there are two main criticisms that can be applied to this study. First, the assessment of exposure to vicariously traumatic events used in this study was relatively simple. It assumed that a greater number of trauma clients was equivalent to a greater exposure. Previous researchers have suggested that aspects such as exposure to graphic details and an individual assessment of which situations are traumatic for each therapist should be included (Brady et al., 1999; Pearlman and Maclan, 1995). Secondly, the finding that the majority of participants had no or mild levels of trauma and the consequent lack of participants with high levels of trauma symptomatology might have obscured the role of some variables within this study.

This study was distinct from other studies in that it did not claim to measure the effects of vicarious traumatisation. Rather, it focused on trauma symptoms that were not tied directly to a specific source. This was a more accurate way of describing the effects that this and other studies have explored given that a measure of vicarious traumatisation per se has not been discovered. However, focusing purely on classic symptoms of PTSD may have missed many symptoms that have been reported in the literature e.g. somatic reactions, dissociation, depression, complex PTSD (Stamm, 1999). This raises the need for more complex

measures of trauma symptoms and other measures of psychological well-being to be adapted for trauma-related therapist distress.

It is surprising that whilst vicarious traumatisation has been considered in terms of PTSD more general findings in the PTSD literature have not been applied. For example, personality, coping, and social support have been found to play a role in PTSD (Joseph, 1999a,1999b; Williams, 1999). The inclusion of these variables may well enhance the theoretical and empirical richness of the concept of vicarious trauma.

Further research is recommended in three areas. Firstly, it may be beneficial to focus on the long-term effects of trauma therapy by employing a longitudinal design. Secondly, assessment measures could be created or adapted that can capture the exposure to vicarious events and the wider responses to working with individuals who experience traumatic events. Finally, it may be helpful to turn to other theories to gain an understanding of other factors that might mediate the relationship between exposure and the development of distress.

The clinical implications of this study may, at first, seem to suggest that there is no reason to be concerned about traumatisation in clinical psychologists. There may be a variety of reasons why clinical psychologists who are traumatised did not complete this study. Two possible reasons may be that they may have already left the profession or that those with higher trauma symptoms may have not completed the

questionnaires to avoid reminders of the vicarious events, as they were also likely to score highly on avoidance.

Clinical psychologists should be aware of the possibility of vicarious traumatisation, particularly in those with high caseloads of trauma clients and the interaction between working with trauma and the psychologists' own experience of trauma. This research suggests that efforts should be made to achieve balanced caseloads and support should be offered to those working with trauma who have personal experience of traumatic events. Neuman and Gamble (1995) recommend organisational factors that may help in ameliorating the traumatisation of therapists. These include tolerance of mistakes and "not knowing", professional development, training, supportive attitudes towards personal therapy and overt recognition for work. They and Saakvitne and Pearlman (1996) also emphasise the therapists' responsibility to maintain self-care. This corresponds with ethical/practice guidelines (DCP, 1995), this can include reconnecting with one's body and senses, personal psychotherapy, setting boundaries between home and work and leading a fulfilling personal life.

In conclusion, this study showed that most clinical psychologists were psychologically healthy. However, methodological and assessment issues may have contributed to these findings. A minority of clinical psychologists, particularly those with high caseloads of trauma clients and personal trauma histories, may experience some psychological

distress as a result of working with trauma. Clinical psychologists who work with trauma should be aware of these effects and together with their employers steps can be taken to address the issue of the psychological effects of working with trauma.

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CHAPTER THREE: BRIEF PAPER

The Emotional and Cognitive Reactions of Clinical Psychologists Working with Traumatised Clients

This paper has been prepared for submission to Clinical Psychology and Psychotherapy (See Appendix 3)

This study has received ethical approval from Coventry University Ethics Committee (See Appendix 4)

ABSTRACT

This study explored the emotional and cognitive reactions of clinical psychologists working with trauma-related clinical material. Participants completed the Revised Impact of Event Scale (IES-R; Weiss *et al.*, 1995) and a qualitative questionnaire relating to a specific clinical event. Events were categorised into vicariously traumatising, directly traumatising and stressful (non-traumatising) events and emotional and cognitive responses were broadly categorised into negative, positive and mixed reactions. Although a wide range of emotions and cognitions were reported, no differences were found on the IES-R across vicarious and stressful types of events. No participants met "clinical caseness" for posttraumatic stress disorder. As a broader range of cognitive and emotional reactions were reported this suggests that PTSD measures may be too restrictive in their focus.

INTRODUCTION

Recent research has considered the impact on therapists of working with individuals who have experienced traumatic events. This phenomenon has been given various names but is most commonly referred to as vicarious traumatisation (McCann & Pearlman, 1990a, 1990b). Vicarious traumatisation is concerning to professionals as research indicates the possible consequences may include emotional distress, burnout, early retirement and professional misconduct (Figley, 1995; Stamm, 1999). This research has indicated the need for a better understanding of the psychological effects of working therapeutically with this client group (Brady *et al.*, 1999; Pearlman & Maclan, 1995).

Research into vicarious traumatisation has focused on two main areas, emotional reactions and cognitions. The majority of the research into the emotional effects of working with trauma survivors has used a measure of PTSD, usually the Impact of Events Scale (IES) (Brady *et al.*, 1999; Chrestman, 1999; Kassam-Adams,1999; Pearlman & Maclan, 1995; Schauben & Frazier, 1995). Others have used more widespread symptom measures e.g. stress, burnout or psychological well being measures (Chrestman, 1999; Johnson & Hunter, 1997; Schauben & Frazier, 1995; Van Minnen & Keijsers, 2000). However, it is difficult to draw comparisons as data on these measures has rarely been reported.

Qualitative studies have described a wide range of emotional responses:

- Horror, shock, numbing, anger, sadness, visual images and somatic complaints (Iliffe and Steed, 2000)
- PTSD symptoms, somatic complaints and relationship difficulties (Van Minnen and Keijsers, 2000)
- Anger, sadness, fear, helplessness and powerlessness (Schauben and Frazier, 1995)

Compared to the use of specific measures the qualitative information suggests that focusing on a narrow definition of PTSD symptoms e.g. intrusions, avoidance, arousal may be too narrow an approach and that it risks missing other responses. However, the qualitative studies are limited by low numbers and focusing on therapists who work with very specific groups of trauma victims e.g. sexual/domestic violence. Therefore, there is concern with regard to the generalisability of the findings of these studies.

There are a number of cognitive theories of PTSD that suggest that traumatic events often challenge views about the self, world and others (Epstein, 1994; Janoff-Bulman, 1992). McCann and Pearlman (1990a, 1990b) proposed that particular schemas about the self and others e.g. safety, esteem, trust, control and intimacy are disrupted by trauma. Studies of vicarious trauma have used the TSI Belief Scale (Pearlman & Maclan, 1994) to assess these schemas. Cognitive reactions of

vicarious traumatisation have been exclusively assessed with this measure or derivations thereof.

Qualitative studies have described cognitive changes in therapists working with trauma. Iliffe and Steed (2000) indicated participants reported changes in their worldview, particularly in relation to issues such as security, trust, power and control. Van Minnen and Keijsers (2000) reported positive (e.g. feeling better prepared for the world) and negative (e.g. greater suspicion and less naivety) changes.

There appears to be some degree of overlap between the themes reported in the qualitative studies and the different schema assessed by the TSI Belief Scale. However, the qualitative studies are again limited by small numbers and specific populations.

This research aims to explore the emotional and cognitive reactions to working with trauma in a large group of clinical psychologists drawn from a range of clinical specialties. The study will use both quantitative and qualitative information to assess the severity and breadth of reported responses.

METHOD

DESIGN

The design of the study is a cross-sectional survey, using qualitative and quantitative information to assess the emotional and cognitive reactions to a distressing or traumatising event that occurred in a clinical session.

MEASURES

Participants were asked to complete the following questionnaires:

- A questionnaire, asking participants to identify a specific event and the emotional and cognitive reactions to it, was designed (see appendix 12). Based on the theoretical work of Epstein (1994) and Jannoff-Bulman (1992) three categories of cognitions, beliefs about the self, others and the world, were included. Changes over time were also reported. The questionnaire was piloted on a group of fourteen trainee clinical psychologists.

- The Revised Impact of Events Scale (IES-R (see appendix 13) – Marmar *et al.*, 1996; Weiss *et al.*, 1995)

  The IES-R is a 22-item scale that assesses the presence of intrusive, avoidant and hyperarousal symptoms that are consistent with the PTSD criteria in DSM-IV [American Psychiatric Association (APA), 1994]. It has three subscales, intrusion, avoidance and hyperarousal. Items are scored on a 4-point scale ranging from 1 – not at all to 5 - often. The IES-R has been

validated with samples of emergency personnel and disaster survivors (Marmar *et al.*, 1996; Weiss *et al.*, 1995). Weiss and Marmar (1997) report good test-retest reliability (0.51-.94) and good internal consistency (0.79-0.82).

PARTICIPANTS

360 potential participants were contacted, all were clinical psychologists identified through the West Midlands DCP and clinical psychology doctorate courses in the West Midlands. 123 (34%) participants returned questionnaires, of these, 110 (31%) participants completed questionnaires about a specific event that they found traumatising or distressing. Participants were aged between 27-66 (mean = 42.06, s.d. = 8.57). 37% of the participants were male and 63% were female. The majority of participants were married (57%) and of Caucasian origin (92%)

PROCEDURE

Participants were part of a larger study (see Hancock *et al.*, 2002). They were sent the questionnaires (see appendix 12 & 13), a covering letter (see appendix 10) and an information leaflet (see appendix 11) explaining the purpose of the study. A prepaid envelope was provided for the return of their questionnaires.

The instructions for completing the qualitative questionnaire included:

This section asks you to remember a specific experience that happened during your clinical work that left you feeling more traumatised or distressed than usual. We are interested in your reactions to this experience.

Please describe a recent event that occurred during your clinical work that left you feeling traumatised or distressed.

Describe your feelings about the event you have described

Describe the thoughts that you are aware of now whilst you are recalling this event and any you can remember from the time when this event took place. Think about the thoughts you have about yourself, about others and about the world.

Participants were then asked to complete the IES-R and the following instructions were added:

Whilst thinking about the traumatising or distressing event, that you described that occurred during your clinical work, please complete the following questions.

ANALYSIS OF QUALITATIVE INFORMATION

Content analysis (Dey, 1993; Boyatzis 1998) was used to code the written qualitative information concerning the event and emotional and cognitive reactions. Codes were arrived at both inductively and deductively. Deductive codes were derived from the research questions and theoretical ideas. Codes derived from the research questions included, type of event, emotions and cognitions. These were divided into reactions at the time and now. However, the analysis revealed no difference between reactions at the time and now, so this distinction was dropped. On the basis of theoretical ideas (Epstein, 1994; Jannoff-Bulmann, 1992) cognitions were further divided into beliefs about the self, others and the world.

Further themes (codes) were developed for emotional and cognitive reactions. The processes suggested by Dey (1993) and Boyatzis (1998) were used to guide the development of these themes. Initially codes were developed from examining a small selection (10%) of the data. These were then further refined and amalgamated following the examination of all data. A definition of these themes was created during this process and a codebook containing this information was developed (see appendix 14). An independent rater established the reliability of the codes using this codebook.

The type of event was coded into vicariously traumatising, directly traumatising or stressful (non-traumatising). Four (4%) could not be

categorised due to the lack of/ambiguous information regarding the event. Inter-rater agreement (percentage agreement across categories) was 87%.

Emotional and cognitive reactions were coded into negative, positive and mixed. Seventy (9%) reactions were either missing or not coded due to the ambiguous nature of statements. Inter-rater agreement (percentage agreement across categories) was 93%

RESULTS

The mean score for the IES-R was 9.25 (s.d = 10.66). Internal consistency for the scale was good (α = .88). Although there are no strict cut off points for the IES-R, the classification that was used in this study was 0-8 low distress, 9-19 medium distress and 20 or more high distress (Church & Vincent, 1986). No participants showed high distress, 9 (8%), 11 (10%) and 1 (1%) showed medium distress on intrusion, avoidance and arousal subscales respectively and 100 (92%), 98 (90%) and 108 (99%) showed low distress on intrusion, avoidance and arousal subscales respectively.

Although the content analysis revealed three types of events, most participants reported a vicariously traumatising or stressful event. Hence, total scores on the IES across these two categories of events were compared using independent samples t-tests. The results indicated

that there were no significant differences (t (95) = -1.523, p = .131) on the IES scores for vicarious and stressful events.

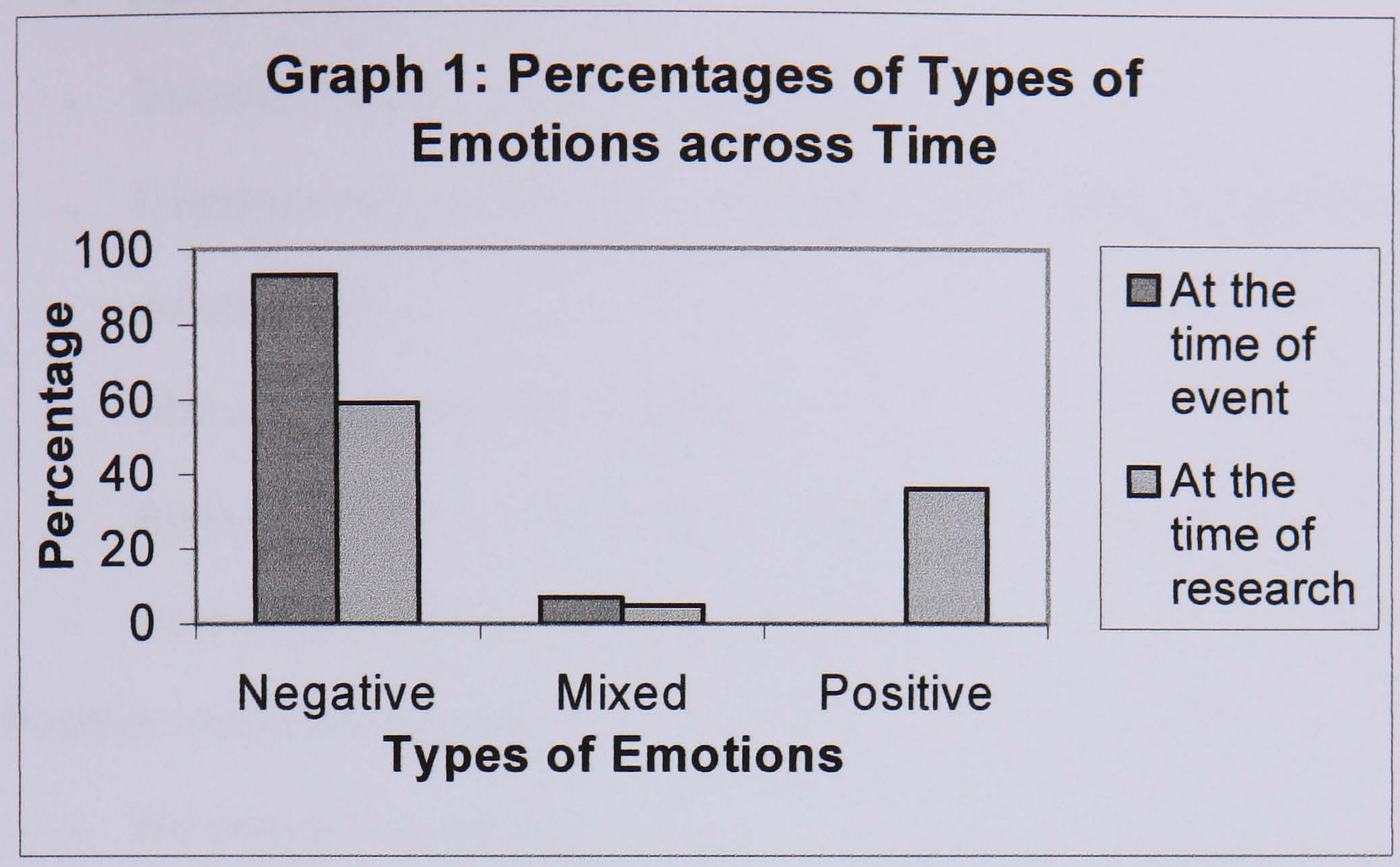
TYPE OF EVENT

The descriptions of events ranged from a single sentence to a more detailed description of 3 or 4 lines. 47 (45%) participants reported vicarious events including clients' recollections/descriptions of abuse, rape, murder, accidents, assault, torture and war. 49 (47%) participants reported stressful events, these varied more considerably and included managing difficult clinical sessions e.g. distress, aggression; clinical issues e.g. self-harm, suicide, child protection; death or injury of client along with a variety of other events. Examples of other events included hearing about traumatic events and then finding out they were not true, clients' description of loss/bereavement and blackmail. Nine participants (9%) reported direct events, these included being stalked by a client, being assaulted (or the threat of) by clients and traumatic responses to the sudden, often violent, death of a client.

EMOTIONAL REACTIONS

Descriptions of emotional reactions ranged from single words e.g. *"angry"* to a collection of between 2 and 6 words e.g. *"sad, respectful, compassionate", "scared, angry, vulnerable, guilty, paranoid"*. In total participants reported 60 words describing emotional reactions. The frequencies with which negative, mixed and positive emotional reactions

varied across time were reported (see graph 1).



At the time of the event and at the time the research was carried out the majority of participants (93% and 59% respectively) reported negative emotional reactions. No (0%) wholly positive reactions were reported at the time of the event. However, a sizeable minority (36%) reported positive emotions at the time the research was carried out. Over time meaningful changes were observed, the percentage reporting negative emotions considerably decreased and the percentage reporting positive emotions considerably increased. There was a very small decrease observed for mixed emotional reactions from 7% to 5%.

Frequencies of positive, negative and mixed reaction changed over time, however the actual content of the types of reactions did not differ across time.

Negative emotional reactions included:

- Horror, disgust, repulsion
- Disbelief, shock, numbness, surprise
- Helplessness, inadequacy, powerlessness, feeling overwhelmed, vulnerability
- Distress, sadness, tearfulness
- Anger, frustration, annoyance, irritation
- Scared, anxious, nervous, terror, panic

Positive reactions included:

- No distressing feelings
- Compassion, empathy
- Acceptance, resolution
- Calmness, relief

Participants also reported a combination of positive and negative words (i.e. mixed reactions).

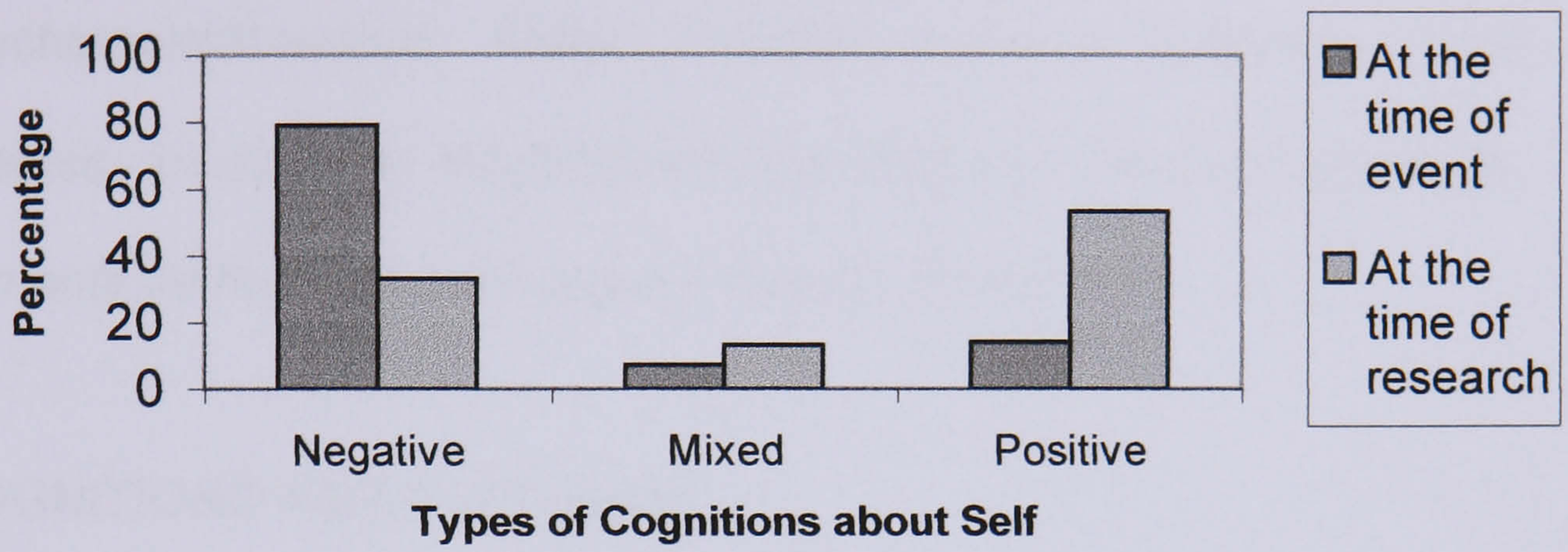
COGNITIVE REACTIONS

Descriptions of cognitive reactions ranged from single words to a whole sentence. The frequencies of negative, mixed and positive cognitive reactions revealed a number of tentative inferences. Whilst frequencies of positive, negative and mixed reaction changed over time the actual content of these types of reactions did not differ across time.

COGNITIONS ABOUT SELF

The frequencies with which negative, mixed and positive cognitions about the self varied across time were reported (see graph 2).

Graph 2: Percentages of Types of Cognitions about Self across Time



At the time of the event out the majority of participants (79%) reported negative cognitions and a minority (14%) reported positive cognitions about self. Although, at the time the research was carried out the majority of participants (53%) were reporting positive cognitions. However, a sizeable minority (33%) continued to report negative cognitions at the time the research was carried out. Over time meaningful changes were observed, the percentage reporting negative cognitions considerably decreased and the percentage reporting positive cognitions considerably increased. There was a small increase observed for mixed reactions from 7% to 13%.

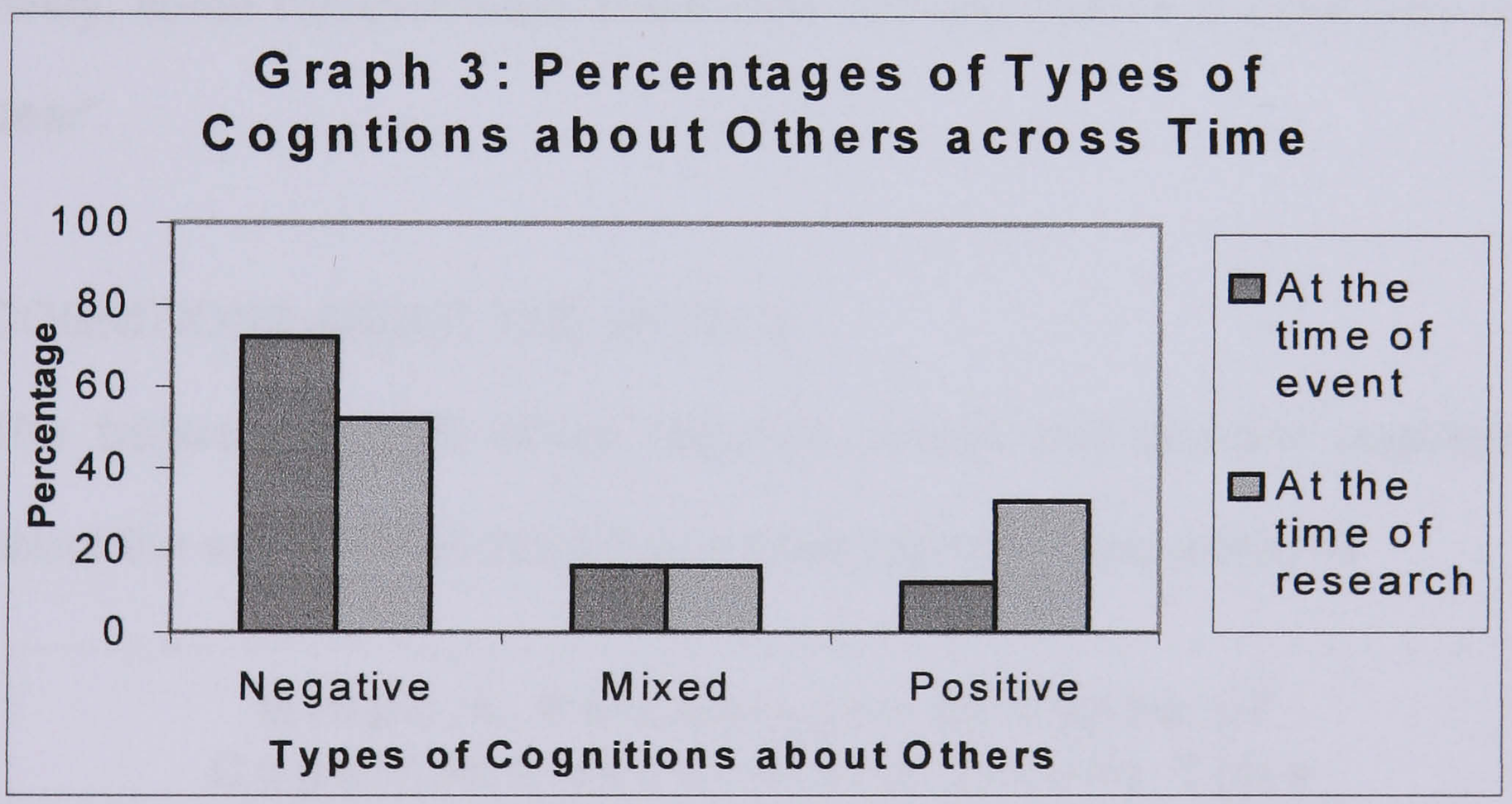
Cognitions about the self were mainly general comments; negative reactions viewed the self as *"abusive"*, *"vulnerable"*, *"powerless"*, *"selfish"* and *"naïve"*. Positive reactions about the self included viewing

the self as *"lucky/blessed"*, *"human"* and *"the same as others"*. Participants also reported a combination of positive and negative words or statements (i.e. mixed reactions).

Some participants described thoughts about themselves as a psychologist/therapist. These included negative reactions *"I am a useless, inadequate, incompetent therapist"* and positive comments, *" I can only do my best, I am a good enough therapist"*.

COGNITIONS ABOUT OTHERS

The frequencies with which negative, mixed and positive cognitions about others varied across time were reported (see graph 3).



At the time of the event and at the time the research was carried out the majority of participants (75% and 52% respectively) reported negative cognitions about others. At the time of the event a minority (12%) reported positive cognitions about others, however, at the time the research was carried out a sizeable minority (32%) reported positive

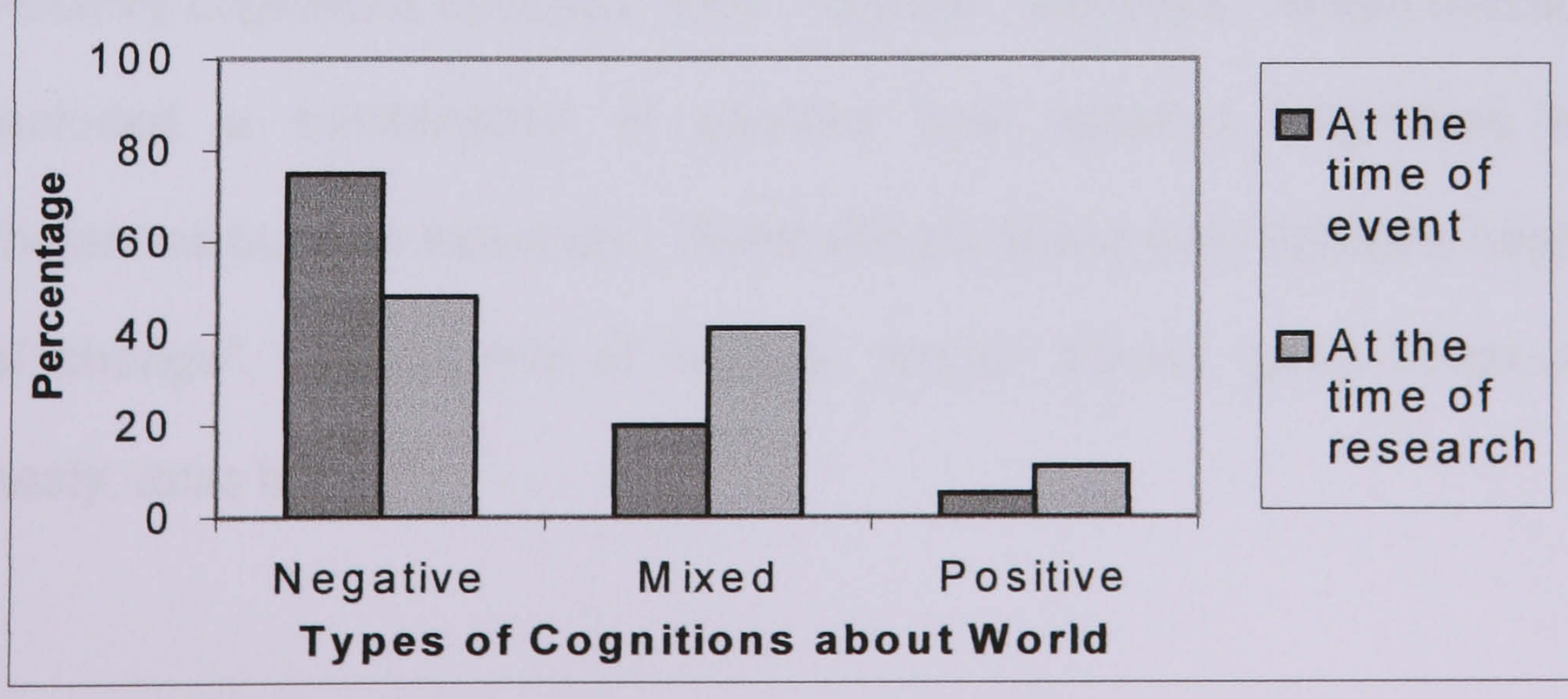
cognitions. Over time meaningful changes were observed, the percentage reporting negative cognitions considerably decreased and the percentage reporting positive cognitions considerably increased. There was no change (16% reported mixed cognitions at both points) observed for mixed reactions.

Negative cognitions about others included *"cruel"*, *"untrustworthy"*, *"manipulative"*, *"selfish"*, *"damaged"* and *"incompetent"*. Positive cognitive reactions included as *"resilient"*, *"brave"*, *"courageous"*, *"human"*, *"compassionate"* and *"understanding"*. Mixed reactions included a combination of positive and negative cognitions e.g. "mostly trustworthy, but some cruel and untrustworthy", "some are inadequate, nasty, some compromised, powerless and impressive at what they can bear".

COGNITIONS ABOUT THE WORLD

The frequencies with which negative, mixed and positive cognitions about the world varied across time were reported (see graph 4).

Graph 4: Percentages of Types of Cognitions about World across Time



At the time of the event the majority of participants (75%) reported negative cognitions and a minority (20%) of participants reported mixed cognitions about the world. At the time the research was carried out nearly equal proportions reported negative and mixed reactions (48% and 41% respectively). Positive reactions were the least frequent type of cognition about the world at the time of the event and at the time the research was carried out (5% and 11% respectively). Over time meaningful changes were observed, the percentage reporting negative cognitions considerably decreased and the percentage reporting mixed cognitions considerably increased. There was a small increase in those reporting positive cognitions.

It is of note that most cognitive and emotional reactions showed a shift over time from negative to positive. However, cognitions about the world did not follow this trend and instead demonstrated a shift from negative to mixed cognitions.

Negative cognitions about the world included statements that the world was an “unpredictable”, “dangerous”, “cruel”, “evil” or “unfair” place. Positive cognitions included “safe”, “happy”, “beautiful”. Mixed reactions included a combination of positive and negative cognitions e.g. “balanced but with extremes”, “filled with good and bad, variable, hopeful of change”, “painful mix of healthy, sound, honest, good things and nasty, toxic things”.

DISCUSSION

This study did not indicate there were clinical psychologists with high degrees of trauma symptomatology, this was in contrast with previous research (Chrestman, 1999; Kassam-Adams,1999; Illife & Steed, 2000; Pearlman & Maclan, 1995; Schauben & Frazier, 1995).

However a wide range of emotional and cognitive reactions were reported. A significant proportion of participants still reported negative responses at the time of completing the questionnaire. It is noteworthy that no wholly positive emotional reactions at the time of event were reported although most emotional and cognitive reactions appeared to show some degree of positive change over time. It is also interesting to note that cognitions about the self appeared to change most over time in comparison to cognitions about other and about the world. This might help to explain why high levels of trauma were not found. The participants seemed to have fairly robust thoughts about themselves that whilst they showed some transient changes were not permanently effected and therefore showed minimal indications of distress.

It is crucial that the results reported here are seen as tentative conclusions. The high proportion of non-responders could have caused a response bias. Although, the demographics of the sample indicate that the sample was representative in terms of gender and age (Cushway *et*

al., 1996; Norcross *et al.*, 1992). Reasons for non-participation are largely unknown.

The nature of the design of this study meant that only brief qualitative comments could be made and this limited the depth of the content analysis. Alternative methodologies e.g. interviews, focus groups would have enabled richer qualitative data to be collected and therefore more in depth analysis would have been possible. Whilst these cautions are noted the analysis within this study seems appropriate for a preliminary exploration and hopefully encourages further work in this area.

The results of this study may also have important implications for other studies into vicarious traumatisation. The lack of differentiation on scores on trauma measures between vicarious and stressful events may call into question whether scores on PTSD measures exclusively tap into vicarious traumatisation.

The results of this study indicate that a wide range of cognitive and emotional reactions to an event occurring within therapy are reported for both stressful and vicarious events. Research into the effects of working with trauma survivors has used existing trauma history and symptomatology measures (Brady *et al.*, 1999; Chrestman, 1999; Kassam-Adams,1999; Pearlman & Maclan, 1995; Schauben & Frazier, 1995). This study perhaps indicates the need to go beyond these measures and consider a wider range of distress and events. This study

highlights the need for a more multi-faceted approach to assessment of vicarious trauma, including not just trauma related symptoms but also a wide range of indicators of psychological distress. Existing tools for measuring psychological health may need to be adapted or new measures created. It is also recommended that the focus of measures should be on breadth of responses rather than severity or psychopathology.

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CHAPTER FOUR: RESEARCH REVIEW

The Research Journey: Issues, dilemmas, discussions and reflections

INTRODUCTION

This research review captures the journey that I have made whilst completing this thesis. Within this journey, there are aspects, processes and discussions that were not appropriate for inclusion within the literature review, main or brief paper.

The literature review focused on the concepts used to describe the phenomenon of trauma-related responses to working with individuals who have experienced traumatic events. The main paper focused on the variables associated with vicarious traumatisation or posttraumatic symptomatology and the brief paper explored the qualitative descriptions of the emotional and cognitive reactions that were associated to working with this client group. Together with this paper, these four papers constitute my thesis, which is submitted as part of my doctorate in clinical psychology.

During the research, I endeavoured to record the thoughts, dilemmas and discussions that seemed relevant to the development, operationalisation and completion of the research ideas contained within this volume. Through this record and my contemplations of the past two years it became clear that a number of themes repeatedly arose. I have chosen to discuss the major themes that evolved out of this account. These themes have included the research process, methodological

issues, researching PTSD and trauma and the impact that this research has had on me.

RESEARCH PROCESS

The research process is defined as a series of steps the researcher goes through during a project (Barker, Pistrang & Elliott, 1994). There were aspects of the research process that did not happen as smoothly as expected or that raised unexpected issues. These aspects and issues stemmed from a position of novice and inexperience as a researcher. The process did not match up with textbook accounts of it (Robson, 1993, Barker *et al.*, 1994). On reflection, the issues seem obvious, however I have included them, as they caught me unaware.

IDENTIFYING RESEARCH QUESTIONS AND HYPOTHESES

Identifying a research question seems a simple proposition. In fact, identifying the area I wanted to research was relatively simple. I had considered other ideas but whilst presenting interesting areas, specific questions were hard to identify and practical problems in recruiting and accessing suitable participants began to look overwhelmingly impossible. However, these ideas were in areas that I had clinical experience of and some knowledge of the theoretical literature.

A supervisor, who also spotted the potential problems with operationalising my previous idea happened to mention a presentation she had attended about vicarious traumatisation and that it was an area where there were potential research questions to be addressed. Having a general interest in trauma I was interested in pursuing the idea further. Reflecting on my clinical experience I was of the opinion that clinical psychologists were often asked to work with traumatised clients. Whilst the psychological effects might not be conceptualised as PTSD for that individual client I had often found that a traumatic life event(s) was important in the development or maintenance of the client's difficulties. Given this I felt that the impact of working with trauma would be of interest to clinical psychologists and therefore, it would be a meaningful topic to research.

Whilst I had a general interest in trauma and a basic knowledge of stress, I had no specific knowledge about the effects of working with traumatised clients or the stresses of being a therapist/clinical psychologist. This meant that in order to develop a significant question I had to familiarise myself with the literature. My research questions were developed following learning about the literature but not however, when I possessed an in-depth understanding of it. This understanding arose over time, with deeper immersion in the literature and following discussions with interested psychologists about the focus of my research. During the research process I conceived several other ideas for potential research questions. This process is a natural part of the

evolving research process, where research is carried out and further questions are identified and more appropriate methodologies are sought (Barker *et al*, 1994). Although my research was worthwhile and was one of the next logical steps into the development of this area my recommendations would be 1) to choose an area that one has an existing knowledge base in and 2) if this is not possible, become engaged with the literature, rather than simply learning it and discuss it with parties with an interest in or experience of the area one has chosen to research.

A similar process also occurred with the more specific research hypotheses. I identified specific hypotheses in the early stage of planning my research but I was tempted to change these in the later stages. This issue dominated the process as I began the initial stages of data analysis.

I, probably, made an obvious mistake that frequently befalls novice researchers. In an attempt to include all the variables that my literature review had associated with working with traumatised clients I was over-inclusive. During data analysis, I was thrown into indecision. There seemed so many possibilities for different hypotheses and options for analyses. This confusion had a domino effect on the other aspects of the research process; I was unable to complete the literature review or the introductions for papers, as I was unsure of the focus of my research. I partly resolved this by contemplating which research questions were

fundamentally important and of most interest and partly by delving further into the data analysis. However, this step brought further issues.

DATA ANALYSIS

The process of data analysis helped me to clarify my earlier dilemma about which hypotheses to answer. The results of exploratory data analysis (EDA) indicated that due to the characteristics of particular variables (i.e. severe negative skew), particular analyses were unlikely to be possible and therefore specific questions were unanswerable. EDA also created a further question for me. Research texts recommended an exploration of the data rather merely than confirming hypotheses in order not to miss any essential new conclusions (Breakwell, Hammond & Fife-Schaw, 2000). This ran the risk of overanalysing my data. I decided not to pursue this to its limits for risk of finding a significant result by chance.

I was surprised to learn how subjective statistical analyses could be. Even when guidelines about the appropriateness of a statistical procedure were followed there seemed to be several ways in which the results could be analysed. The decision over which analysis was appropriate involved a balancing out of the disadvantages and advantages of each technique. Each type of analysis carried its own assumptions none of which were entirely and/or strictly met by the data. I realised that this surprised me because I had, naively, assumed statistics would provide definitive answers.

RESEARCHING TRAUMA AND POSTTRAUMATIC STRESS DISORDER

The principal theoretical challenge to confront me was researching trauma, to some extent, within the confines of posttraumatic stress disorder (PTSD). The conceptualisation of trauma responses as PTSD was an issue that confronted me at several stages throughout the research process.

I was influenced by ongoing debates within the PTSD literature. When PTSD was introduced into the DSM [American Psychiatric Association (APA), 1980] it was met with great appreciation as it legitimised the consequences of trauma and promoted the event as the therapeutic focus. Since then, PTSD has received criticism. These criticisms centre on the limitations of PTSD as the only response to trauma. Pure PTSD is rare; it is associated with other symptoms and disorders (Alarcon, Glover & Deering, 1999; APA, 1994; Van der Kolk et al, 1996; Yehuda & McFarlane, 1995). Van der Kolk et al (1996) states that for the vast majority of patients with PTSD the diagnosis does not describe the full extent of suffering. It is now known that PTSD is not the only psychiatric response to trauma (Mezey & Robbins, 2001).

The implications of this, for me were both philosophical and practical. It brought home issues regarding the utility of diagnoses. This is an issue that reaches far wider than PTSD and that I continue to struggle with

clinically. Diagnostic labels are commonly used and I was aware that I was uncomfortable with this. I was aware of the debates surrounding the advantages and disadvantages of using reductionist, categorical labels to describe a persons experience (e.g. Pilgrim, 2000; Marzillier, 2000). This prompted my concern about using PTSD measures and also was reflected in my ongoing clinical practice where the debate of diagnoses extended to schizophrenia and personality disorders. The PTSD diagnosis invaded my research both in subtle and obvious ways.

The development of PTSD as a diagnosis had been a feature in varying degrees in the literature about working with traumatised clients and the majority of the research had used PTSD measures. PTSD had also influenced the measures in more subtle ways; the PTSD concept was used to identify trauma therapists, to identify clients who were traumatised, to estimate exposure to vicarious events and to estimate the therapists' trauma history. I realised that my choice of measures had been influenced by the very dominant paradigm of conceptualising trauma responses as PTSD.

I was also surprised that the concept of PTSD had not pervaded the research more. There is an argument that this has been both helpful and unhelpful. The negative consequence of this is that well-established findings for PTSD regarding variables that influence the course and development of PTSD and theoretical models have not been applied. As a positive consequence, the theoretical models for trauma related to

working with this client group had not been compromised by focusing on PTSD as the only outcome following traumatic events.

METHODOLOGICAL DILEMMAS

I would like to expand on the methodological aspects that I touched on in the discussions of my brief and main paper. However this will be a brief discussion, as I want the focus of this paper to concentrate on the impact the process had on me and vice versa rather than technical issues.

CROSS-SECTIONAL VS. LONGITUDINAL

I felt that one of the most likely potential confounding variables was the lack of measurement of reactions over time. People's reactions to events that distress or traumatise them naturally change over time, as a consequence of the cross-sectional design some participants would have experienced events recently and some not so recently. This may have obscured findings regarding variables that were associated with levels of traumatisation as different variables may affect people's reactions at different times following an event.

Finally, it was also difficult to explore, in any more than a relatively simplistic manner, the potential cumulative effects of a number of events. However the constraints of time, resources and of the population

meant that a longitudinal design might have been inappropriate. Narrowly confining my populations to those who had experienced an event within a specified time period would have dramatically affected my potential sample size. However it is possible that improvements in assessing exposure may have increased the validity of my results.

QUANTITATIVE VS. QUALITATIVE

One issue that I had contemplated at the outset of this research and returned to was the issue of qualitative or quantitative methods. Initially I had paid lip service to qualitative descriptions of events and impact and concentrated more on the measures and numbers. I felt unprepared to take on a qualitative methodology. However, as I began to receive people's accounts of events and their reactions to them I felt that this was important and of interest, hence my brief paper. Taking a qualitative methodology from the start would have allowed a richer account of psychologists' experiences. The brief paper might have been compromised by the inability to tie down individual reactions specifically to emotional and cognitive reactions. It also may have been interesting to explore what individuals' perceptions of the factors that protected or increased their risk of becoming distressed following their work with traumatised clients. Such a question may have richly informed current models of traumatisation in therapists and may have had wider implications for the PTSD literature.

PERSONAL REFLECTIONS

Whilst this account so far has been about my reflections on academic, practical or technical issues there are aspects that have had a more personal impact.

THE PERSONAL IMPACT OF RESEARCHING TRAUMA

I had wondered what receiving the questionnaires would be like. I was also aware that I put off exploring the qualitative accounts of the events. I wondered whether these accounts would touch me personally and professionally. I contemplated whether I would be touched by people's accounts of events and their reactions, whether I would be concerned about the trauma levels people were demonstrating or whether I would become disillusioned with the role of a clinical psychology if I read about the effects of working with clients and hearing their stories.

I was affected by what I was reading; I was concerned that people seemed to be affected. I was also touched by the descriptions that participants gave of the experiences their clients faced. However, I was able to counter these negative effects by acknowledging the research question specifically asked about negative effects and by talking with colleagues and reading the literature that emphasises why we choose to do this work and the personal gains we make from it. It did make me think carefully about my development as a clinical psychologist and

about which aspects were important to me to ensure that I would be able to continue to work therapeutically with individuals.

PROFESSIONAL DEVELOPMENT

I have reflected on the risk/protective factors for and the self-care literature on secondary or vicarious traumatisation. Empirical literature suggests personal therapy, caseload, supervision, training, hours and experience may all play a role in preventing/exacerbating traumatic reactions. Self-care literature (Saakvitne & Pearlman, 1996) discusses the importance of organisational context, attitude towards clients and psychologists, resources, supervision, training, experience, personal life events and beliefs and expectations about emotional expression and professional ability. These factors have been particularly relevant as I am approaching the final stages of training and preparing for my first post as a qualified clinical psychologist.

The qualitative responses of individuals to the additional factors that may have made the vicarious event more traumatising brought home these factors in a more 'real' way. Participants emphasised organisational factors *"limited access to other team members, no back up, out of hours"*, *"very busy, huge waiting lists, seeing lots of clients for individual work"*, the amount of distress experienced by clients *"client was dissociated and reliving it very palpably"*, current personal stressors *" my own health was under threat and my marriage was folding"*, identification with the clients *"I had received similar treatment"* and the beliefs that

they had to cope *"professional responsibility, a sense of having to cope"* and that they would traumatise others by speaking about it *"couldn't talk to others – all too traumatised to support each other"*.

With this in mind, I have considered my needs from a working environment. I have also contemplated what I can take personal responsibility for in balancing my personal and professional life and to ensure that I regularly practice self-care. The most important aspect has been the continuing need to monitor my awareness of my emotions and thoughts, my ability to tolerate emotional distress and the interaction between clients needs and my own. These aspects are encapsulated by reflectivity.

REFLECTIVITY

The ability to be reflective and the acceptance of a reflective attitude to oneself and one's work is one of the aspects that I have found most important. During training, I have able been able to share my doubts about my abilities, work through professional and personal issues and explore how working therapeutically affects me. This has been a vital part of how I have learnt both professionally and personally during training.

Participants' accounts confirmed the empirical literature (e.g. Astin, 1997; McCann and Pearlman 1990) that an event would particularly touch a therapist if the issues involved were particularly salient, for

instance if a therapist had similar experiences or concerns. It also emphasised the need to be aware of countertransference response, both regarding myself and the client, as a fundamental part of trauma work. Having used the opportunities provided by training to address similar issues this research has reaffirmed its importance and my need to continue this reflectivity throughout my career.

CLINICAL /PROFESSIONAL IMPLICATIONS

The final area that I have contemplated is the professions' responsibility and attitude towards psychologists in distress. The Professional Practice Guidelines (DCP, 1995) are clear that clinical psychologists have a responsibility to safeguard their fitness to practice. However, I am concerned that one of my reflections is an uncertainty to how fellow colleagues or managers would respond to those in distress and the implications this might have for individual clinicians. I have a stereotype of some clinical psychologists as unaware that it is possible that they can become traumatised or distressed in the same way as their clients have. May (2000) and Harper (2001) have commented on a similar issue, that of "thinking that our clients are separate and different from us who are normal". They have referred to this as them-and-us thinking.

The profession, managers and individual clinicians have a joint responsibility for ensuring the psychological health of clinical psychologists. Training may be available for stress or time management. However, little is formally available for vicarious or secondary

traumatisation or even more generally the impact that our work can have on us. Individuals may address this through supervision, personal therapy or psychologists may form peer groups to support each other. These measures should be encouraged. Literature about self-care, stress, burnout and traumatisation should be made as freely available as texts or manuals that guide the treatment of clients.

CONCLUSIONS

This research journey had a variety of consequences. I have gained a new area of knowledge. I have developed a new interest and would be keen to follow this up in future work. I have also learned about the research process and hopefully I am not as naïve as I once was about the complexity of conducting research with real issues (e.g. Robson, 1993). The unexpected area was the impact of this research has had on my thoughts about my own professional development, the resources I would need in a new working environment and my personal responsibilities that would enable me to work as effectively and compassionately with people as I am able to. It has, most importantly, taught me the value of being more forgiving and tolerant of my self particularly with regard to my expectations of my abilities and accomplishments as a clinical psychologist.

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APPENDIX 1: Journal of Traumatic Stress - Instructions to Authors

1. Manuscripts, in quadruplicate and in English, should be submitted to the Editor:

Regular mail
Dr. Dean G. Kilpatrick
Medical University of South Carolina
National Crime Victims Research and Treatment Center
165 Cannon Street
P.O. Box 250852
Charleston, South Carolina 29425

Tel.: (843) 792-4237

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* (no longer than 6,000 words, *including* references, figures, 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.

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 1/2 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 four 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, telephone and fax numbers, and e-mail address 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 key 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 prints are acceptable. Identify figures on the back with author's name and number of

the illustration. Electronic artwork submitted on disk should be in the TIFF or EPS format (1200 dpi for line and 300 dpi for half-tones and gray-scale art). Color art should be in the CYMK color space. Artwork should be on a separate disk from the text, and hard copy ***must*** accompany the disk.

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 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 authors' 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 strict APA style -- illustrated by the following examples (however, use indentation below):

Journal Article
Friedrich, W. N., Urquiza, A. J., & Beilke, R. L. (1986). Behavior 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 anger problems. In D. Meichenbaum & 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 numeral for citation in the text.

11. **The journal follows the recommendations of the 2001 *Publication Manual* of the American Psychological Association (Fifth 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 should be submitted to the Editor's Office as hard copy accompanied by electronic files on disk. Label the disk with identifying information -- software, journal name, and first author's last name. **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.

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

APPENDIX 2: British Journal of Clinical Psychology - Instructions to Authors

Notes for Contributors

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 through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited :

- Papers reporting original empirical investigations;
- Theoretical papers, provided that these are sufficiently related to the empirical data;
- 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;
- Brief Reports and Comments (see below).

1. Circulation

1. The circulation of the Journal is worldwide. There is no restriction to British authors; papers are invited and encouraged from authors throughout the world.

2. Length

1. Pressure on Journal space is considerable and papers should be as short as is consistent with clear presentation of the subject matter. Papers should normally be no more than 5,000 words, although the Editor retains discretion to publish papers beyond this length.

3. Refereeing

1. The journal operates a policy of anonymous peer review. Papers will normally be scrutinised and commented on by at least two independent expert referees (in addition to the Editor) although the Editor may process a paper at his or her discretion. The referees will not be made aware of the identity of the author. All information about authorship including personal acknowledgements and institutional affiliations should be confined to a removable front page (and the text should be free of such clues as identifiable self-citations ('In our earlier work...')).

4. Submission requirements

(a) Four copies of the manuscript should be sent to the Editor (Professor Karin Mogg/ Professor Brendan Bradley, BPS Journals Department, St. Andrews House, 48 Princess Road East, Leicester, LE1 7DR, UK). Submission of a paper implies that it has not been published elsewhere and that it is not being considered for publication in another journal. Papers should be accompanied by a signed letter indicating that all named authors have agreed to the submission. One author should be identified as the correspondent and that person's title, name and address supplied.
(a) Contributions must be typed in double spacing with wide margins and on only one

side of each sheet. All sheets must be numbered.
(a) Tables should be typed in double spacing, each on a separate piece of paper with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
(a) Figures are usually produced direct from authors' originals and should be presented as good black or white images preferably on high contrast glossy paper, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Paper clips leave damaging indentations and should be avoided. Any necessary instructions should be written on an accompanying photocopy. Captions should be listed on a separate sheet.
(a) For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusion. Review articles should use these headings : Purpose, Methods, Results, Conclusions (more details on Structured Abstracts can be obtained by contacting the Journals Department).
(a) Bibliographic references in the text should quote the author's name and the date of publication thus: Smith (1994). Multiple citations should be given alphabetically rather than chronologically: (Jones, 1998; King, 1996; Parker, 1997). If a work has two authors, cite both names in the text throughout: Page and White (1995). In the case of reference to three or more authors, use all names on the first mention and et al. thereafter except in the reference list.
(b) References cited in the text must appear in the list at the end of the article. The list should be typed in double spacing in the following format:
a) Herbert, M. (1993). Working with children and the Children Act (pp. 76-106). Leicester: The British Psychological Society.
a) Moore, R.G., & Blackburn, I.M. (1993). Sociotrophy, autonomy and personal memories in depression. British Journal of Clinical Psychology, 32, 460-462.
b) Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
(b) SI units must be used for all measurements, rounded off to practical values if appropriate, with the Imperial equivalent in parentheses (see The British Psychological Society Style Guide at: http://www.bps.org.uk/publications/jAuthor.cfm).
(a) Authors are requested to avoid the use of sexist language.
(c) Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations etc for which they do not own copyright.

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6. Brief reports and comments

1. These allow rapid publication of research studies, and theoretical, critical or review comments with an essential contribution to make. Case studies are normally published only as Brief Reports. They should be limited to two printed pages with the text, including references and a 100 word abstract set at 150 lines. Abstracts should also be structured under these headings: Purpose, Methods, Results, Conclusions (more detailed guidelines on structured abstracts are available from the Journals Department). 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) 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 as a mathematical operator.

7. Ethical considerations

5. The code of conduct of The British Psychological Society requires psychologists 'Not to allow their professional responsibilities or standards of practice to be diminished by consideration of religion, sex, race, age, nationality, party politics, social standing, class or other extraneous factors. The Society resolves to avoid all links with psychologists and psychological organizations and their formal representatives that do not affirm and adhere to the principles in the clause of its Code of Conduct. In cases of doubt, the Journals Department may ask authors to sign a document confirming the adherence to these principles. Any study published in this journal must pay due respect to the well-being and dignity of research participants. The British Psychological Society's Ethical Guidelines on Conducting Research with Human Participants must be shown to have been scrupulously followed. These guidelines are available at http://www.bps.org.uk/about/rules5.cfm

5. Supplementary data

1. Supplementary data too expensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

6. Proofs

2. Proofs are sent to authors for correction of print but not for rewriting or the introduction of new material. Fifty complimentary copies of each paper are supplied to the senior author, but further copies may be ordered on a form accompanying the proofs.

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8. Checklist of requirements:

- A signed submission letter
- Correspondent's title/name/address
- A cover page with title/author(s)/affiliation
- Double spacing with wide margins
- Tables/figures at the end
- Complete reference list in APA format
- Four good copies of the manuscript (or an e-mail attachment)

APPENDIX 3: Clinical Psychology and Psychotherapy - Instructions to Authors

Initial Manuscript Submission. Submit three copies of the manuscript (including copies of tables and illustrations) to either of the Editors:

Professor Paul Emmelkamp, *Faculty of Psychology, Department of Clinical Psychology, University of Amsterdam, Roetersstraat 15, 1018 WB Amsterdam, The Netherlands.*

Professor Mick Power, *Department of Psychiatry, Royal Edinburgh Hospital, University of Edinburgh, Edinburgh EH10 5HF, UK.*

Authors **must** also supply:

- an electronic copy of the final version (see section below),
- a Copyright Transfer Agreement with original signature(s) - without this we are unable to accept the submission, and
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Submitted manuscripts should not have been previously published and should not be submitted for publication elsewhere while they are under consideration by Wiley. Submitted material will not be returned to the author unless specifically requested.

Electronic submission. The electronic copy of the final, revised manuscript must be sent to the Editor **together with** the paper copy. Disks should be PC or Mac formatted; write on the disk the software package used, the name of the author and the name of the journal. We are able to use most word processing packages, but prefer Word or WordPerfect and TeX or one of its derivatives.

Illustrations must be submitted in electronic format where possible. Save each figure as a separate file, in **TIFF** or **EPS** format preferably, and include the source file. Write on the disk the software package used to create them; we favour dedicated illustration packages over tools such as Excel or Powerpoint.

Manuscript style. The language of the journal is English. All submissions including book reviews must have a title, be printed on one side of the paper, be double-line spaced and have a margin of 3cm all round. Illustrations and tables must be printed on separate sheets, and not be incorporated into the text.

- The **title page** must list the full title, a short title of up to 70 characters and names and affiliations of all authors. Give the full address, including email, telephone and fax, of the author who is to check the proofs.
- Include the name(s) of any **sponsor(s)** of the research contained in the paper, along with **grant number(s)**.
- Supply an **abstract** of up to 150 words for all articles except book reviews. An **abstract** is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.

Research Articles: Substantial articles making a significant theoretical or empirical contribution.

Assessments: Articles reporting useful information and data about new or existing measures.

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Reference style. References should be quoted in the text as name and year within brackets and listed at the end of the paper alphabetically. Where reference is made to more than one work by the same author published in the same year, identify each citation in the text as follows: (Collins, 1998a), (Collins, 1998b). Where three or more authors are listed in the reference list, please cite in the text as (Collins *et al*., 1998)

All references must be complete and accurate. Online citations should include date of access. If necessary, cite unpublished or personal work in the text but do not include it in the reference list. References should be listed in the following style:

Breslau N, Davis GC, Andreski P, Peterson E. 1991. Traumatic events and post-traumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry* **48**: 216-222.

Beck AT, Rush AJ, Shaw BF, Emery G. 1979. *Cognitive Therapy of Depression*. Guilford: New York.

Spielberger CD, Johnson EH, Russell S, Crane R, Jacobs G, Borden T. 1985. The experience and expression of anger: Construction and validation of an anger expression scale. In *Anger and Hostility in Cardiovascular and Behavioral Disorders*, Chesney M, Rosenman R (eds). Hemisphere: Menlo Park, CA; 5-30.

The Geriatric Website. 1999. http://www.wiley.com/oap/ [1 April 1999]

Illustrations. Supply each illustration on a separate sheet, with the lead author's name and the figure number, with the top of the figure indicated, on the reverse. Supply original **photographs**; photocopies or previously printed material will not be used. Line artwork must be high-quality laser output (not photocopies). Tints are not acceptable; lettering must be of a reasonable size that would still be clearly legible upon reduction, and consistent within each figure and set of figures. Supply artwork at the intended size for printing. The artwork must be sized to the text width of 7 cm (single column), 15 cm (double column).

The cost of printing **colour** illustrations in the journal will be charged to the author. The cost is approximately £700 per page. If colour illustrations are supplied electronically in either **TIFF** or **EPS** format, they **may** be used in the PDF of the article at no cost to the author, even if this illustration was printed in black and white in the journal. The PDF will appear on the *Wiley InterScience* site.

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APPENDIX 4: Ethical Approval

COVENTRY UNIVERSITY - SCHOOL OF HEALTH & SOCIAL SCIENCES

STUDENT SUBMISSION TO SCHOOL RESEARCH ETHICS COMMITTEE

1. Student's name: VICKI HANCOCK 2. Course: CLINICAL PSYCHOLOGY DOCTORATE

3. Title of project: VICARIOUS TRAUMATISATION: THE ROLE OF COGNITION, TRAUMA HISTORY & CLINICAL

4. Summary of the project in jargon-free language and in not more than 120 words:

Sample: CLINICAL PSYCHOLOGISTS WORKING IN THE WEST MIDLANDS AND WHO ARE MEMBERS OF THE DIVISION OF CLINICAL PSYCHOLOGY

Research site: COVENTRY UNIVERSITY

Design (e.g. experimental): CROSS SECTIONAL SURVEY (POSTAL)

Methods of data collection:

A VARIETY OF QUESTIONNAIRES INCLUDING:-

* DEMOGRAPHIC QUESTIONNAIRE: INCLUDING INFORMATION ON AGE, GENDER, ETHNIC ORIGIN + WORK SETTING
* INFORMATION ON WORK + CLIENTS: INCLUDING INFORMATION ABOUT WORKLOAD, NUMBER + NATURE OF CLIENTS SEEN WITH TRAUMA EXPERIENCES.
* TRAUMA HISTORY QUESTIONNAIRE
* POST TRAUMATIC STRESS DISORDER SCALE
* TRAUMATIC STRESS INSTITUTE BELIEF SCALE
* QUALITATIVE QUESTIONNAIRE INVOLVING DESCRIPTION OF TRAUMATIC EVENT IN THERAPY AND COGNITIVE + EMOTIONAL REACTIONS TO IT
* IMPACT OF EVENTS SCALE AND/OR ACUTE STRESS DISORDER SCALE

Access arrangements (if applicable):

VIA DCP MEMBERS LIST (WEST MIDLANDS CNCH)

5. Will the project involve patients(clients) and/or patient(client) data? Yes [ ]; No [✓]

6. Will any invasive procedures be employed in the research? Yes [ ]; No [✓]

7. Is there a risk of physical discomfort to those taking part? Yes [ ]; No [✓]

8. Is there a risk of psychological distress to those taking part? Yes [✓]; No [ ]

9. Will specific individuals or institutions (other than the University) be identifiable through data published or otherwise made available? Yes [ ]; No [✓]

10. Is it intended to seek informed consent from each participant (or from his or her parent or guardian)? Yes [✓]; No [ ]

Student's signature: V Hancock Supervisor's signature: K A Gray Date: 20th August 2001

FOR COMMITTEE USE:

Immediate approval	[✓]	Referral to full School Committee	[ ]
Referral to local Hospital Ethics Committee	[ ]	Decision pending receipt of further information (specify below)	[ ]

Committee Member's signature: David Giles Date: 21/08/01

APPENDIX 5: Demographic Questionnaire

INSTRUCTIONS

Thank you for agreeing to complete these questionnaires. Your participation in this project is important to us and the profession. Completing this booklet should take approximately 30 minutes.

It would be helpful if you could complete this page even if you decide not to complete the following questionnaires.

THANK YOU

Demographic Information

Age: ..... **Gender:** Male ☐ Female ☐

Marital Status:

Married ☐ Single ☐ Divorced ☐ Widowed ☐

Separated ☐ Co-habiting ☐

Ethnic Background:

White ☐ Afro-Caribbean ☐ Asian ☐ European ☐

Other (please specify) .....

IF YOU HAVE DECIDED NOT TO TAKE PART IN THIS RESEARCH ANSWER THE QUESTION BELOW AND RETURN THE QUESTIONNAIRE.

Please describe your reasons for not taking part in this research.

.....

.....

.....

APPENDIX 6: Professional and Personal Factors Questionnaire

Information about Work Environment

How many hours per week do you work? .....

What client group do you work with?
(e.g. adults, child, eating disorder) .....
What setting do you work in?
(e.g. multidisciplinary team, psychology department) .....

How many days of trauma related training have you attended in the last year? .....

How many years have you been a clinical psychologist? .....

How often do you receive supervision?

Weekly ☐ Fortnightly ☐ Monthly ☐ Other .....

Have you received personal therapy? Yes ☐ No ☐

APPENDIX 7: Trauma History Questionnaire

Information about your clients

Please rate the number of clients you are **currently** seeing who have personally experienced or witnessed any of the following events:

1.	Serious accident, fire or explosion e.g. an industrial, farm, car, plane or boating accident	**0 / 1 / 2 / 3 / 4+**
2.	Natural disaster e.g. tornado, hurricane, flood or major earthquake	**0 / 1 / 2 / 3 / 4+**
3.	Non-sexual assault by a family member or someone they know e.g. being mugged, physically attacked, shot, stabbed or held at gunpoint	**0 / 1 / 2 / 3 / 4+**
4.	Non-sexual assault by a stranger e.g. being mugged, physically attacked, shot, stabbed or held at gunpoint	**0 / 1 / 2 / 3 / 4+**
5.	Sexual assault by a family member or someone they know e.g. rape or attempted rape	**0 / 1 / 2 / 3 / 4+**
6.	Sexual assault by a stranger e.g. rape or attempted rape	**0 / 1 / 2 / 3 / 4+**
7.	Military combat or a war zone	**0 / 1 / 2 / 3 / 4+**
8.	Sexual contact when they were younger than 18 with someone who was 5 or more years older than them e.g. contact with genitals, breasts	**0 / 1 / 2 / 3 / 4+**
9.	Imprisonment e.g. prison inmate, prisoner of war, hostage	**0 / 1 / 2 / 3 / 4+**
10.	Torture	**0 / 1 / 2 / 3 / 4+**
11.	Life-threatening illness	**0 / 1 / 2 / 3 / 4+**
12.	Other traumatic event	**0 / 1 / 2 / 3 / 4+**

What is the percentage of these clients in your caseload? .....

APPENDIX 7 (cont.) : Trauma History Questionnaire

Information about your trauma history

Please indicate whether you have personally experienced or witnessed any of the following events:

1.	Serious accident, fire or explosion e.g. an industrial, farm, car, plane or boating accident	**Yes / No**
2.	Natural disaster e.g. tornado, hurricane, flood or earthquake	**Yes / No**
3.	Non-sexual assault by a family member or someone you know e.g. being mugged, physically attacked, shot, stabbed or held at gunpoint	**Yes / No**
4.	Non-sexual assault by a stranger e.g. being mugged, physically attacked, shot, stabbed or held at gunpoint	**Yes / No**
5.	Sexual assault by a family member or someone you know e.g. rape or attempted rape	**Yes / No**
6.	Sexual assault by a stranger e.g. rape or attempted rape	**Yes / No**
7.	Military combat or a war zone	**Yes / No**
8.	Sexual contact when you were younger than 18 with someone who was 5 or more years older than you e.g. contact with genitals, breasts	**Yes / No**
9.	Imprisonment e.g. prison inmate, prisoner of war, hostage	**Yes / No**
10.	Torture	**Yes / No**
11.	Life-threatening illness	**Yes / No**
12.	Other traumatic event	**Yes / No**

APPENDIX 8: Posttraumatic Diagnostic Scale

Below is a list of problems that people sometimes have after experiencing a traumatic event. Read each one carefully and circle the number (0-3) that best describes how often that problem has bothered you IN THE PAST MONTH.

0	1	2	3
Not at all or only one time	Once per week or less/once in a while	2 to 4 times per week/ half the time	5 or more times per week/almost always

1.	Having upsetting thoughts or images about the traumatic event(s) that came into you head when you didn't want them to	**0**	**1**	**2**	**3**
2.	Having bad dreams or nightmares about the traumatic event(s)	**0**	**1**	**2**	**3**
3.	Reliving the traumatic event(s), acting or feeling as if it was happening again	**0**	**1**	**2**	**3**
4.	Feeling emotionally upset when you were reminded of the traumatic event(s) (e.g. feeling scared angry, sad, guilty etc.)	**0**	**1**	**2**	**3**
5.	Experiencing physical reactions when you were reminded of the traumatic event(s) (e.g. breaking out in a sweat, heart beating fast)	**0**	**1**	**2**	**3**
6.	Trying not to think about, talk about or have feelings about the traumatic event(s)	**0**	**1**	**2**	**3**
7.	Trying to avoid activities, people or places that remind you of the traumatic event(s)	**0**	**1**	**2**	**3**
8.	Not being able to remember an important part of the traumatic event(s)	**0**	**1**	**2**	**3**
9.	Having much less interest or participating much less often in important activities	**0**	**1**	**2**	**3**
10.	Feeling distant or cut off from people around you	**0**	**1**	**2**	**3**
11.	Feeling emotionally numb (e.g. unable to cry, unable to have loving feelings)	**0**	**1**	**2**	**3**
12.	Feeling as if your future plans or hopes will not come true (e.g. you will not have a career, marriage, children, long life)	**0**	**1**	**2**	**3**
13.	Having trouble falling or staying asleep	**0**	**1**	**2**	**3**
14.	Feeling irritable or having fits of anger	**0**	**1**	**2**	**3**
15.	Having trouble concentrating (e.g. drifting in and out of conversations, losing track of a story on television, forgetting what you have read)	**0**	**1**	**2**	**3**
16.	Being overtly alert (e.g., checking to see who is around you, being uncomfortable with your back to the door)	**0**	**1**	**2**	**3**
17.	Being jumpy or easily startled (e.g. when someone walks up behind you)	**0**	**1**	**2**	**3**

APPENDIX 9: Traumatic Stress Institute Belief Scale

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.

1 Disagree strongly	2 Disagree	3 Disagree somewhat	4 Agree somewhat	5 Agree	6 Agree strongly

1. I generally feel safe from danger	**1**	**2**	**3**	**4**	**5**	**6**
2. People are wonderful	**1**	**2**	**3**	**4**	**5**	**6**
3. I can comfort myself when I'm in pain	**1**	**2**	**3**	**4**	**5**	**6**
4. I find myself worrying a lot about my safety	**1**	**2**	**3**	**4**	**5**	**6**
5. I don't feel like I deserve much	**1**	**2**	**3**	**4**	**5**	**6**
6. I can usually trust my own judgment	**1**	**2**	**3**	**4**	**5**	**6**
7. I feel empty when I am alone	**1**	**2**	**3**	**4**	**5**	**6**
8. I have a lot of bad feelings about myself	**1**	**2**	**3**	**4**	**5**	**6**
9. I'm reasonably comfortable about the safety of those I care about	**1**	**2**	**3**	**4**	**5**	**6**
10. Most people destroy what they build	**1**	**2**	**3**	**4**	**5**	**6**
11. I have a difficult time being myself around other people	**1**	**2**	**3**	**4**	**5**	**6**
12. I enjoy my own company	**1**	**2**	**3**	**4**	**5**	**6**
13. I don't trust my own instincts	**1**	**2**	**3**	**4**	**5**	**6**
14. I often think the worst of others	**1**	**2**	**3**	**4**	**5**	**6**
15. I believe I can protect myself if my thoughts become self-destructive	**1**	**2**	**3**	**4**	**5**	**6**
16. You can't trust anyone	**1**	**2**	**3**	**4**	**5**	**6**
17. I'm uncomfortable when someone else is leading the group	**1**	**2**	**3**	**4**	**5**	**6**
18. I feel good about myself most days	**1**	**2**	**3**	**4**	**5**	**6**
19. Sometimes I think I'm more concerned about the safety of others than they are.	**1**	**2**	**3**	**4**	**5**	**6**
20. Other people are no good	**1**	**2**	**3**	**4**	**5**	**6**
21. Sometimes when I'm with people, I feel disconnected	**1**	**2**	**3**	**4**	**5**	**6**
22. People shouldn't place too much trust in their friends	**1**	**2**	**3**	**4**	**5**	**6**
23. Mostly, I don't feel like I'm worth much	**1**	**2**	**3**	**4**	**5**	**6**

1 Disagree strongly	2 Disagree	3 Disagree somewhat	4 Agree somewhat	5 Agree	6 Agree strongly

24. I don't have much control in my relationships	**1**	**2**	**3**	**4**	**5**	**6**
25. My capacity to harm myself scares me sometimes	**1**	**2**	**3**	**4**	**5**	**6**
26. For the most part, I like other people	**1**	**2**	**3**	**4**	**5**	**6**
27. I deserve to have good things happen to me	**1**	**2**	**3**	**4**	**5**	**6**
28. I usually feel safe when I'm alone	**1**	**2**	**3**	**4**	**5**	**6**
29. If I really need them, people will come through for me	**1**	**2**	**3**	**4**	**5**	**6**
30. I can't stand to be alone	**1**	**2**	**3**	**4**	**5**	**6**
31. This world is filled with emotionally disturbed people	**1**	**2**	**3**	**4**	**5**	**6**
32. I am basically a good person	**1**	**2**	**3**	**4**	**5**	**6**
33. For the most part, I can protect myself from harm	**1**	**2**	**3**	**4**	**5**	**6**
34. Bad things happen to me because I'm bad	**1**	**2**	**3**	**4**	**5**	**6**
35. Some of my happiest experiences involve other people	**1**	**2**	**3**	**4**	**5**	**6**
36. There are many people to whom I feel close and connected	**1**	**2**	**3**	**4**	**5**	**6**
37. Sometimes I'm afraid of what I might do to myself	**1**	**2**	**3**	**4**	**5**	**6**
38. I am often involved in conflicts with other people	**1**	**2**	**3**	**4**	**5**	**6**
39. I often feel cut off and distant from other people	**1**	**2**	**3**	**4**	**5**	**6**
40. I worry a lot about the safety of loved ones	**1**	**2**	**3**	**4**	**5**	**6**
41. I don't experience much love from anyone	**1**	**2**	**3**	**4**	**5**	**6**
42. Even when I'm with other people, I feel alone	**1**	**2**	**3**	**4**	**5**	**6**
43. There is an evil force inside of me	**1**	**2**	**3**	**4**	**5**	**6**
44. I feel uncertain about my ability to make decisions	**1**	**2**	**3**	**4**	**5**	**6**
45. When I'm alone, I don't feel safe	**1**	**2**	**3**	**4**	**5**	**6**
46. When I'm alone, it's like there's no one there	**1**	**2**	**3**	**4**	**5**	**6**
47. I can depend on my friends to be there when I need them	**1**	**2**	**3**	**4**	**5**	**6**
48. Sometimes I feel like I can't control myself	**1**	**2**	**3**	**4**	**5**	**6**
49. I feel out of touch with people	**1**	**2**	**3**	**4**	**5**	**6**
50. Most people are basically good at heart	**1**	**2**	**3**	**4**	**5**	**6**
51. I sometimes wish I didn't have any feelings	**1**	**2**	**3**	**4**	**5**	**6**

1 Disagree strongly	2 Disagree	3 Disagree somewhat	4 Agree somewhat	5 Agree	6 Agree strongly

52. I'm often afraid I will harm myself	**1**	**2**	**3**	**4**	**5**	**6**
53. I am my own best friend	**1**	**2**	**3**	**4**	**5**	**6**
54. I feel able to control whether I harm others	**1**	**2**	**3**	**4**	**5**	**6**
55. I often feel helpless in my relationships with others	**1**	**2**	**3**	**4**	**5**	**6**
56. I don't have a lot of respect for the people closestto me	**1**	**2**	**3**	**4**	**5**	**6**
57. I enjoy feeling like part of my community	**1**	**2**	**3**	**4**	**5**	**6**
58. I look forward to time I spend alone	**1**	**2**	**3**	**4**	**5**	**6**
59. I often feel others are trying to control me	**1**	**2**	**3**	**4**	**5**	**6**
60. I envy people who are always in control	**1**	**2**	**3**	**4**	**5**	**6**
61. The important people in my life are relatively safe from danger	**1**	**2**	**3**	**4**	**5**	**6**
62. The most uncomfortable feeling for me is losing control over myself	**1**	**2**	**3**	**4**	**5**	**6**
63. If people really knew me, they wouldn't like me	**1**	**2**	**3**	**4**	**5**	**6**
64. Most people don't keep the promises they make	**1**	**2**	**3**	**4**	**5**	**6**
65. Strong people don't need to ask for others' help	**1**	**2**	**3**	**4**	**5**	**6**
66. Trusting other people is generally not very smart	**1**	**2**	**3**	**4**	**5**	**6**
67. I fear my capacity to harm others	**1**	**2**	**3**	**4**	**5**	**6**
68. I feel bad about myself when I need others' help	**1**	**2**	**3**	**4**	**5**	**6**
69. To feel at ease, I need to be in charge	**1**	**2**	**3**	**4**	**5**	**6**
70. I have sound judgment	**1**	**2**	**3**	**4**	**5**	**6**
71. People who trust too much are foolish	**1**	**2**	**3**	**4**	**5**	**6**
72. When my loved ones aren't with me, I fear they may be in danger	**1**	**2**	**3**	**4**	**5**	**6**
73. At times my actions pose a danger to others	**1**	**2**	**3**	**4**	**5**	**6**
74. I feel confident in my decision-making ability	**1**	**2**	**3**	**4**	**5**	**6**
75. I can't work effectively unless I'm the leader	**1**	**2**	**3**	**4**	**5**	**6**
76. I often doubt myself	**1**	**2**	**3**	**4**	**5**	**6**
77. I can usually size up situations pretty well	**1**	**2**	**3**	**4**	**5**	**6**
78. I generally don't believe the things people tell me	**1**	**2**	**3**	**4**	**5**	**6**
79. Sometimes I really want to hurt someone	**1**	**2**	**3**	**4**	**5**	**6**
80. When someone suggests I relax, I feel anxious	**1**	**2**	**3**	**4**	**5**	**6**

APPENDIX 10: Introductory Letter

Programme Director
Doctorate Course in Clinical Psychology
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THE UNIVERSITY OF WARWICK

COVENTRY UNIVERSITY

Our ref

Dear Colleagues

WARNING: THIS PROFESSION MAY DAMAGE YOUR HEALTH!

We are writing to ask for your help with a research project that is being undertaken as part of a clinical psychology doctorate. The project explores the potential distressing effects of working with clients who are traumatised or who have experienced traumatic events. Vicarious traumatisation is a risk to all therapists and it is considered a normal reaction to working with a population of traumatised clients. However, vicarious traumatisation may, if unrecognised, lead to emotional distress, burnout and possibly to experienced and highly trained clinicians leaving the profession early. This results in great costs to the clinician and to the profession as a whole.

The West Midlands region has a reputation for pioneering research into the psychological health of its' clinicians and we hope that we can build on and enhance this reputation with this current project.

Is this project relevant to me?
Yes. We are not just looking at clinicians who are experienced in working with trauma and clients who have experienced traumatic events. We are interested in exploring the differences between those clinicians who work with clients who have not necessarily experienced traumatic experiences through to those who work exclusively with this population.

What do I do next?
We would be grateful if you would complete and return the questionnaires in the enclosed SAE. There is also an information leaflet enclosed with this letter that contains further information about this project. Completing the questionnaires will take around 30-40 minutes. We do appreciate how busy you are but we believe this area is worthy of your time and that your assistance will invaluable in developing this critical issue.

Thank you, in advance, for your help. We look forward to receiving your replies.

Yours sincerely

Vicky Hancock
Trainee Clinical Psychologist

Kay Garvey
Clinical Director

Delia Cushway
Course Director

Dean of School of Health and Social Sciences Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Telephone 024 7688 8357
Chair of Department of Psychology Professor Koen Lamberts BA BSc MSc PhD University of Warwick Coventry CV4 7AL Telephone 024 7652 3096

APPENDIX 11: Information Leaflet

WORKING WITH TRAUMA:
The Effects on Clinicians

INFORMATION LEAFLET

Please read this leaflet carefully before completing the questionnaires. It contains information about the research project. The information contained in this leaflet will help you to decide whether to take part in this research.

What is the purpose of this research?

Although the psychological effects of trauma have become a popular topic for research and theoretical debate relatively little is known about the psychological effects of working with those who have experienced trauma. Research has shown that there may be a number of variables that mediate the relationship between vicarious exposure to traumatic events and posttraumatic symptomatology. Although the presence of vicarious trauma is universally acknowledged within the research literature there are conflicting findings regarding the possible mediating variables. This study will examine the role of schemas, trauma history and gender in predicting posttraumatic symptomatology. It is hoped that this research will add to the existing literature and provide information that will be of use to clinical psychologists working with clients who have experienced trauma.

Who is organising the research?

This research is organised by Vicky Hancock, Trainee Clinical Psychologist, as part of her research thesis for the Universities of Coventry and Warwick Clinical Psychology Doctorate. Kay Garvey, Clinical Director and Delia Cushway, Course Director are supervising this project.

Consent
You do not have to take part in this research. If you decide to take part in this research your legal rights are not affected in any way.

If you complete and return the questionnaires it will be assumed that you have given consent and that you have read and that you have agreed to the information contained in this leaflet.

What does it involve?
If you would like to take part in the study it will involve completing several questionnaires. These questionnaires ask about traumatic events that you may have experienced, including those experienced vicariously as part of offering therapy to clients with trauma histories, and your reactions to them. Completing all the questionnaires may take around 30-40 minutes. Once you have completed them you will be asked to return them in a pre-paid stamped addressed envelope.

What are the disadvantages to taking part?
The main disadvantage is the time it takes to complete the questionnaires. I am aware that your time is at a premium and I have tried to keep the time taken to complete these questionnaires to a minimum. However, this has to be balanced against obtaining sufficient information to provide meaningful conclusions.

You may also find that answering questions about traumatic experiences is distressing. If you find that you are distressed by this research please take this opportunity to discuss your reactions with a colleague or supervisor or through the Therapy Network and follow the relevant professional guidelines on self-care.

What are the advantages?
There is no direct personal benefit to taking part in this research. However the information gained from this research should provide valuable information about the risks of offering trauma therapy and the factors that mediate this. Hopefully this information will ultimately be of benefit to all clinical psychologists who work with clients who have experienced trauma.

Confidentiality
All questionnaires are completed anonymously and no attempt will be made to recognise individuals. Your name is not required in any of the documentation. If you are interested in the results of this research you are asked to forward your details separately so that anonymity can be maintained.

Ethics Approval
Coventry University Ethics Committee has approved this project.

What will happen to the results of the study?
The results of this research will form part of a final year research thesis by the researcher. They will also be submitted for publication in relevant academic journals. Anyone who wishes to have copies of the research results or details of journal publications (if accepted) can contact the researcher (details below) with your name and address/email address.

Contact Details
Vicky Hancock, Trainee Clinical Psychologist

Address: Clinical Psychology Doctorate, School of Health and Social Sciences, Coventry University, Priory Street, Coventry, CV1 5FB.
Telephone: 024 7688 8328
E-mail address: vickyhancock@btinternet.com

Please do not hesitate to contact me if you would like any further information or if you have any questions regarding this research project.

APPENDIX 12: Qualitative Information Questionnaire

Information about a specific vicarious event

This section asks you to remember a specific experience that happened during your clinical work that left you feeling more traumatised or distressed than usual. We are interested in your reactions to this experience.

Please describe a recent event that occurred during your clinical work that left you feeling traumatised or distressed

How long ago did this event happen?

EMOTIONAL AND COGNITIVE REACTIONS

Describe your feelings about the event you have described

At the time:

Now:

Describe the thoughts that you are aware of now whilst you are recalling this event and any you can remember from the time when this event took place. Think about the thoughts you have about yourself, about others and about the world.

When I think about this event I think **I AM** .....
At the time:

Now:

When I think about this event I think **OTHERS ARE** .....
At the time:

Now:

When I think about this event I think **THE WORLD IS** .....
At the time:

Now:

Were there any other factors about the therapy session, your workplace or additional events at the time, which made the experience more distressing?

APPENDIX 13: Impact of Events Scale – Revised

Whilst thinking about the traumatising or distressing event, that you described that occurred during your clinical work, please complete the following questions.

Below is a list of comments made by people after stressful life events. Please check each item indicating how frequently these comments were true for you DURING THE PAST SEVEN DAYS with respect to the event you have just described.

0	1	2	3
Not at all	Rarely	Sometimes	Often

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

APPENDIX 14: Qualitative Analysis - Codebook

Descriptions and Illustrations of types of events experienced in clinical work as distressing or traumatising

CODE	DESCRIPTION
Vicarious Events	1. Client/other reports event experienced by them. 2. The event reported by the client meets criterion A of the diagnostic criteria for PTSD e.g. experience, witnessing or confrontation with actual or threatened death or serious injury or threat to physical integrity of self or others (APA, 1994). 3. Where events does not typically meet criterion A the clients' response to event must involve fear, helplessness or horror.
Direct Events	As vicarious event except therapist not client experiences event.
Stressful Events	1. Events experienced by therapist or that client reports. 2. Events do not meet criterion A and response does not involve fear, helplessness or horror.

Descriptions of types of emotional and cognitive reactions

CODE	DESCRIPTION
Negative Reactions	Reactions that describe a negative thought or emotion that would be universally be considered negative
Mixed Reactions	Both positive and negative statements are used to describe reaction. May consist of separate sentence indicating each reaction or a single idea expressing positive and negative aspects.
Positive Reactions	Reactions that describe a positive thought or emotion that would be universally be considered positive