The Psychological Cost of Working with Traumatised Children

and

Research Portfolio

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Acknowledgements

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Small Scale Service Evaluation Project

Evaluation Of An Informal Consultation Opportunity Provided By A Clinical Child Psychologist To Other Professionals In The Community

prepared for submission to *Health Bulletin*

(see Appendix 1.1 for Notes for Contributors)

Evaluation Of An Informal Consultation Opportunity Provided By A Clinical Child Psychologist To Other Professionals In The Community

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ABSTRACT

Objective

To describe the use of an informal consultation opportunity provided by a Grade 'B' Clinical Child Psychologist to other professionals within the community in the north sector of Glasgow, between May 1995 and December 1996, and to evaluate the efficacy of consultancy as a method of service delivery by clinical child psychologists.

Design

A retrospective analysis was performed of all informal consultations between the clinical child psychologist and other professionals which had taken place May 1995-December 1996 using database information held by the former.

A structured telephone interview took place with a smaller sample of professionals, identified within the database, who had used the service during a six month period (July-December 1996).

Setting

Yorkhill NHS Trust Community Child Health Services (Glasgow, north sector).

Subjects

Professionals in the community who made use of the informal consultation opportunity (July-December 1996).

Results

In total, 159 consultations were carried out between May 1995 and December 1996. The rate of requests for informal consultation opportunities showed an initial high demand followed by a decreasing trend over the full study period. The mode length of consultation time was 15 minutes or less. Consultations were mainly sought by clinical medical officers (42.8%), health visitors (25.8%), and paediatricians (13.8%) and predominantly concerned behavioural (52.8%) and anxiety (15.1%) problems. Most involved the clinical psychologist giving advice only (67.3%) and did not necessitate further direct work. Most consultations concerned pre-school children (67.9%) followed by those of primary school age (30.2%). Secondary school aged children were only involved in 1.3% of consultations.

In the smaller sample analysed in more detail, twenty consultations were requested by fourteen different professionals. Of these, eleven professionals (73.3%) were able to complete a structured interview by telephone. The types of presenting problems, professionals seeking informal consultation, age-groups of children involved, and outcomes of consultation were largely consistent with the overall sample. Male children accounted for 45% and 55% concerned female children. The informal consultation opportunity was identified as a rapid means of harnessing clinical psychology input and was uniformly positively evaluated regarding its' usefulness, effectiveness, appropriateness, and accessibility. Findings suggest consultation provides an efficacious means of targeting scarce clinical psychology resources.

Conclusion

The informal consultation opportunity provided by the clinical child psychologist appears to be an expeditious means of providing diverse professionals with clinical psychology

input. This method of service delivery appears to be an enabling and supporting process for other professionals in the community and to represent an efficacious method of service delivery. Recognition and development of the consultation role is recommended in order to maximise efficiency in meeting children's mental health needs.

INTRODUCTION

It is estimated that 23% of all under 18s (i.e. about 8,155 children and young people) in the north sector of the city of Glasgow are likely to be experiencing a mental health problem[1]. A shortfall has been reported between current local service need and service provision with particular reference to the shortage of clinical psychologists[1]. The relative paucity in numbers of clinical child psychologists in comparison with other professions in the child field is acknowledged at a national level along with the recognition that clinical child psychologists have a unique contribution to make in the management of complex psychological issues[2]. Increased use of consultancy between clinical psychologists and other professionals represents one method of trying to bridge the gulf between service demand and service provision. A preferred model of care in which direct clinical work is balanced with an active role in liaison and consultancy with other services has been advocated[1,3] and the positive attitude of other professionals to clinical psychologists carrying out such work endorsed[4,5]. A caution against a substantial expansion of the consultancy role has, however, been advised[6].

An informal consultation opportunity for other professionals with a clinical child psychologist has been operating since the establishment of community child psychology services in the north sector of the city in May 1995. It was considered useful to obtain a clearer picture of how this informal service was being used and to assess other

professionals' perceptions of the consultation opportunity in order to evaluate the efficacy of this model of service delivery.

METHOD

A database of all consultation work undertaken by the clinical child psychologist across different community settings in the north sector of the city of Glasgow was employed to investigate overall patterns of usage of the informal consultation opportunity between May 1995 and December 1996. SPSS (Statistical Package for Social Scientists) was used to evaluate: (a) consultation frequencies; (b) duration of consultations; (c) age groups of the children concerned; (d) types of presenting problems; (e) types of professionals seeking consultation; and (f) consultation outcomes.

A structured interview was devised (Appendix 1.2) to elicit the perceptions of professionals who had made use of the consultation opportunity and to evaluate the efficacy of the latter. Issues upon which a service's efficacy may be judged were included, namely: accessibility, appropriateness, effectiveness, and usefulness[8]. In light of previous poor response rates to postal questionnaires[4] it was decided to conduct the questionnaire by telephone and, in order to maximise accurate recall of specific details related to the consultation, the interviews were limited to all professionals who had consulted with the clinical psychologist during the six months prior to the start of the study (i.e. July-December 1996). Interviewees were asked to answer questions from options provided by the interviewer. An open question regarding any additional comments on the consultation opportunity was also asked at the end of the interview. A total of twenty consultations involving fourteen different professionals were undertaken during the six month time period of interest. Professionals involved included: health visitors (HV, n=7);

paediatricians (PAED, n=2); senior clinical medical officers (SCMO, n=1); a clinical medical officer (CMO, n=1); a clinical psychologist (CLINPSY, n=1); a social worker (SOCWK, n=1); and a speech & language therapist (SLT, n=1). An attempt was made to contact all fourteen professionals by telephone. The aims of the present study were explained to those contacted and arrangements made to telephone them again at a mutually convenient time to carry out the structured interview. Of the fourteen professionals identified, eleven (73.3%) completed the interview regarding a total of fifteen consultations with the clinical psychologist. Of the three who did not participate, one was reported to have left the profession and two were unable to recall specific details related to the cases concerned. Each telephone interview lasted approximately fifteen minutes.

RESULTS

A. Database Information Regarding Consultations May 1995-December 1996

Analysis of database information by SPSS revealed a total of 159 consultations were carried out between May 1995 and December 1996 (figure 1). Examination of the figures according to five month time blocks reveals: 50 consultations during the first five months; 67 in the second; 18 in the third; and 17 in the fourth (missing data=7).

INSERT FIGURE 1

The length of time of each consultation was categorised according to fifteen minute slots (table 1). The mode consultation time consisted of 15 minutes or less.

INSERT TABLE 1

The sex of the children involved in the consultations was not available from the database. Pre-school aged children were involved in 67.9% of the consultations and 30.2% concerned primary school aged children. Only 1.3% of consultations were regarding children of secondary school age (figure 2).

INSERT FIGURE 2

Consultations were concerned with disorders of behaviour (52.8%), anxiety (15.1%), sleep (11.3%), elimination (8.8%), mood (4.4%), eating (3.8%), and development (1.9%). Figure 3 shows frequencies of types of presenting problems.

INSERT FIGURE 3

The majority of the overall consultations were requested by CMOs (42.8%) and health visitors (25.8%) followed by paediatricians (13.8%) and speech and language therapists (5%). Figure 4 demonstrates frequencies of informal consultations according to the professional group.

INSERT FIGURE 4

Overall, consultation was more likely to result in the clinical child psychologist giving advice only (67.3%) rather than precipitating formal referral to clinical child psychology (19.5%). The consultation resulted in further joint work between the consultee and the clinical child psychologist in 8.8% of cases (i.e. involving the clinical child psychologist either attending a case discussion or a joint appointment with the consultee). Involvement of another agency following consultation was the least likely outcome (1.9%). Figure 5 shows frequencies of informal consultation outcomes.

INSERT FIGURE 5

B. Structured Interview By Telephone Interview Regarding Consultations July-December 1996

The subset selected for further analysis by structured interview by telephone was largely found to be representative of the overall sample: 66.7% of the children in the subset were of pre-school age (compared with 67.9% of the overall sample); 33.3% were of primary school age (vs. 30.2%); and 0% of secondary school age (vs. 1.3%). Types of presenting problems were also largely representative of the overall sample with behavioural and anxiety problems predominant (table 2).

INSERT TABLE 2

In both the subset and the overall sample, the types of agencies seeking consultation the most frequently were the same (i.e. CMOs, health visitors, and paediatricians), however, the greater portion in the subset were requested by health visitors (53.3%) followed by CMOs and paediatricians (13.3% respectively) whereas in the overall sample consultation was sought most frequently by CMOs (42.8%), followed by health visitors (25.8%), and paediatricians (13.8%).

Finally, the majority of consultations in the subset, as in the overall sample, resulted in advice only (66.7% in the former and 67.3% in the latter). Referral to clinical child psychology was also the second most frequent outcome in both (26.7% vs. 19.5%).

The sex of the child concerned in the consultation was only available for the twenty consultations occurring in the six month period selected for further investigation by structured telephone interviews. Of these twenty children, 55% were female and 45% were male.

Accessibility

The greater portion of respondents were able to access the clinical child psychologist rapidly (66.7%) or within an acceptable time frame (26.7%). Only one respondent (6.7%) believed access was difficult and not within an acceptable time frame, however, they reported that this would not deter them from trying to consult again in the future.

Appropriateness

The advice provided by the clinical psychologist was reported to be 'very appropriate' to the case concerned by 73.3% and 'appropriate' by 26.7%. No consultee believed the advice they were given was 'inappropriate'.

All respondents (100%) believed that they had been taken seriously by the consultant clinical child psychologist and that they had been listened to.

Effectiveness

A total of 92.9% reported their questions had been fully answered during the consultation and 7.1% thought their questions had been partially answered. No respondent believed their questions had not been answered at all.

The duration of the consultation was stated to be about right by 93.3%. Only one consultee (6.7%) thought that the consultation had been too short with not enough time to cover all relevant issues. No respondent found the length of the consultation too long.

Overall, 66.7% overall believed that the advice given during the consultation was either 'highly applicable' (26.7%) or 'applicable' (40.0%) to other cases. One third of those interviewed reported the advice provided was 'inapplicable' to other cases.

Usefulness

All consultees (100%) either reported the consultation opportunity to have been 'very useful' (80.0%) or 'useful' (20.0%). In no instance was the opportunity to consult deemed 'not useful'.

When questioned further about what specifically the respondents had found most useful about the opportunity to consult with the clinical child psychologist: 38.5% reported 'the opportunity to discuss issues surrounding the case'; 26.9% stated 'feeling supported by a colleague'; 23.1% listed 'specific cognitive-behavioural advice'; and 11.5% 'fresh insight into the case'.

Patterns Of Usage

The majority of those interviewed by telephone (80.0%) reported that they had learned about the opportunity through contact with community clinical child psychology services. A further 13.3% had learned about the opportunity through a fellow professional and 6.7% through contact with the hospital based clinical child psychology service.

One third of those contacted had previously consulted with community based clinical child psychology services. The majority (66.7%), however, had no previous contact with a clinical child psychologist.

Formal referral to clinical child psychology ensued in 26.7% of consultations. The majority of consultations (66.7%) resulted in advice alone. Referral to another service - the Department of Child & Family Psychiatry (DCFP) - occurred only once (6.7%).

Had consultation with the clinical child psychologist not been available: one respondent (6.7%) reported they would have made a formal referral to another service (DCFP); 33.3% would have made a formal referral to clinical child psychology and continued managing the case themselves; 6.7% would have made a formal referral to clinical

psychology and closed the case; and 40.0% would have sought advice from another source (including: health visitors, GP/CMO, and educational psychology).

Nearly half of those contacted (46.7%) reported they had used the consultation opportunity again since the episode concerned in the present survey and 93.3% reported they would use the service again in the future. (One respondent would not use the service again but this is only because they are no longer based in Glasgow).

DISCUSSION

The consultation opportunity provided by the clinical child psychologist has been used by a broad spectrum of professionals within the community setting with the majority of consultations, to date, being requested by CMOs, health visitors, and paediatricians. The endorsement of clinical psychology input by different professional groups with their own different skill levels points to the unique contribution which clinical child psychologists have to offer in the management of mental health issues[2].

The mode consultation duration was 15 minutes or less, however, the longest consultation lasted 2 hours 15 minutes. This demonstrates the time demands incumbent upon a clinical psychologist who makes consultation opportunities available and highlights the necessity of recording consultancy activity in order to acknowledge it as an important and integral part of clinical psychologists' work and to preserve the visibility of the profession[6,7].

Overall, the majority of consultations concerned behavioural and anxiety problems, involved the clinical psychologist giving advice only, and concerned predominantly pre-school or primary school aged children. Secondary school aged children appear under-

represented. The latter could be a reflection of the fact that most consultations were requested by CMOs who have little contact and health visitors who have no contact with secondary school aged children. It may be that the small number of consultations concerning secondary school aged children reflects access issues for this particular group. It is suggested that consultation work in the future should therefore encompass a wider range of professionals involved with children and young people (e.g. reporters to the children's panel). An expansion of the consultancy role to provide a service directly accessible to young people themselves in the style of an advice and walk-in clinic[12] might overcome the under-representation of secondary school aged children found in the current study.

The number of consultations requested by other professionals within the community was found to decrease from a peak in the second five month period to the final five month period studied. A decrease could reflect changing rotations of staff and hence awareness of the consultation opportunity as an available resource may have been lost due to the informal nature of the service. It is also possible that the observed peak was due to increased awareness of the consultation opportunity and that professionals in the community now use the opportunity more selectively and appropriately with increased knowledge of what clinical psychology can offer. Reasons for the apparent decrease in consultations merits further investigation as the current data does not allow for any conclusions to be drawn.

Concern has been reported by referrers that NHS child and adolescent mental health services appear to be a scarce and inaccessible resource and that a model of care which allows referrers access to practitioners to seek their advice and views on potential referrals

should become the norm[1]. The consultation opportunity with the clinical child psychologist appears to provide such an example of service delivery. The structured interview found the informal service to be perceived as accessible and useful. Respondents reported that they had been listened to, taken seriously, and that the advice they were given was appropriate. It has been suggested that other professionals might not want to use clinical psychology services[6], however, the professionals in the current survey viewed the opportunity as a positive one. Overall, professionals contacted believed that their questions had been answered and that the length of the consultation was about right. The advantages of having a clinical psychologist at the same community base were acknowledged as were resource issues (with requests for more clinical psychologists) in the 'Additional Comments' section of the interview. The recent appointment of a second clinical child psychologist in the north sector of Glasgow should further improve accessibility issues to clinical child psychology services, however, this does not detract from the scarcity of provision in the child field[1,2] and the need for continuing innovations in service delivery in order to maximise the impact and effectiveness of clinical child psychology services.

The importance of the majority of consultation opportunities resulting in indirect contact must be viewed in context of the finding that, if consultation with the clinical child psychologist had not been available, 40% of professionals interviewed would have made a formal referral to clinical child psychology whereas in only 26.7% of cases were the third level skills of a clinical psychologist[9] deemed appropriate and formal referral to clinical psychology actually instigated. It can be speculated that this will have a positive bearing on the clinical psychologist's clinical satisfaction through greater control over their caseload as well as limiting an increase in the waiting list. Involvement of clinical

psychologists in pre-referral discussions has previously been found to reduce inappropriate referrals[5] and the current study supports this. Consultation opportunities provided to health visitors and district nurses have been found to result in a decrease in referrals from these professionals and a corresponding increase in demand for training and joint work[10]. Future work might examine the effect of a more formalised consultation service on referral rates by other professionals.

In the present study, the consultation opportunity was described in the 'Additional Comments' section of the interview as providing a rapid means of accessing psychological knowledge for early intervention in mental health issues. It has been suggested that many cases discussed at consultation subsequently materialise as referrals in the future[11]. It would be of interest to investigate if this is the case or whether consultation averts the development of secondary problems later.

The endorsement of 'the opportunity to discuss issues surrounding the case' followed by 'feeling supported by a colleague' as the most useful aspects of the consultation might reflect the finding that the opportunity to consult with a clinical psychologist may contain a referrer's anxiety about a case[11]. 'Specific cognitive-behavioural advice' and 'fresh insight into the case' were ranked third and fourth most useful aspects respectively. Consultation thus appears to be a supporting and enabling process which helps professionals develop new skills (the majority of respondents reporting that the advice given by the clinical psychologist was applicable to other cases too).

CONCLUSIONS

The consultation opportunity provided since the development of community child psychology in the north sector of the city of Glasgow seems to fulfil many criteria advocated as constituting good clinical practice[1-5,8-11] and to be an efficacious service valued by different professionals of various skill levels.

Findings from the current study suggest that consultation is an enabling and supporting process which allows for the effective targeting of scarce clinical psychology resources. Future development and application of this model of service delivery is therefore suggested including: formalising the consultation service; making the service available to a wider range of professionals and perhaps even directly available to young people themselves; and setting aside specific clinical time for consultation work. Further investigations also of the evident change in the frequency with which professionals are using the consultation opportunity along with the effect of consultation work on the overall referral rate to clinical child psychology are proposed. The latter, of course, depend on the recognition of consultation work by NHS Trust managers. Rather than serving to detract from the profession of clinical psychology[6] judicious development of the consultancy role is likely to add value to the profession as it is seen to be dealing more efficiently with appropriate clients. More efficient ways of working are also likely to have a positive impact upon those working in the profession itself.

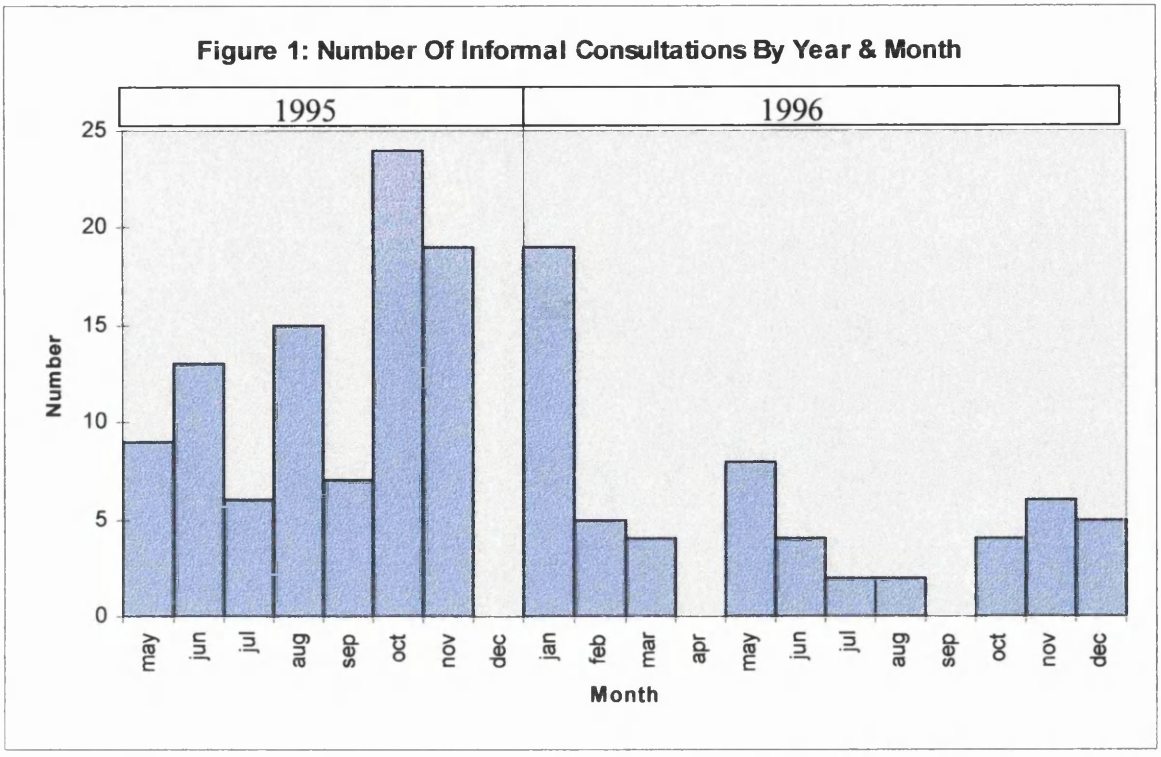

Table 1: Overall Frequencies Of Consultation Time Periods

Maximum Duration In Minutes	Frequency	Percent
15	71	44.7
30	17	10.7
45	2	1.3
60	6	3.8
75	2	1.3
90	2	1.3
105	1	0.6
135	1	0.6
Missing Data	57	35.8

Figure 2: Frequency Of Informal Consultations By Age Group Of Child Concerned

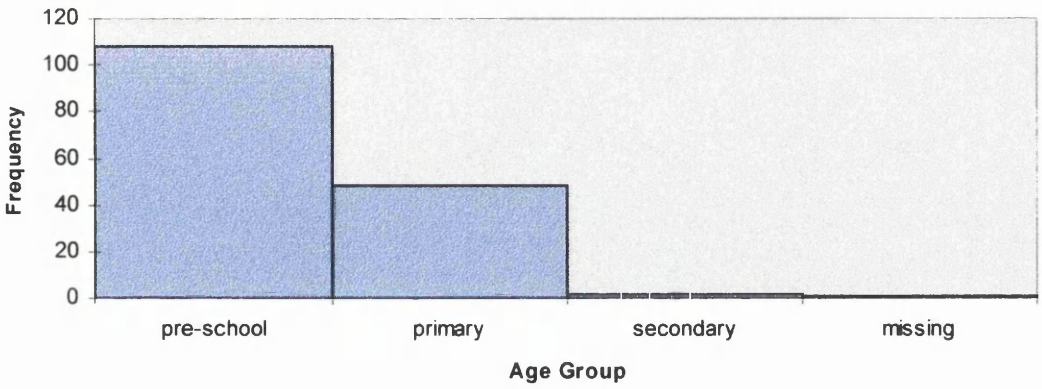

Figure 3 - Frequency Of Presenting Problems

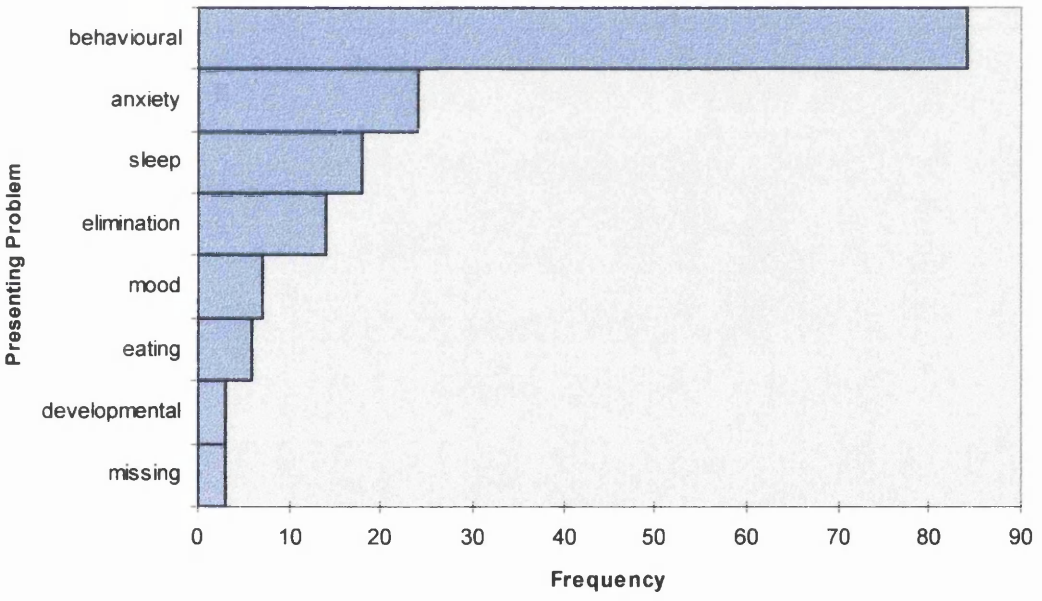

Figure 4: Frequency Of Informal Consultations According To Professional Group

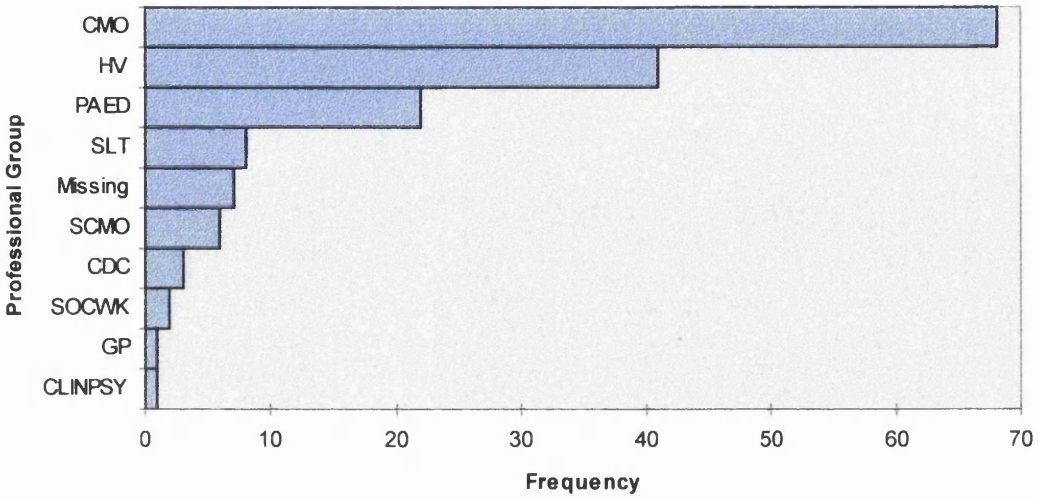

Figure 5: Frequency Of Consultation Outcome

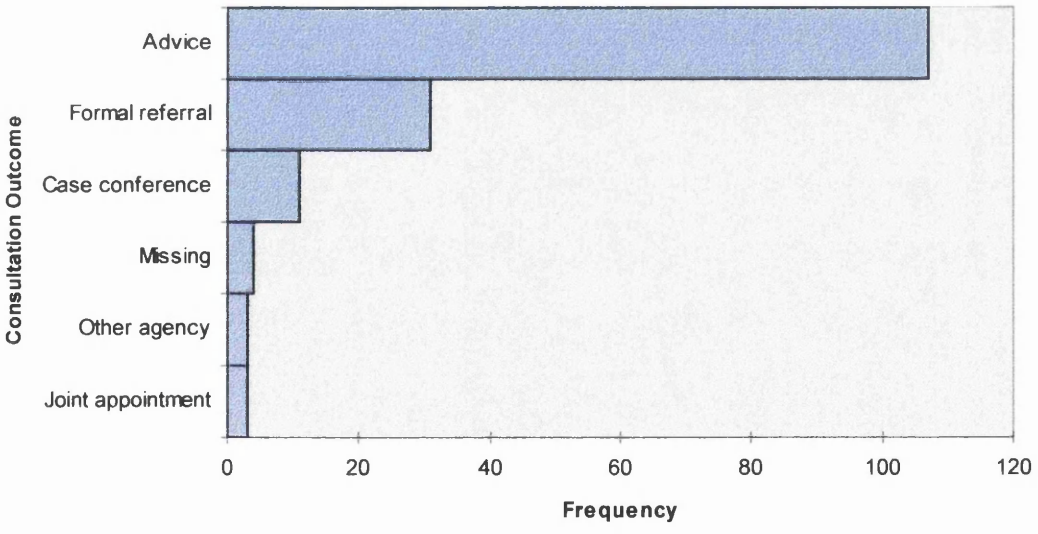

Table 2: Types Of Presenting Problems

Presenting Problem	**Overall Sample: May 1995-December 1996** %	**Subset Interviewed By Telephone: May-December 1996** %
Behavioural	52.8	53.3
Anxiety	15.1	20.0
Sleep	11.3	6.7
Elimination	8.8	13.3
Eating	3.8	6.7
Mood	4.4	0.0
Developmental	1.9	0.0

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Major Research Project Literature Review

The Psychological Cost Of Working With Traumatised Children

- A Review of the Literature

prepared for submission to the *Journal of Traumatic Stress*

(see Appendix 2.1 for Instruction to Contributors)

The Psychological Cost Of Working With Traumatised Children

- A Review of the Literature

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ABSTRACT

This review considers the potential effects on workers of working with traumatised children. The author begins with a description of post-traumatic stress disorder and then focuses on the concept of secondary traumatic stress. Different theoretical models are briefly examined and particular attention is paid to constructivist self development theory. Reference is made to the manifestation of PTSD in children, the particular demands posed by working with traumatised children, and the clinical and behavioural effects of such work. Further research is needed in the field of secondary traumatic stress in order to further develop a theoretical model of the concept and to explore future applications to clinical and research practice.

KEY WORDS: Post-traumatic stress disorder, secondary traumatic stress, constructivist self development theory, working with traumatised children.

POST TRAUMATIC STRESS DISORDER

Post traumatic stress disorder (PTSD) is a relatively recent diagnostic classification having only been officially recognised in 1980 with the publication of the third Diagnostic and Statistical Manual of Mental Disorders (APA, 1980). DSM-IV (APA, 1994) diagnostic criteria include: exposure to a traumatic event, re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, plus persistent symptoms of increased arousal. To fulfil diagnostic criteria symptoms must be of more than one month duration and must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. DSM-IV additionally acknowledged for the first time that bearing witness to an event that involves actual or threatened death or serious injury or a threat to the physical integrity of others can also fulfil criterion A (the stressor) thus recognising the concept of vicarious traumatisation. PTSD is a persistent, normative, and primary consequence of exposure to severe trauma (Engdahl, Dikel, Eberly & Blank, 1997).

Lifetime prevalence rates of PTSD have been estimated at between 1%-9% (Helzer, Robbins & McEvoy, 1987; Breslau, Davis, Andreski & Peterson, 1991) and in women as much as 12% (Resnick, Kilpatrick, Dansky, Saunders & Best, 1993). Possible predictors of PTSD include: demographic features, nature of involvement in the event, cognitive appraisal of the stressor, pre-trauma variables, coping strategies and treatment given (McFarlane, 1989; Green, 1993; Engdahl et al, 1997).

Theoretical Models of Post Traumatic Stress Disorder

Theoretical models of PTSD based in biological, physiological, cognitive, behavioural, and psychodynamic theories have been proposed, however, no one theory fully explains the

disorder (Black, Newman, Harris-Hendriks & Mezey, 1997). Psychoanalytical models focus on the effect of trauma on the adult psychic structure (Van Velsen, 1997). Behavioural models advocate that PTSD symptoms are classically conditioned and are maintained through instrumental conditioning (e.g. avoidance) and incubation (e.g. flashbacks) (Keane, Zimmering & Caddell, 1985c). Cognitive approaches suggest that pre-existing schemata and basic assumptions about the world influence the individual's response to the trauma. Hypothesised beliefs include: a belief in personal invulnerability, the perception of the world as meaningful and comprehensible, and a view of the self in a positive light (Janoff-Bulman, 1992). Information processing theory emphasises the role of encoding, storing, and retrieving information from memory through the development of schemas. Resick & Schnicke (1992) advocate a cognitive processing model in which five schema areas can be disrupted by victimisation (i.e. safety, trust, power, esteem, and intimacy). Each of these areas is further divided into schemata relating to self and schemata relating to others. Cognitive processing theory assumes PTSD symptoms are caused by conflicts between prior schemata and new information as a result of the trauma as the latter will be inconsistent with pre-existing beliefs and will be schema discrepant. A paradoxical interaction is hypothesised to occur between the trauma and the individual's basic assumptions. This can lead to assimilation in which information is altered or distorted to fit existing schemata or to accommodation in which existing schemata are changed in order to accept new, incompatible information. A complete change in beliefs and schemata can also ensue (i.e. overaccomodation). Cognitive and behavioural avoidance are said to prevent successful accommodation thereby maintaining symptomatology (figure 1).

INSERT FIGURE 1

Post Traumatic Stress Disorder in Children

Specific recognition of PTSD symptomatology in children only emerged with the revised publication of DSM-III-R (APA, 1987). Diagnostic criteria made reference to: 'repetitive play in which themes or aspects of the trauma are expressed' (criterion B1); 'loss of recently acquired developmental skills such as toilet training or language skills' (criterion C4) in young children; and to 'a sense of foreshortened future, e.g. child does not expect to have a career, marriage, or children, or a long life' (criterion C7).

The recognition of PTSD in children was further acknowledged in DSM-IV through reference to the fact that: intense fear, helplessness, or horror 'in children, may be expressed instead by disorganised or agitated behaviour' (criterion A2); that 'in children, there may be frightening dreams without recognisable content' (criterion B2); and that 'in young children, trauma-specific re-enactment may occur' (criterion B3).

The incidence and prevalence of PTSD in children and adolescents is unknown, however, evidence supports the existence of PTSD symptoms in children which are similar to those found in adults (March & Amaya-Jackson, 1993). PTSD symptoms have been documented in child victims of sexual abuse (McLeer, Callaghan, Henry & Wallen, 1994), children with burns (Stoddard, Norman, Murphy & Beardslee, 1989), and after child bone marrow transplant (Stuber, Nadar, Yasuda, Pynoos & Cohen, 1991). The use of a post traumatic stress model in understanding some of the symptoms of paediatric bone marrow

transplantation survivors and of other children exposed to the double life threat of serious illness and intensive medical intervention has been suggested by Stuber et al (1991). Possible predictors of PTSD in children include: the degree of exposure to the stressor, demographic factors, the presence of psychiatric comorbidity, other life events, social cognition, and family functioning (Pynoos et al, 1987; March & Amaya-Jackson, 1993).

Working with the Traumatised

Mitchell & Dyregrov (1993) report the growing acknowledgement that helpers are not necessarily exempt from stressful psychological, social and physical reactions similar to those experienced by victims and survivors. They suggest that helpers may in fact be more seriously affected due to the fact many suppress their emotions in order to deal with the situation in hand.

Perceptions that professionals are trained to deal with traumatic situations may result in a reluctance to discuss reactions to traumatic experiences, a reticence to seek help and support when it is needed, and may potentially result in the development of psychological morbidity (Bamber, 1994).

Alexander (1993) found that most police officers did not demonstrate psychiatric morbidity three years after a major disaster and that indeed a number of them gained from their experiences. In a study of the psychological and physical health of police officers involved in the Lockerbie disaster, however, Mitchell, McLay & Cecchi (1991) challenge the assumption that professionals emerge from such work unscathed. Irritability, impatience and frustration, sleep disturbances, feelings of sadness, anger, guilt, shame, horror, disgust and depression, painful memories, and feeling that "the security of a stable,

predictable belief system had slowly dissolved" have all been documented in counsellors treating refugees (Kinzie, 1995, p.254).

Weissberg & Katz (1991) reported that, although psychological morbidity in rescue personnel was common, the potential risk to hospital based staff has not been acknowledged. The authors report that the care of patients was compromised in the weeks following a disaster and conclude that hospital based staff do indeed experience significant emotional effects as a result of disasters in spite of self-selection to the caring profession, socialisation, and training.

Nurses working in a burns unit have to distance themselves from patients who may die and they may find themselves in the paradoxical position of providing painful procedures to children who may also may the victims of abuse and/or neglect and who they might believe would be better dead (Brack, LaClave & Campbell, 1987). Nurses experience extreme stress as a result of the burns patient's pain from treatment (Perry, 1984) and have been found to display symptoms of depression and PTSD six months after beginning to work on a burns unit (Holaday & Yabrough, 1996).

Working with Traumatised Children

Death or serious trauma to children has been identified as the worst event emergency personnel and those involved in more long-term care experience (Mitchell, 1984; Vachon, 1987). Dealing with traumatised children is reported to intensify stress on the worker even in more routine hospital work (Dyregrov & Mitchell, 1992) with many helpers viewing the involvement of children as the "worst case scenario" (Dyregrov, Kristoffersen & Gjestad 1996, p.552). Therapists dealing with child victims of sexual abuse reported they were

more bothered by intrusive feelings about the children than about the parents (Oliveri & Waterman, 1993).

Working with traumatised children may have a particularly profound effect on helpers and interfere with the helping relationship due to motivating forces in the helper's personality and identification with the victim (Dyregrov & Mitchell, 1992; Simon, 1993). The latter may be more intense when working with a group of victims who are considered innocent and unable to protect themselves and due to the helper's own roles as a parent, sibling etc. and to their own memories of being a child (McCarroll, Ursano, Wright & Fullerton, 1993). The presence of children may further lead to the adaptive coping mechanism of humour to be suppressed or inhibited (Dyregrov, Kristoffersen & Gjestad, 1996). Although routine emergency calls have been found to have a cumulative effect on A&E road crews the more critical ones such as attending the death of a baby or a child mutilated in a car accident were more highly associated with acute PTSD in workers (Ravenscroft, 1994). Although professional and personal development may ensue from working in the field of child sexual abuse (Shapiro, Burkey, Dorman & Welker, 1996), distress and PTSD symptoms have also been reported by therapists secondary to their treatment of children who have been sexually abused (Oliveri & Waterman, 1993). A trend toward a significant association with PTSD symptoms was also found among police officers investigating child abuse cases (Martin, McKean & Veltkamp, 1986). One therapist experienced intrusive images of adults sexually abusing children when she observed fathers interacting with their daughters at her child's day-care centre (McCann & Pearlman, 1993). A Judge acknowledged that a social worker suffered a 'stress related anxiety state' as a result of his responsibility for four teams of social workers dealing with child abuse cases thus pointing

to the inherently stressful nature of social services work with child victims of abuse (Howard, 1995).

SECONDARY TRAUMATIC STRESS

Secondary traumatic stress is defined by Rudolph, Stamm & Stamm (1997, p.1) as "the presence of PTSD-like symptoms in a caregiver - more likely tied to the patient's Criterion A1 experience than their own - mixed with the provider's life experiences".

According to Herman (1992, p.140), "Trauma is contagious. In the role of witness to disaster or atrocity, the therapist is at times emotionally overwhelmed. She experiences to a lesser degree, the same terror, rage, and despair as the patient. This phenomenon is known as 'traumatic countertransference' or 'vicarious traumatization'. The therapist may begin to experience symptoms of post-traumatic stress disorder."

Many different conceptual terms have been used to describe the effects on helpers of exposure to a client's traumatic material including: countertransference (Johansen, 1993), burnout (Pines & Aronson, 1993), vicarious traumatisation (McCann and Pearlman, 1990), plus secondary traumatic stress disorder and 'compassion fatigue' (Figley, 1995). Stamm (1997) proposes the use of 'secondary traumatic stress' (STS) as the most encompassing term for the effects upon the helper of being exposed to another's traumatic material.

Countertransference

Countertransference may be viewed as a response based model of stress (figure 2) in so far as the helper's responses are a function of their previous unresolved psychological

conflicts (McCann & Pearlman, 1990) and represent an emotional response to a client by a therapist (Figley, 1995). Countertransference refers to our reactions to our clients and their material whereas secondary traumatic stress, compassion fatigue, and vicarious traumatisation are conceptualised as inducing more permanent changes to our values, beliefs, and behaviours. Countertransference can occur outside of the context of exposure to traumatic material whereas secondary traumatic stress, compassion fatigue, and vicarious traumatisation always arise as a result of exposure to a client's traumatic material.

INSERT FIGURE 2

Burnout

Burnout is described as a state of physical, emotional, and mental exhaustion (Pines & Aronson, 1988) and is posited as being associated with organisational and job characteristics rather than individual characteristics and, as such, represents an example of a stimulus based model of stress (figure 3) (Sutherland & Cooper, 1990; Stamm, 1997; McCann & Pearlman, 1990). Increased workload and institutional stress are the precipitating factors in burnout, not trauma (Stamm, 1997).

INSERT FIGURE 3

Compassion Fatigue and Vicarious Traumatisation

Both compassion fatigue and vicarious traumatisation are viewed as 'occupational hazards' (Figley, 1995; Pearlman & Saakvitne, 1995). Figley (1995) proposes that compassion fatigue is a natural consequence of working with people who have experienced extremely stressful events and develops as a result of the helper's exposure to their clients' experiences combined with their empathy for their clients.

Vicarious traumatisation has its basis in constructivist self development theory (CSDT) which emphasises the role of meaning and adaptation rather than symptoms whereas compassion fatigue has its foundations in a symptom based diagnosis (Pearlman & Saakvitne, 1995). CSDT views the individual's adaptation to trauma within an interactive process model in which the individual's personality, personal history, the traumatic event and its context within the social and cultural contexts all interact (figure 4). Vicarious traumatisation results in disruptions in the therapists' sense of identity, world-view, spirituality, ability to tolerate strong affect, and central cognitive schemas (e.g. core beliefs about safety, trust, esteem, control, and intimacy). The latter develop in an emotionally significant, relational context provided by primary caregivers (Pearlman & Saakvitne, 1995; Janoff-Bulman, 1992) and specific areas of disruption differ for individuals according to which area is more or less salient to them as a result of their unique life history (McCann & Pearlman, 1993). Vicarious traumatisation may also affect the therapist's imagery system of memory with disturbances in imagery often being linked to disrupted schema areas (McCann & Pearlman, 1993). According to Pearlman & Saakvitne (1995), the effects of vicarious traumatisation are cumulative, pervasive, and enduring and can result in the therapist experiencing many of the same signs and symptoms as their client but at sub-clinical levels (including PTSD, anxiety, and depression symptoms).

INSERT FIGURE 4

Secondary Traumatic Stress In Those Working with Traumatised Children

According to McCann & Pearlman (1993), specific ways in which working with traumatised children may vicariously traumatise therapists include: fear that their own children will be molested and wariness of adults who come into contact with their children (disruption to their safety schema); suspicion of other people's motives and distrust of other adults who come into close contact with children (disruption to their trust/dependency schema); despair at their own helplessness in preventing child abuse (disruption to their power schema); restriction of their own children's independence because of the risk of child abuse (disruption to their independence schema); loss of belief in the benevolence of other people or the world in that it involves a loss of youthful idealism and optimism (disruption to their esteem schema); isolation in one's work (disruption to their intimacy schema); and preoccupation with the question of why there is so much cruelty in the world and why adults perpetrate violence on defenceless children (disruption to their frame of reference).

A Theoretical Model of Secondary Traumatic Stress

Little is known about who is most likely to develop secondary traumatic stress, how to prevent it, and how to intervene (Pickett, Walsh, Greenberg, Licht & Worrell, 1994). According to Rudolph, Stamm & Stamm (1997, p.1), "There are no causal explanations for development or cure (of secondary traumatic stress) at this point, the best available literature suggests that individual and organisational factors combine in complex ways to

give form to important risk and protective factors for developing (it)." There is currently no reported empirical evidence documenting the prevalence of secondary traumatic stress reactions in trauma workers (Dutton & Rubinstein, 1995) and all of the risk and protective factors have not yet been identified (Pearlman & Saakvitne, 1995).

Risk Factors For Secondary Traumatic Stress

Conflicting evidence has been found regarding the significance of a helper's own traumatic experiences in the development of secondary traumatic stress. Workers with personal histories involving traumatic experiences have been found to be at increased risk for the development of trauma symptoms (Figley, 1993; Rudolph, Stamm & Stamm 1997; Pearlman & MacIan, 1995). Elliott & Guy (1993), however, found no differences in levels of psychological distress between abused and non-abused mental health professionals. Follette, Polusny & Milbeck (1994) similarly found evidence that professionals personal trauma history and the percentage of their caseload reporting a sexual abuse history was not significantly predictive of trauma symptoms.

Contradictory empirical evidence has also emerged regarding differences in levels of symptomatology as a function of level of experience and training. A higher level of emotional distress in inexperienced young personnel exposed to the dead has been documented (Jones, 1985) and volunteer disaster workers have been found to demonstrate significantly higher Impact of Events scores at one month than professional disaster workers (Dyregrov, Kristoffersen & Gjestad, 1996). Training as a therapist, however, does not necessarily inoculate one against the impact of a tragedy (Carbonell & Figley, 1996) and number of years service was not found to be associated with measured stress in a study by Beaton & Murphy (1995).

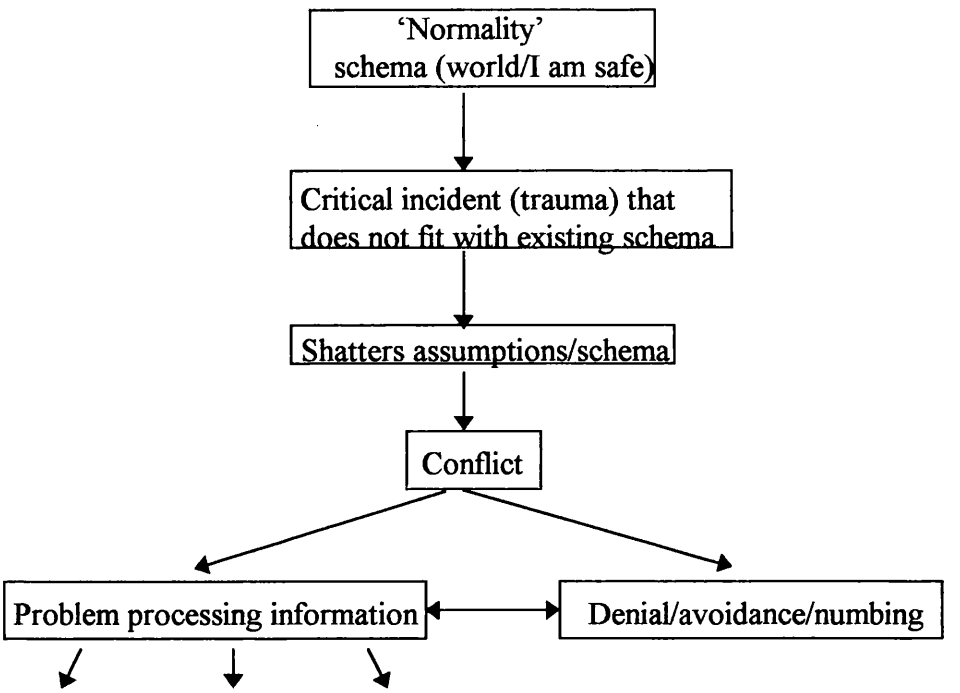
Other risk factors identified in the literature for the development of secondary traumatic stress include: exposure to a client's trauma history (Rudolph, Stamm & Stamm 1997); a greater percentage of trauma focused work (Schauben & Frazier, 1995); lack of adequate trauma focused supervision (Pearlman & Saakvitne, 1995); less experience (Pearlman & MacIan, 1995); lack of support (Keilson, 1992: McCarroll et al, 1993); being of female gender (Kassam-Adams, 1994); a perceived level of personal stress (Follette, Polusny & Milbeck, 1994); those who view themselves as 'rescuers' (Figley, 1995); and perceptions of invulnerability - the 'John Wayne Syndrome' (Mitchell, 1985b).

The Effects of Secondary Traumatic Stress on Care Receivers

Professionals affected by STS are at a higher risk of making poor professional judgements than those professionals who are not affected (Pearlman & Saakvitne, 1995) and this is likely to affect both the quality of care provided (Rudolph, Stamm & Stamm 1997) as well as the future course of recovery (Dunning, 1995; McCann & Pearlman, 1993; Nadar, 1995).

It is thus necessary to evaluate levels of STS in a range of professionals who routinely deal with traumatised children in order to develop a better understanding of the concept and to deal more effectively with the implications which exist for the quality of care delivered by professionals to children and for the mental health of the professionals themselves.

Figure 1: A Cognitive Processing Model of PTSD



(Woods, personal communication 1997)

Figure 2: A Response Based Model Of Stress

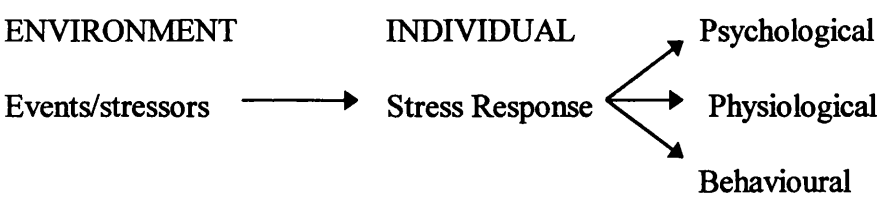


Figure 3: A Stimulus Based Model Of Stress

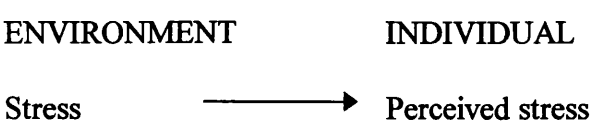
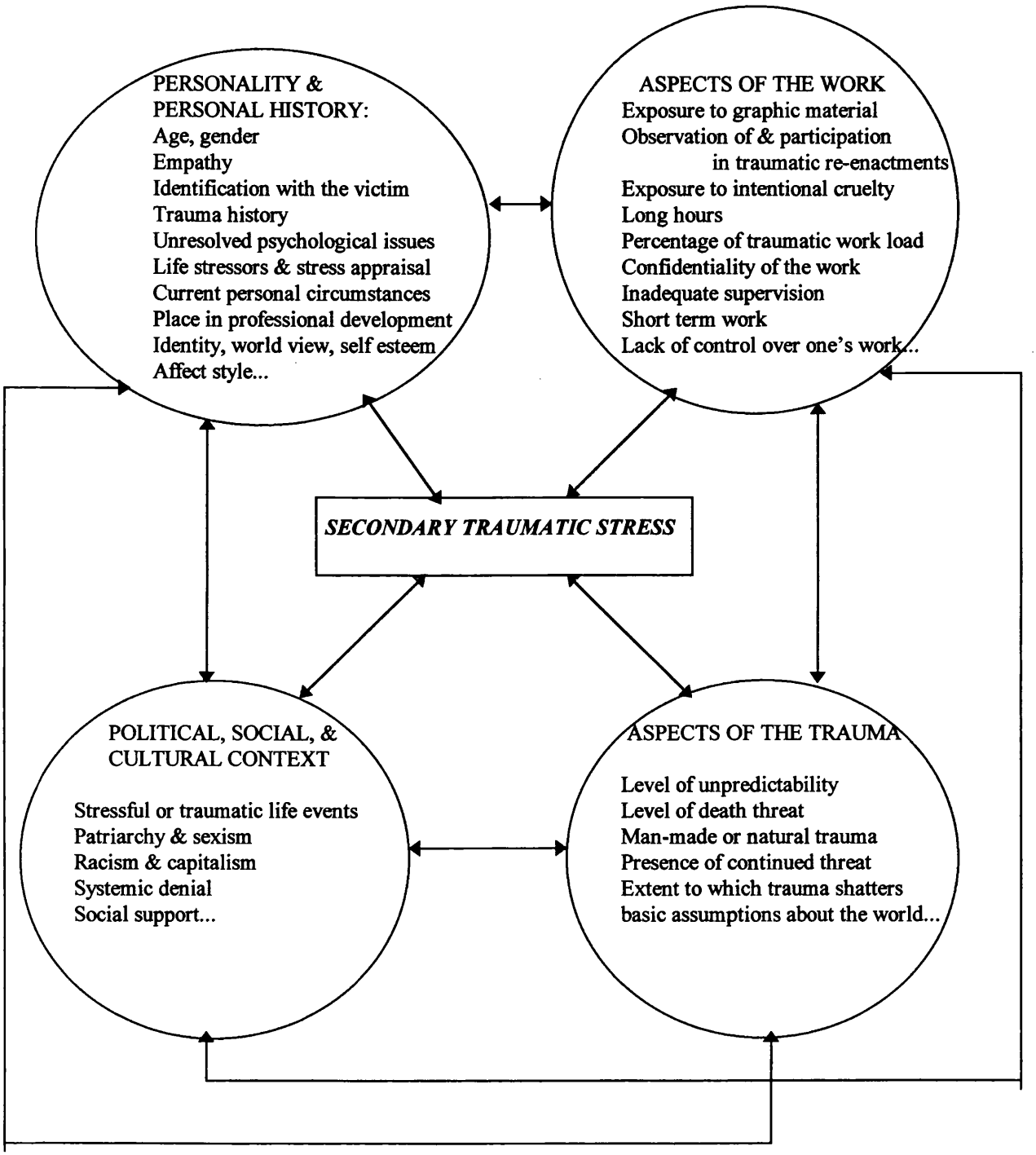


Figure 4: An Interactive Process Model Of STS



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Major Research Project Proposal

The Psychological Cost Of Working With Traumatised Children

SUMMARY

A research project aiming to describe the psychological profile of those working with traumatised children is proposed. The project will specifically seek to investigate levels of secondary traumatisation in staff as a result of their work with traumatised children in light of the recognition that children can suffer Post Traumatic Stress Disorder (APA, 1987) and due to the increasing recognition of the concept of secondary traumatisation. The psychological and emotional effects on the 'hidden victims' of disasters has been increasingly acknowledged (Mitchell & Dyregrov, 1993) and differences have been documented regarding PTSD symptomatology between professional and non-professional disaster workers (Dyegrov, Kristoffersen & Gjestad 1996; Ersland, Weisaeth & Sund, 1989). Less is known, however, about how repeated exposure to traumatic events to children affect the workers who have to deal with them as part of their every day working life. The current research project will thus seek to apply clinical and descriptive measures on a variety of different professionals and non-professionals working with traumatised children in order to describe this population in a quantitative manner.

INTRODUCTION

Since the initial recognition of post-traumatic stress disorder (PTSD) in DSM-III (APA, 1980) a burgeoning literature has emerged in relation to the assessment and treatment of the disorder. With the publication of DSM-IV (APA, 1994) the indirect effects of traumatic experience were also recognised with the acknowledgement that "learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate" (p.424) can also constitute a traumatic experience.

Research carried out in the field of secondary traumatisation has concentrated on disaster workers (Mitchell, McLay, Boddy & Cecchi, 1991), trauma therapists (Carbonell & Figley, 1996; McCann & Pearlman, 1990), and spouses of war veterans (Nelson & Wright, 1996). Mediating variables postulated to explain the latter have largely centred on the concepts of countertransference (Johansen, 1993), vicarious traumatisation (McCann & Pearlman, 1990), and 'compassion fatigue' (Figley, 1995). Stamm (1997) proposes the use of 'secondary traumatic stress' (STS) as the most encompassing descriptor of the effects upon the helper of being exposed to clients' traumatic material. Interactive models in which STS is viewed as an inevitable part of doing trauma work have been proposed by Figley (1995) and Pearlman & Saakvitne (1995). Figley (1995) advocates a symptom based model whereas Pearlman & Saakvitne (1995) base their model in constructivist self development theory. The latter emphasises the role of meaning and adaptation and suggests that the individual's personality, personal history, aspects of the work, aspects of the trauma, and the social, cultural, and political context in which the trauma occurs all potentially contribute to the development of STS (figure 1).

INSERT FIGURE 1

Although the empirical evidence regarding the effects of exposure to other people's traumatic material on emergency personnel through their professional relationship is quite well developed other professions are lagging behind (Stamm, 1997). Further research is needed that compares the effects of working with different types of trauma (Schauben &

Frazier, 1995) and there is a need to extend research to a variety of crisis worker populations beyond police officers and fire-fighters (Beaton & Murphy, 1995).

Within the literature pertaining to disaster workers there is acknowledgement that the involvement of children can potentially result in a more profound effect on helpers (Dyregrov & Mitchell, 1992). There is a dearth of literature, however, concerning STS in staff who are exposed to children's trauma as part of their routine working experience (for example, burns unit nurses and social workers amongst others). The need to examine the effect of working with traumatised children on workers is reflected by the fact that: (i) children can suffer post traumatic stress disorder (APA, 1987); (ii) that vicarious traumatisation is likely to be cumulative, pervasive, and enduring (McCann & Pearlman, 1990); (iii) that greater exposure to traumatic material is associated with a higher level of emotional distress (Johnsen et al, 1997; Marmar et al, 1996); (iv) that more psychological difficulties have been reported in professionals with less experience (Pearlman & Mac-Ian, 1995); and (v) that secondary traumatisation is likely to affect an individual's ability to function on both a professional and personal level (Weissberg & Katz, 1991). The current project aims to describe the psychological and emotional stress associated with varying degrees of exposure to traumatised children.

AIMS & HYPOTHESES

The aims of the project are:

1. To describe briefly the psychological profile of those working with traumatised children.

2. To provide an empirical investigation of the phenomenon of secondary traumatisation and to explore the impact on different staff groups of providing services to traumatised children.
3. To look at predictors of psychological morbidity in those working with traumatised children.

The hypotheses of the project are that: :

1. Levels of psychological morbidity in those working with traumatised children will generally be below clinical threshold of 'caseness'.
2. The greater the exposure to traumatised children, the more severe the helpers' STS symptoms.
3. The more training in post-traumatic stress the worker has, the less severe their STS reaction will be.
4. The presence of previous traumatic histories and recent personal adversity in the workers' lives will be associated with greater levels of STS.
5. The more supervision and support a worker receives, the less severe their psychological morbidity will be.

PLAN OF INVESTIGATION

Participants

496 professionals and non-professionals working either full or part time with children in Greater Glasgow will be asked to volunteer to take part in the study through the appropriate channel (e.g. the Research & Development Department at Glasgow City Council Social Work Department, Nursing Director...). Participants to be targeted include: social workers working in the field of child protection (n=170), nursing and

medical staff (n=171) working at four units at a paediatric teaching hospital (i.e. intensive care, oncology/haematology, accident and emergency, and the burns units), and workers at a telephone help-line for children (n=155).

Measures (Appendix 3.1)

The main questionnaire will be composed of:

1. Consent Form.
2. Background Information - consisting of general demographic data concerning the individual and their work.
3. Behavioural Scale (Burns, 1999) - consists of items which the literature suggests might be associated with working with traumatised populations. Items are rated on a 4-point Likert-type scale ['not at all'(0), 'rarely'(1), 'sometimes'(2), or 'often'(3)]. A total Behavioural Scale score is obtained by summing individual behavioural item scores.
4. Schema Questions - 8 items which are believed to represent specific ways in which cognitive schema can be disrupted through working with traumatised children (McCann & Pearlman, 1993).
5. Impact of Events Scale-Revised (IES-R, Horowitz, 1979) - a 15 item scale devised to measure intrusive and avoidant responses to traumatic stress.
6. Hospital Anxiety and Depression Scale (HAD, Zigmond & Snaith, 1983) - a brief 14 item self report measure to detect the presence of clinical 'caseness' of anxiety and depression.
7. Traumatic Stress Institute Autonomy and Connection Scale (TSI A&C Scale, Stamm, Pearlman & Bieber, 1996) - a 28 item self report scale to measure disruptions in beliefs about self and others which arise from psychological trauma

or from vicarious exposure to trauma material through psychotherapy or other helping relationships.

8. Opt-in form for the follow-up telephone interview.

Design & Procedures

Pilot Study

A pilot study shall be carried out in December 1998 on seven clinical psychology trainees who have completed child placements as part of their doctoral course in clinical psychology at the University of Glasgow. The latter will be asked to complete the main questionnaire.

Main Study

A non-experimental design will be employed with different professionals and non-professionals working with children in Greater Glasgow. Any adaptations to the main questionnaire, recommended as a result of the pilot study, will be incorporated.

Participants will receive a letter inviting them to volunteer to take part in the study, briefly informing them of the purpose of the study, and informing them that results from the questionnaires will be confidential to the researcher involved and will not be divulged to their employers (Appendix 3.2). Participants will be invited to contact the researcher at any point for clarification of any issues relating to the project and will be provided with a list of organisations that can be contacted for support and advice (Appendix 3.3). It is anticipated that approximately 20 minutes will be required to complete all measures. Completed questionnaires will be returned to the researcher at a Freepost address in envelopes provided.

Anonymised follow-up telephone interviews will be carried out on a random sub-sample of respondents who opt-in to gain more detailed information about the effects of working with traumatised children and the coping strategies used (Appendix 3.4).

Settings & Equipment

Participants will complete all self-report measures at their workplace and will be located in Greater Glasgow. There is no requirement of access to clients or to clients' files.

Data Analysis

The data will be collated, stored, and analysed by the first applicant using Statistical Package for Social Scientists (SPSS/PC+). Multivariate and bivariate statistical analyses will be carried out (including but not limited to correlational and regression analyses).

PRACTICAL APPLICATIONS

The present study will provide an insight into the potential effects of the emotionally and psychologically demanding nature of the work carried out by those working with traumatised children and may guide future service delivery issues as well as further research into this field.

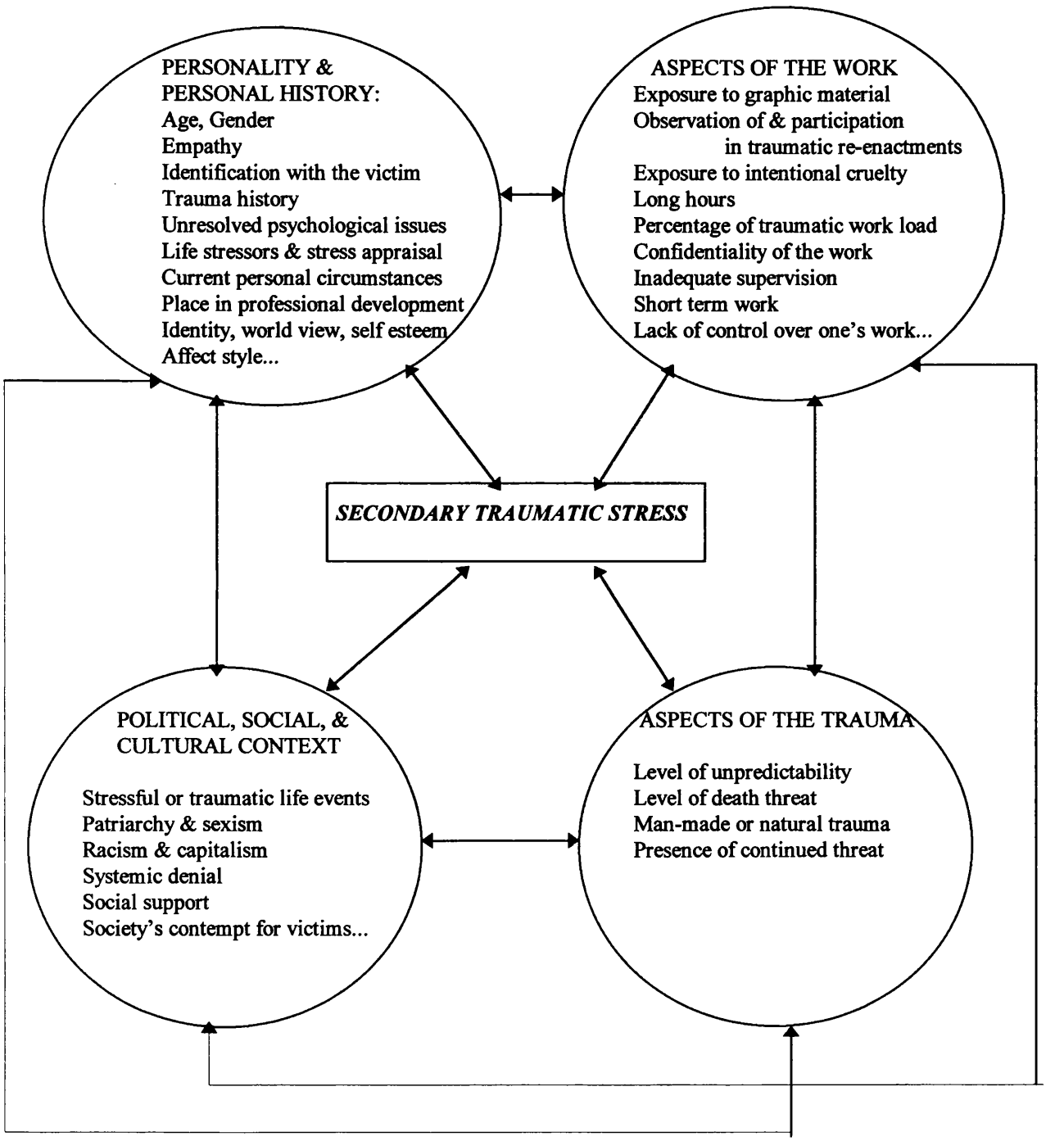
TIMESCALES

It is proposed that the project will start December 1998 and that data collection will be completed by April 1999. The final report will be presented in August 1999.

ETHICAL APPROVAL

Ethical approval will be obtained from Greater Glasgow Community and Mental Health Services NHS Trust to conduct this research. Permission will also be sought from the Research and Development Department at Glasgow City Council Social Work Department, from the national headquarters of the telephone help-line for children, and from senior nursing and medical staff in the hospital units of interest at the local paediatric teaching hospital.

Figure 1: A Model of STS



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Major Research Project Paper

The Psychological Cost Of Working With Traumatised Children

prepared for submission to the *Journal of Traumatic Stress*

(see Appendix 4.1 for Instruction to Contributors)

The Psychological Cost Of Working With Traumatised Children

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ABSTRACT

This paper examines the psychological cost of working with traumatised children in general and the concept of secondary traumatic stress (STS) in particular. Postal questionnaires were completed by 119 helpers (comprising professionals and non-professionals) and 29 follow-up telephone interviews were carried out. Sixty one percent of respondents obtained medium to high levels of post-traumatic stress symptomatology (Horowitz, 1982), and 53.8% and 15.3% reported 'caseness' levels of anxiety and depression respectively (Zigmond & Snaith, 1983). Social workers in the field of child protection were found to be experiencing the most psychological difficulties as measured by the Behavioural Scale (Burns, 1999), the Impact of Event Scale - Revised (IES-R, Horowitz, 1979), and the Hospital Anxiety and Depression (HAD) Scale (Zigmond & Snaith, 1983). No significant predictors of disrupted cognitive schemas associated with vicarious exposure to trauma material through helping relationships were identified. This study suggests a need for recognition of potential STS reactions in those working with 'high risk' populations. Further research of a longitudinal nature is recommended.

KEY WORDS: secondary traumatic stress, traumatised children, professional and non-professional helpers, social workers.

INTRODUCTION

"trauma is contagious"

(Herman, 1992)

Traumatic events affect both those directly and those indirectly involved. Significant mental health consequences can potentially result in rescue workers, health professionals, and family members following vicarious exposure to trauma (Marmar, Weiss, Metzler, Ronfeldt & Foreman, 1996; Weissberg & Katz, 1991; Harkness, 1993). Stamm (1997) proposes the use of the term 'secondary traumatic stress' (STS) as the most encompassing descriptor of the effects upon the helper of being exposed to clients' traumatic material. According to Pearlman & Saakvitne (1995), the effects of STS are cumulative, pervasive, and enduring and can result in the therapist experiencing many of the same signs and symptoms as their client but at sub-clinical levels (including PTSD, anxiety, and depression symptoms). Different theoretical models have been proposed to describe the effects on helpers of working with traumatised clients. An interactive process model in which the individual's personality, personal history, the traumatic event and its context within the social and cultural environments, interact has been described (Pearlman & Saakvitne, 1995). The literature, however, is at an evolutionary stage and contradictory findings have emerged regarding the significance of variables deemed to contribute towards STS. In light of the fact that STS is likely to result in both deleterious effects on helpers and impaired care for clients, more research is required to explore further the risk and protective factors involved.

The current study aimed:

- To describe briefly the psychological profile of helpers working with traumatised children in Greater Glasgow.

- To provide an empirical investigation of the phenomenon of secondary traumatisation and to explore the impact on different helpers of providing services to traumatised children.
- To look at predictors of psychological morbidity in those working with traumatised children.

On the basis of the trauma literature, the following exploratory hypotheses were made:

1. Levels of psychological morbidity in those working with traumatised children will generally be below clinical threshold of 'caseness'.
2. The greater the exposure to traumatised children, the more severe the helpers' STS symptoms.
3. The more training in post-traumatic stress the worker has, the less severe their STS reaction will be.
4. The presence of previous traumatic histories and recent personal adversity in the workers' lives will be associated with greater levels of STS.
5. The more supervision and support a worker receives, the less severe their psychological morbidity will be.

METHOD

Participants

The study examined the effects of working with traumatised children in three groups: (1) workers at a telephone helpline for children (n= 155); (2) social workers in the field of child protection (n=170); and (3) nursing and medical staff (n=171) working at a paediatric teaching hospital. Hospital staff targeted included those working in Accident &

Emergency (n=52), the Intensive Care Unit (n=49), Haematology/Oncology (n=40), and the Burns Unit (n=30).

Questionnaire measures were returned by 42 helpline workers, 39 social workers, and 38 hospital staff (a response rate of 23.99%). A total of 60 respondents opted-in for the follow-up interview (73.8% of helpline workers, 42.1% of social workers, and 35.1% of hospital based staff). Follow-up telephone interviews were carried out with a random sample of 10 helpline workers, 10 social workers, and 9 hospital staff (i.e. 48.3% of those who opted-in). Thus the total sample consisted of 119 subjects and a subset of 29 subjects for the follow-up.

Measures

A. The main questionnaire was a structured self-report instrument consisting of eight discrete sections:

1. Consent Form.
2. Background Information - general demographic data concerning the individual and their work.
3. Behavioural Scale (Burns, 1999) - composed of items which the trauma literature suggests might be associated with working with traumatised populations and which were not included within the other psychometric scales. Responses are rated on a 4-point Likert-type scale ['not at all'(0), 'rarely'(1), 'sometimes'(2), or 'often'(3)]. A total Behavioural Scale score is obtained by summing individual behavioural item scores. The reliability of the Behavioural Scale was assessed using Cronbach alpha, a measure of internal consistency based on the average inter-item correlation. Alpha was

0.88 for the Behavioural Scale total score. The latter indicates satisfactory reliability for the Behavioural Scale.

4. Schema Questions - 8 items believed to represent specific ways in which cognitive schema can be disrupted through working with traumatised children (McCann & Pearlman, 1993). No normative data available although the view that "trauma disrupts fundamental beliefs about the self and world is consistent with a number of contemporary trauma theories" (McCann & Pearlman, 1993, p.29).
5. Impact of Events Scale-Revised (IES-R, Horowitz, 1979) - a 15 item scale devised to measure intrusive and avoidant responses to traumatic stress.
6. Hospital Anxiety and Depression Scale (HAD, Zigmond & Snaith, 1983) - a brief 14 item self report measure to detect the presence of clinical 'caseness' of anxiety and depression. A score of 8-10 is considered within the borderline range and scores of 11-14 deemed to be clinically significant.
7. Traumatic Stress Institute Autonomy and Connection Scales (TSI A&C Scales) (Stamm, Pearlman & Bieber, 1996) - a 28 item self report scale based on the longer TSI Belief Scale (Revision L) to measure disrupted cognitive schemas which arise from psychological trauma or from vicarious exposure to trauma material through psychotherapy or other helping relationships (Stamm & Pearlman, 1996). Overall reliability (Cronbach's alpha) is .98. Normative sample mean scores are available for mental health professionals (166.83), students (192.41), out-patients (227.08), and chronic patients (280.64). Higher scores are indicative of greater disruption to cognitive schema. Scores on the A&C Scale were pro-rated to make them comparable to normative data for the longer 80 item TSI Belief Scale by multiplying each participant's score by 80 and dividing by 28. Previous studies have used the TSI A&C

Scales to address schema disruption and the effect of being the emotional support provider for the victim of physical or sexual assault (Varra & Stamm, 1992).

8. Opt-in form for the follow-up telephone interview.

B. Follow-up telephone interviews were conducted to assess both positive and negative aspects of working with traumatised children and coping strategies used. The semi-structured interview used was based on: (a) the Structured Interview for Post-traumatic Stress Disorder (Figley, 1985); and (b) interviews conducted with personnel to determine coping strategies used before, during, and after their work with people who had died violently (McCarroll, Ursano, Wright & Fullerton, 1993).

Procedures

Ethical approval was obtained from Greater Glasgow Community and Mental Health Services NHS Trust to undertake this research. Permission was also gained from the Research and Development Department at Glasgow City Council Social Work Department, from the national headquarters of the helpline, and from senior nursing and medical staff at the paediatric hospital.

A pilot study was carried out in December 1998 on seven clinical psychology trainees who had completed child placements as part of their doctoral course in clinical psychology at the University of Glasgow. The latter were asked to complete all questionnaire measures. The IES-R was adapted following the pilot study to incorporate "*with respect to your work with traumatised children*" to direct participants to endorse work-related traumatic symptomatology.

Packs containing: (a) a letter inviting individuals to participate in the study, assuring them of anonymity, and informing them briefly of the aims of the research; (b) the main questionnaire; and (c) a resource list of organisations which could be contacted for support and advice, were distributed individually in sealed envelopes via subjects' place of work. Questionnaires were completed between January and March 1999. Participants were instructed to seal their completed surveys in self-addressed Freepost envelopes provided and return them directly to the researcher.

Follow-up telephone interviews were conducted between March and April 1999. A research assistant retained all opt-in forms separately from completed questionnaires and was responsible for contacting the participants by telephone. The research assistant informed the participant that in order to protect their anonymity the telephone interview would then be carried out by the main researcher.

RESULTS

Demographic and background variables

Appendix 4.2 provides a full description of participants' demographic and personal background details. Kruskal Wallis tests found a significant difference between the amount of chronic difficulties in the last 12 months by organisational group ($p=.009$). Post hoc Tamhane T2 tests found social workers demonstrated a significantly greater amount of chronic difficulties than helpline workers ($p=.014$). No other significant differences were evident between participants demographic and personal background details by organisational group ($p>.05$).

For the sample as a whole, 85.2% were female, ages ranged from the 20-25 years age band to the >60 years band (median age 31-35 years), and the median number of children was one. The median amount of support received at home by the total sample was rated as 'a considerable amount'. The majority of respondents had not received previous treatment by a psychologist/psychiatrist, and had no personal trauma within the last 12 months but had experienced personal trauma within their lifetime. A median of 'some' chronic difficulties and 'some' life events which most people would consider stressful were reported in the last 12 months.

Due to the constraints of anonymity it was not possible to make any comparison with the demographic or occupational characteristics of the non-responders.

Appendix 4.3 provides a full description of participants' work characteristics. Table 1 presents results of Kruskal Wallis tests of differences in participants' work characteristic variables by organisational group. Post hoc Tamhane T2 tests found helpline workers had significantly less number of hours per week working with traumatised children than social workers and hospital staff ($p=.019$ and $p=.000$ respectively). Helpline workers were also found to have significantly more support at work than hospital staff ($p=.011$). No other statistically significant differences were found between participants' work characteristic variables by organisational group ($p>.05$).

Insert Table 1

For the total sample, the number of years work experience ranged from <1 year to >30 years and the median value was 6-10 years. The number of years working with traumatised children also ranged from <1 year to >30 years but the median was only 1-5 years. On average, helpers had <5 hours exposure to traumatised children a week, had less than one week's training in the psychological effects of trauma, and 'a moderate amount' of support at work.

Hypothesis 1: Overall, levels of psychological morbidity in staff working with traumatised children will generally be below clinical threshold for 'caseness'.

Figure 1 shows the mean rank scores obtained by Kruskal Wallis tests on all questionnaire measures by organisational group.

Insert Figure 1

Table 2 presents the mean scores and standard deviations obtained by the group as a whole on questionnaire measures, results of Kruskal Wallis tests with questionnaire measures as the dependent variables and organisational group the independent variable, and post hoc pair-wise comparisons of significant results using Tamhane T2 tests.

Insert Table 2

Social workers obtained statistically higher mean scores than both helpline workers and hospital staff on all questionnaire measures with the exception of the A&C Scale. No significant differences were evident on dependent measures between helpline workers and hospital staff.

Figure 2 presents the percentage of participants in the total sample and by organisational group who scored in the 'high' distress range on the IES-R using Horowitz' (1982) criteria for 'high' (more than or equal to 19), 'medium' (more than 9), and 'low' (less than or equal to 9).

Insert Figure 2

As many as 61% of the total sample belonged to either the 'high' or 'medium' distress groups on the IES-R (57.2% helpline workers, 84.6% of social workers, and 40.5% hospital staff).

Figure 3 presents the percentage of participants who scored in the clinically significant range on the HAD Scale using Zigmond & Snaith's (1983) research criteria for inclusion of all possible 'cases' (i.e. either above the clinical threshold for 'caseness' or within the borderline range).

Insert Figure 3

23.9% of the pooled sample were found to demonstrate significant anxiety levels when only those cases which have a high probability of suffering from a mood disorder (i.e. a low probability of false positives) are included. Of these, 57.1% were social workers, 21.4% were hospital based staff, and 21.4% were helpline workers. Clinically significant depression scores were only obtained by 3.4% of the sample as a whole (5.3% of social workers and 5.4% of hospital based staff) when only those with a high probability of a mood disorder were included.

Figure 4 presents the mean A&C Scale scores obtained by the normative samples (Stamm, Pearlman & Bieber, 1996) and by the current sample (by organisational group).

Insert Figure 4

The overall group mean on the A&C Scale obtained in the current study was higher than the mental health professional normative sample, comparable to the students normative sample, and less than that obtained by outpatient and chronic patient normative samples.

Table 3 describes the percentage of participants who endorsed 'not at all/rarely' and 'sometimes/often' to the eight Schema Questions and results of Kruskal-Wallis tests (organisational group as the independent factor).

Insert Table 3

Post hoc comparisons by Tamhane T2 tests found social workers were significantly more likely to: feel isolated in their work than helpline and hospital staff (p=.000 and p=.004 respectively); be despairing at their own helplessness in preventing child abuse (p=.032) and to be more distrustful of other adults who come into close contact with children (p=.000) than hospital staff; and to be more suspicious of other people's motives than both helpline and hospital staff (p=.008).

(Refer to Appendix 4.4 for Spearman correlational analyses between questionnaire measures and the independent variables. Refer to Appendix 4.5 for results of Kruskal Wallis and Mann Whitney U Tests comparing questionnaire results by the independent variables of interest).

Hypothesis 2: The greater the exposure to traumatised children, the more severe the workers' STS symptoms.

No statistically significant results were found by Spearman correlational analyses or by Kruskal Wallis tests when amount of exposure, as assessed by 'hours per week' or by

'number of years working with traumatised children', was the independent variable and questionnaire measures the dependent variables.

Significant results were found by Spearman correlational analysis ($p<.05$) and by Kruskal Wallis test ($p=.044$) when the HAD Anxiety Scale was the dependent variable and 'number of years work experience' was the independent variable. A significant difference was also found between the 'number of years work experience' and the Behavioural Scale and the A&C Scale by Kruskal Wallis test ($p=.023$ and $p=.042$ respectively). No significant differences were found between the HAD Anxiety, the Behavioural Scale, or the A&C Scale and the 'number of years work experience' using post hoc Tamhane T2 tests ($p>.05$). Figure 5 presents the mean rank scores obtained by Kruskal Wallis Tests on the Behavioural Scale, the HAD Anxiety sub-scale, and the A&C Scale by 'number of years work experience'.

Insert Figure 5

Hypothesis 3: The more training in post-traumatic stress the worker has, the less severe the STS symptoms.

No statistically significant results were found by Spearman correlational analyses or by Kruskal Wallis tests when 'amount of training in the psychological effects of trauma' was the independent variable and questionnaire measures the dependent variables. Grouping factors were: (1) none, (2) <1 week, (3) 1-2 weeks, (4) 3-4 weeks, (5) >4 weeks. A trend towards statistical significance was, however, found on the Kruskal Wallis test between

the 'amount of training' and depression levels on the HAD Scale (p=.051). Mean ranks for the HAD Depression sub-scale were: (1) 54.22, (2) 67.93, (3) 56.94, (4) 21.0, (5) 47.26.

Hypothesis 4: The presence of previous traumatic histories and recent personal adversity in the workers lives will be associated with greater levels of STS.

'Previous treatment by a psychologist/psychiatrist' was negatively correlated with the Behavioural Scale and the A&C Scale ($p<.05$). Significantly higher mean rank scores on the Behavioural Scale and the A&C Scale were found by Mann Whitney U tests if participants had had previous treatment by a psychologist/psychiatrist (p=.008 and p=.049 respectively). Grouping factors for the analyses were: (1) yes, (2) no. Mean ranks for the Behavioural Scale were: (1) 74.21, (2) 49.67; and for the A&C Scale were: (1) 67.96, (2) 49.9.

Mann Whitney U tests found significantly higher mean rank scores on the Behavioural Scale (p=.026) and the HAD Anxiety and Depression sub-scales (p=.001 and p=.004 respectively) for participants who indicated they had experienced personal trauma in the last 12 months. Grouping factors for the analyses were: (1) yes, (2) no. Mean rank scores for the Behavioural Scale were: (1) 68.84, (2) 50.90; for the HAD Anxiety sub-scale were: (1) 69.6, (2) 48.0; and for the HAD Depression sub-scale were: (1) 67.07, (2) 49.4. Negative correlations between 'personal trauma in the last 12 months' were also obtained with the Behavioural Scale ($p<.05$) and Anxiety plus Depression levels on the HAD Scale ($p<.01$).

'Personal trauma within lifetime' was negatively associated with the Behavioural Scale and with HAD Anxiety and Depression measures ($p<.05$). Mann Whitney U tests found

significantly higher mean rank scores on the Behavioural Scale (p=.011) and HAD Anxiety and Depression sub-scales (p=.014 and p=.018 respectively) for participants who reported they had experienced 'personal trauma within lifetime'. Grouping factors for the latter analyses were: (1) yes, (2) no. Mean ranks for: the Behavioural Scale were: (1) 59.64, (2) 39.45; for the Anxiety sub-scale were: (1) 59.51, (2) 40.05; and for the Depression sub-scale were: (1) 59.36, (2) 40.7.

Significant differences were obtained between number of 'chronic difficulties' and the Behavioural Scale (p=.000), Anxiety (p=.001) plus Depression (p=.000) scores on the HAD Scale, and the A&C Scale (p=.010) by Kruskal Wallis tests. Grouping factors for the analyses were: (1) none, (2) some, (3) a moderate amount, (4) a considerable amount. Post hoc Tamhane T2 tests found significantly lower scores on the Behavioural Scale if participants had not had any chronic difficulties as opposed to some (p=.000), a moderate amount (p=.008), or a considerable amount (p=.013); significantly lower scores on the HAD Anxiety and Depression sub-scales by participants who had experienced no chronic difficulties as opposed to some chronic difficulties (p=.003 and p=.000 respectively); and significantly lower scores on the HAD Depression sub-scale by participants who experienced no chronic difficulties as opposed to a considerable amount (p=.047). Figure 6 presents the mean rank scores obtained by Kruskal Wallis tests on the Behavioural Scale, HAD Scale, and A&C Scale by number of 'chronic difficulties'.

Insert Figure 6

A trend towards statistical significance (p=.053) was found between 'chronic difficulties' and IES-R Avoidance scores by Kruskal Wallis test. Mean ranks for the latter were: (1) 52.09, (2) 61.59, (3) 59.81, (4) 85.63. A trend towards higher scores on the IES-R Avoidance sub-scale and a greater amount of chronic difficulties is evident. 'Chronic difficulties in the last 12 months' was positively correlated with the Behavioural Scale ($p<.01$), Avoidance plus Total scores on the IES-R ($p<.05$), Anxiety plus Depression scores on the HAD Scale ($p<.01$), and with the A&C Scale ($p<.01$).

Kruskal Wallis tests found significant differences between the number of 'life events' and the Behavioural Scale (p=.021), Anxiety scores on the HAD Scale (p=.000), and the A&C Scale (p=.013). Post hoc Tamhane tests only found significantly higher scores on the HAD Anxiety and Depression sub-scales if participants endorsed 'a moderate amount' as opposed to no life events (p=.030 and p=.014 respectively). Figure 7 describes the mean rank scores on the Behavioural Scale, the Anxiety sub-scale of the HAD Scale, and the A&C Scale by 'number of life events'.

Insert Figure 7

'Life events in the last 12 months which most people would consider stressful' was significantly correlated with the Behavioural Scale ($p<.01$), Avoidance/Intrusion/ & Total Scores on the IES-R ($p<.05$), with HAD Anxiety and Depression scores ($p<.01$), and with the A&C Scale ($p<.01$).

Hypothesis 5: The more supervision and support a worker receives, the less severe the STS.

Overall, 57.1% of participants failed, or were unable, to provide answers to the questions regarding the amount of general supervision and trauma related supervision they receive on a weekly basis. This variable was therefore discounted from further statistical analysis.

No statistically significant results were obtained by Spearman correlational analyses or by Kruskal Wallis tests when 'level of support...at work' was the independent variable and questionnaire measures the dependent variables.

Significant differences were found between the 'level of support...at home' and the Behavioural Scale ($p=.049$), IES-R Avoidance ($p=.006$) and Total ($p=.019$) scores, and with HAD Anxiety scores ($p=.023$) by Kruskal Wallis tests. Post hoc pair-wise comparisons by Tamhane T2 tests found significantly lower IES-R Avoidance scores for participants who indicated they had no social support at home as opposed to some ($p=.007$), a moderate amount ($p=.004$), or a considerable amount ($p=.001$); significantly lower IES-R Total scores for participants who endorsed none as opposed to some ($p=.017$), a moderate amount ($p=.011$), and a considerable amount ($p=.015$); and significantly higher scores on the HAD Anxiety scores by participants who had some rather than a considerable amount of social support at home ($p=.020$). Figure 8 presents the mean rank scores obtained by Kruskal Wallis tests on the Behavioural Scale, the Anxiety sub-scale of the HAD Scale, and the IES-R Avoidance and Total Scores by 'level of support at home'.

Insert Figure 8

'Level of social support...at home' was negatively correlated with the Behavioural Scale and with levels of HAD Anxiety and Depression measures ($p<.05$).

Table 4 presents results of the logistic regression analysis carried out in order to examine whether A&C Scale results could be predicted based on a combination of the independent variables. Questionnaire results were first converted into dichotomous variables ('caseness'/'non-caseness') with levels of 'caseness' indicated by scores more than 1 standard deviation above the total group mean. 'Personal trauma within lifetime' was excluded from the analysis due to high standard error (SE=28.62) detected on the first run.

Insert Table 4

None of the independent variables were found to contribute significantly on their own to A&C Scale scores when all independent variables were entered simultaneously although there was a trend towards significance for the 'amount of training in the psychological effects of trauma'.

Follow-up Telephone Interview Responses

Appendix 4.6 contains a full report of responses obtained to follow-up telephone interviews (and to the open-ended question on the main questionnaire about the effects of working with traumatised children). Cohen's kappa was used to measure the inter-rater agreement in the classification of responses to telephone interviews by two independent raters. Kappa value was 0.67 ($p<.000$) implying fair to good reliability in the classification of responses to telephone interviews (Fleiss, 1971).

Child sexual abuse constituted the type of trauma which most respondents (42.4%) found most difficult to deal with. Reasons why certain types of trauma are more difficult to deal with than others included: the impact the trauma had on the whole family (18.2%); adult betrayal/responsibility to prevent harm (15.2%); behaviour/feelings in the child (15.2%); feelings in the worker (15.2%); the powerlessness of the worker (15.2%); the helplessness of the child (12.1%); awareness of the long term damage (6.1%); and maliciousness on the part of the perpetrator (3%).

Overall, 65.5% (90% social workers, 55.6% hospital based staff, and 50% of helpline workers) reported they had seen people who were unable to function at work due to the type of work they were engaged in. Of these, 24.2% were reported to have left the field or engaged in a different type of work; 21.2% were upset/crying at work; 15.2% were stressed; 15.2% were de-skilled/their work impacted; 6.1% avoided appointments/the telephone, were burnt-out, or needed a break; and 3.0% were secretive/withdrawn or had impaired working relationships.

Making use of the team and debriefing opportunities were the main coping strategies used by all three organisational groups (50% helpline workers, 33.3% hospital staff, and 17.4% social workers). Social workers were as likely to make use of alcohol as they were to use debriefing opportunities to help them through rough spots whereas hospital workers' second main coping strategy involved compartmentalising/intellectualising.

Regarding how participants believed their outlook on life had changed as a result of their work with traumatised children, 22.2% of responses overall indicated that they had become more cynical and 22.2% that they were more judgemental, suspicious, and aware. A greater appreciation of family, friends, and life was stated by 13.3%.

Of those interviewed, 68% rated their anxiety levels as moderate and 9.7% perceived themselves as extremely anxious. Moderate levels of depression were reported by 41.9% and no depression at all was reported by 58.1%. Overall, 34.5% respondents had sleep onset problems and early morning wakening, 51.7% reported sleep maintenance problems, and 37.9% had nightmares 'sometimes/often'.

Intrusive thoughts 'sometimes/often' were reported by 56.7%. The latter related to case details (64.7%); thoughts about cases in relation to their own children, themselves, or to other people (29.4%); and thinking about violence (5.9%). Flashbacks to previously traumatic events were experienced by 42%. Of these, 83.3% were reported to be related to a case at work and 16.7% related to the respondent's own traumatic experience. Repeatedly checking windows and/or door locks in their home and startling easily 'sometimes/often' was reported by 28%. Difficulty remembering things was reported 'not at all' by 48.2% and 'sometimes/often' by 51.7%.

Losing interest in their job 'a considerable amount' was reported by 6.9% and 'a moderate amount by' 13.8%. All interviewees made a 'moderate' to 'considerable' effort to socialise with others.

Overall, respondents reported drinking alcohol a mean of 7 days a month (range 0-30) and typically drinking a modal 3-4 units at any one time. The majority did not report binges of heavy drinking (79.3%) and only one respondent stated they used any non-prescribed drugs (cannabis).

Family and friends were reported to be 'very supportive' although 27.6% stated they had difficulties communicating with their partners 'sometimes/ often'. Colleagues were reported to be 'supportive'.

Impacting positively on other peoples lives was the main rewarding aspect of their work with traumatised children (70.3%). Other rewarding aspects of their work included fun (8.1%); keeps you in touch, financial reward, and self-worth (all 5.4%); and recognition from colleagues and learning (both 2.7%).

Overall, 52.9% of participants completed the open-ended question on the main questionnaire regarding any effects working with traumatised children had on them both personally and professionally. The latter responses were combined with responses to the same question during follow-up telephone interviews and with responses to 'any other comments' provided in the follow-up telephone interviews. Responses obtained were predominantly negative. Figure 9 demonstrates the total number of negative and positive comments reported by respondents from each organisational group.

Insert Figure 9

DISCUSSION

The major focus of this study was on disrupted cognitive schemas arising from vicarious exposure to trauma material through helping relationships. No individual predictors of disrupted cognitive schemas were identified on the A&C Scale. Significant differences in A&C Scale scores were, however, found according to the presence of chronic difficulties and life events in the last 12 months, previous treatment by a psychologist/psychiatrist, and number of years work experience.

Consistent with previous studies (Bryant & Harvey, 1996; McFarlane, 1988), a general increase in psychological symptomatology was evident as the number of chronic difficulties and the number of life events increased. The latter could point to a non-specific stress/vulnerability effect in workers. Pre-existing psychological vulnerability has previously been found to be a risk factor for the development of post-traumatic symptomatology (McFarlane, 1988). Results from the current study indicate the same is true for the potential development of STS as 'previous treatment by a psychologist/ psychiatrist' was found to be associated with greater disruptions in schema and higher scores on the Behavioural Scale.

Trauma therapists with a personal trauma history have been shown to be more negatively affected than those without a personal trauma history (Pearlman & MacIan, 1995).

Trauma therapists with a personal trauma history have been shown to be more negatively affected than those without a personal trauma history (Pearlman & MacIan, 1995). Empirical evidence, however, has not consistently found a significant relationship between a personal trauma history and post-trauma symptoms (Elliott & Guy, 1993; Follette, Polusny & Milbeck, 1994). In the current study, personal trauma in the last 12 months and within the respondent's lifetime were not significantly associated with trauma symptoms or disrupted cognitive beliefs as a result of vicarious exposure to trauma. It may be that personal trauma history does not result in greater disruption to cognitive schema as helpers have integrated previous trauma into their schema. In so doing, they may subsequently be less likely to experience cognitive dissonance to the same extent as those without personal trauma upon exposure to more traumatic material at work. An inoculation effect may only be produced for those workers who successfully manage to accommodate their own traumatic experiences into their cognitive schema. Future research should investigate this hypothesis further.

A personal trauma history might also protect workers from disrupted cognitive beliefs due to a habituation effect. A habituation response in helpers could explain anecdotal reports on the follow-up telephone interviews of an increased ability to cope with working with traumatised children through more experience. A greater number of years work experience was significantly associated overall with lower anxiety levels. Evidence against a habituation effect, however, is the finding that exposure level, as measured by 'hours per week' and the 'number of years working with traumatised children', was not significantly related to any outcome measure.

relationship between exposure to traumatised children (as assessed by the 'number of years work experience') and symptomatology.

Levels of training and support at work were not significantly correlated with any outcome measure in the present study. Results are surprising given the recognition in the literature of the buffering effect of support and evidence which suggests that training and preparation are beneficial for those working in traumatic contexts (Paton & Stephens, 1996). More support at home was, however, associated with lower scores on the Behavioural Scale and the HAD Scale and to be significantly related to IES Avoidance and Total scores.

Within the disaster literature, more stress reactions have been documented in non-professional than professionals (Ersland, Weisaeth & Sund, 1989; Dyregrov, Kristoffersen & Gjestad, 1996). Helpline volunteers in the current study, however, displayed significantly less psychological distress than social workers in the field of child protection. All outcome measures were highest for social workers. The latter might be related to the more frequent use of negative coping strategies by social workers (whose second most frequent coping strategy was alcohol use). Maladaptive coping strategies and levels of personal stress have previously been found to be predictive of post-trauma symptoms (Follette, Polusny & Milbeck, 1994; McFarlane, 1988). It may also be that social workers experience more psychological difficulties due to the statutory demands placed upon them. In a study of the influence of the organisational environment on traumatic stress reactions, Paton & Smith (1998) suggest that staff reactivity may be exacerbated when administration procedures increase the amount of time spent in contact with the event and when organisational needs supersede staff needs.

According to Herman (1992, p.141), "just as no survivor can recover alone, no therapist can work with trauma alone" and an adequate support system is necessary to counter professional isolation and the possibility of serious errors. Social workers in the present study reported feeling the most isolated and the greatest need for more support. Social workers also reported a lack of resources to carry out their work, a lack of positive aspects about their work, a perception of working against the organisation, and a significantly greater amount of chronic difficulties. An alternative explanation for the greater symptomatology found in social workers could be that helpers in the other two organisations were under-reporting the deleterious effects of working with traumatised children. Lower scores obtained on questionnaire measure by hospital and helpline workers could be indicative of avoidance (a primary symptom of PTSD). Why did the helpers with the most psychological difficulties (i.e. social workers) not also have more disrupted schemas? It may be that working with traumatised children did not result in social workers' cognitive schemas being disrupted as they displaced the conflict between their personal cognitive schema and their experiences of trauma through their work onto the organisation instead.

A model of risk and protective factors for the development of STS reactions in those working with traumatised children, based on the current research study, and which suggests areas for future research is presented in Figure 10.

Insert Figure 10

Contrary to the opinion that workers emerge unscathed from exposure to trauma (Alexander, 1993), results from the current study support the view that working with traumatised populations does indeed represent a potential 'occupational hazard' (Pearlman & MacIan, 1995). Although workers in the present study reported a low modal number of hours exposure to traumatised children a week, a significant percentage were found to report significant psychological distress. (Refer to Appendix 4.7 for a comparison of IES total distress levels in the current sample with other empirical studies and to Appendix 4.8 for a comparison of mean IES sub-scale scores in the current sample with other research studies). The IES-R data for the current sample when viewed in the context of previous findings suggest that their mean scores are higher than trauma therapists without a trauma history, volunteer fire-fighters, and professional disaster workers (1 month post-disaster) but lower than voluntary disaster workers (1 month post-disaster) and disaster workers (2 weeks post-disaster) (Pearlman & MacIan, 1995; Bryant & Harvey, 1996; Dyregrov et al, 1996). Comparable with trauma therapists, workers in the current sample demonstrated equal levels of intrusion and avoidance symptoms whereas members of the South African Police and fire-fighters had greater avoidance than intrusive symptomatology and disaster workers evidenced more intrusion than avoidance (Kopel & Friedman, 1997; Johnsen, Eid, Lϕvstad & Michelsen, 1997; Dyregrov et al, 1996).

The present findings need to be interpreted in terms of several methodological considerations. There is a potential risk of a Type 1 error due to the number of comparisons made. The low response rate (23.99%) obtained means that findings should be generalised with caution. A previous study of vicarious traumatisation in therapists also yielded a low response rate (24% completed forms, Pearlman & MacIan, 1995) - the latter might reflect a need for workers to protect themselves from admitting to the deleterious

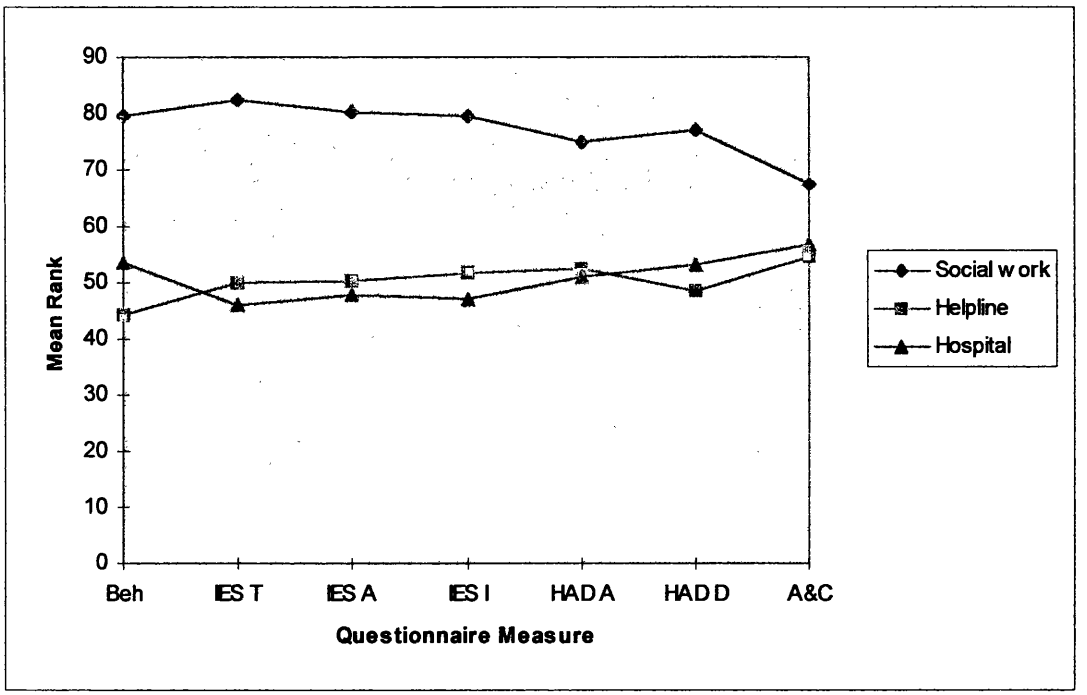
effects due to a socialisation process which dictates that they should be able to cope with the demands imposed by their work. Participants were a self-selected group and it is possible that the prevalence of STS symptoms was underestimated because non-participation in the study could be due to avoidance. Participation was also limited to an inner city area which may have biased results by excluding those working in more rural locations who may feel more isolated. The IES-R instructs items to be answered according to how frequently 'comments were true for you during the past seven days'. Extending the time frame would have permitted reports of less frequently experienced, albeit significant, symptoms that might be missed with the shorter sampling procedure. Future research using longitudinal assessments may illuminate changes according to accumulated experience/traumatic events. Frequent and adequate supervision has been recognised as an important professional coping strategy (Kirk, 1998). It was, however, not possible to comment on the role of supervision in the current study. The role of supervision merits further investigation.

There is clearly a need to further define the extent and type of potential effects of STS on those working with traumatised populations and to construct clear operational definitions of STS in order that further empirical studies can further elucidate the risk and protective factors involved. It is also suggested that we also need to determine the time course of STS given the recognition in the trauma literature of the potentially long term nature of traumatic stress reactions (McFarlane, 1986; Kulka et al, 1990).

Table 1: Comparisons of Work Characteristic Variables by Organisational Group

	Mean Rank			X^2	D.F.	Asymp. Sig.
	Helpline	Social Work	Hospital			
No. of years work experience	50.11	56.07	71.53	8.68	2	.013
No. of years working with traumatised children	43.72	55.47	67.53	9.03	2	.011
Hours per week (working with traumatised children)	39.72	55.47	67.53	17.32	2	.000
Support at work	69.57	58.04	47.01	9.56	2	.008

Figure 1: Mean Rank Scores (By Kruskal Wallis Tests) On All Questionnaire Measures By Organisational Group



KEY:

Beh	-	Behavioural Scale
IES T	-	IES-R Total
IES A	-	IER-R Avoidance sub-scale
IES I	-	IES-R Intrusion sub-scale
HAD A	-	HAD Anxiety sub-scale
HAD D	-	HAD Depression sub-scale
A&C	-	A&C Scale

Table 2: Questionnaire Results For The Total Group & Comparisons Of Questionnaire Results By Organisational Group

		Kruskal Wallis Tests	*Post Hoc*	*Tamhane Tests*
	Mean (S.D.)	X^2 D.F. Asymp. Sig.	Mean Difference *(Social work-Helpline)* Sig.	Mean Difference *(Social work-Hospital)* Sig.
Behavioural Scale	39.19 (9.15)	23.36 2 .000	9.55 .000	6.99 .002
IES-R: Avoidance	7.73 (8.58)	22.49 2 .000	7.12 .000	6.55 .005
IES-R: Intrusion	8.81 (8.17)	20.59 2 .000	7.02 .000	6.97 .001
IES-R: Total	16.54 (15.54)	26.79 2 .000	14.14 .000	13.52 .001
HAD: Anxiety	7.87 (4.10)	11.91 2 .003	2.37 .020	2.38 .028
HAD: Depression	3.91 (3.16)	16.01 2 .000	2.66 .000	1.97 .033
A&C Scale	195.39 (45.92)	3.26 2 .196	-	-

Figure 2: Percentage of Participants Scoring in 'High' Range on IES-R

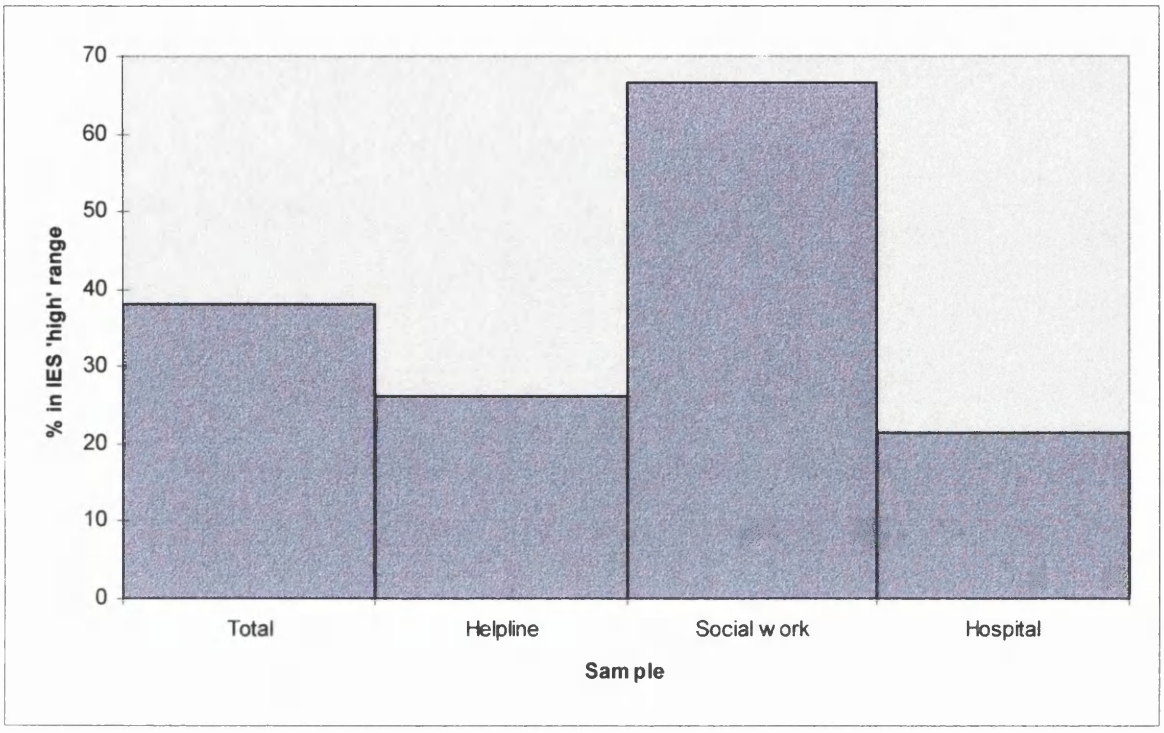


Figure 3: Percentage of Participants Scoring Clinically Significant Levels Of Anxiety and Depression on the HAD Scale (using research criteria to detect all possible 'cases')

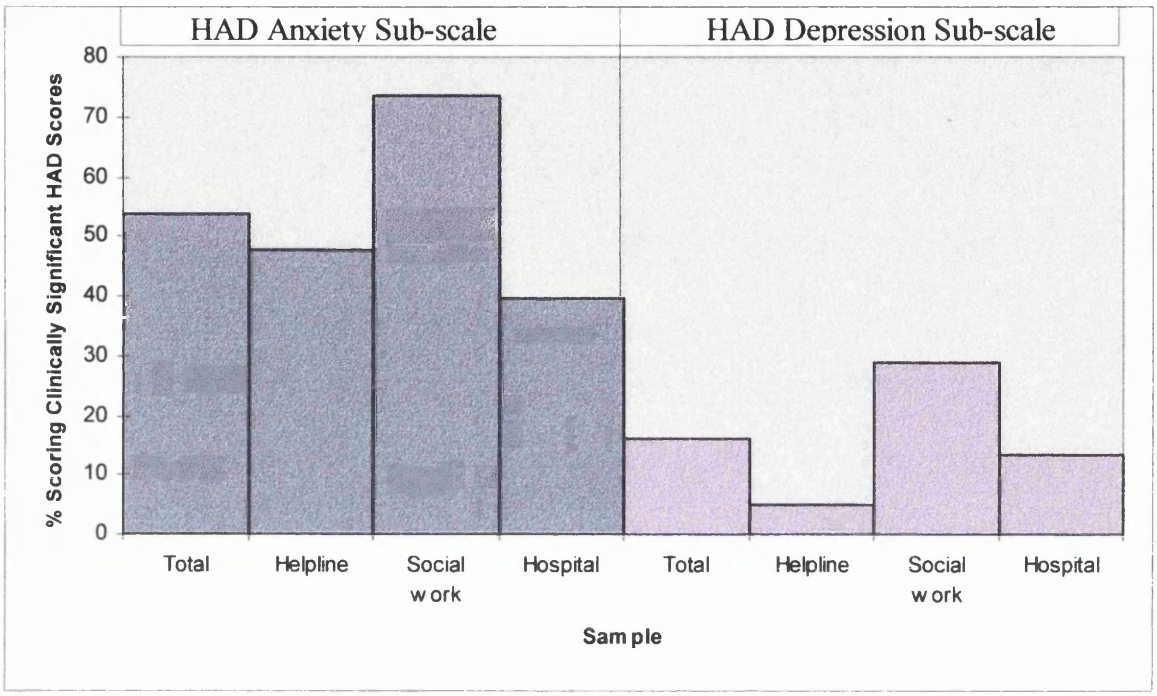


Figure 4: A&C Scale - Normative Sample Mean Scores & Current Study Mean Scores for the Total Sample and by Organisational Group

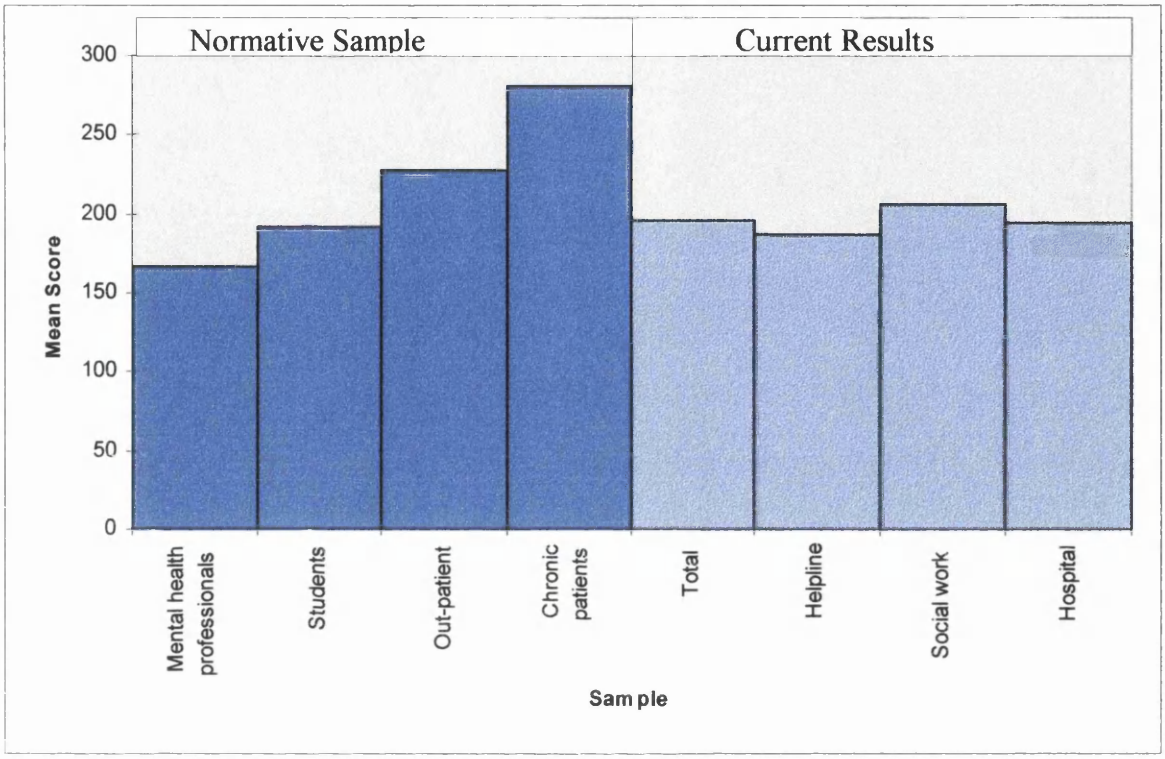


Table 3: Questionnaire Responses By The Total Sample To Schema Questions & Kruskal Wallis Tests Results (by Organisational Group)

	Not at all/ Rarely	Sometimes/ Often	Mean Rank			X^2	DF	Asymp. Sig.
			Helpline	*Social Work*	*Hospital*			
Fearing your own children will be molested	70.6%	29.4%	45.33	47.45	35.80	4.03	2	.134
Suspicious of other peoples' motives	54.8%	45.2%	50.95	71.42	51.29	10.73	2	.005
Distrustful of other adults who come into close contact with children	57.1%	42.8%	55.42	71.92	41.82	17.36	2	.000
Despairing at your own helplessness in preventing child abuse	60.1%	39.8%	55.01	67.72	48.54	6.95	2	.031
Restricting your own children's independence because of the risk of child abuse	81.3%	18.8%	36.93	46.13	38.78	2.92	2	.232
Losing belief in the benevolence of other people or the world	64.2%	35.9%	55.54	68.77	52.54	5.51	2	.064
Feeling isolated in your work	60.0%	40.0%	47.16	74.59	52.68	15.94	2	.000
Preoccupied with why there is so much cruelty in the world and why adults perpetrate violence on children	68.1%	31.9%	56.11	66.72	52.42	4.21	2	.122

Figure 5: Comparison of Significant Results (by Kruskal Wallis Tests) on Questionnaire Measures by 'Number of Years Work Experience'

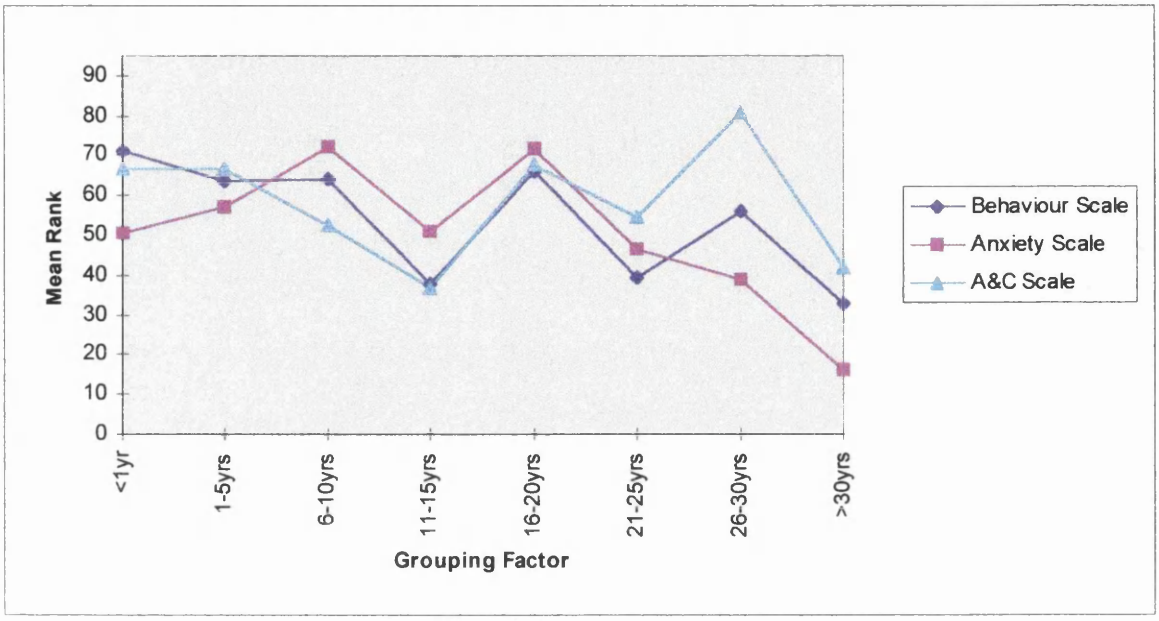
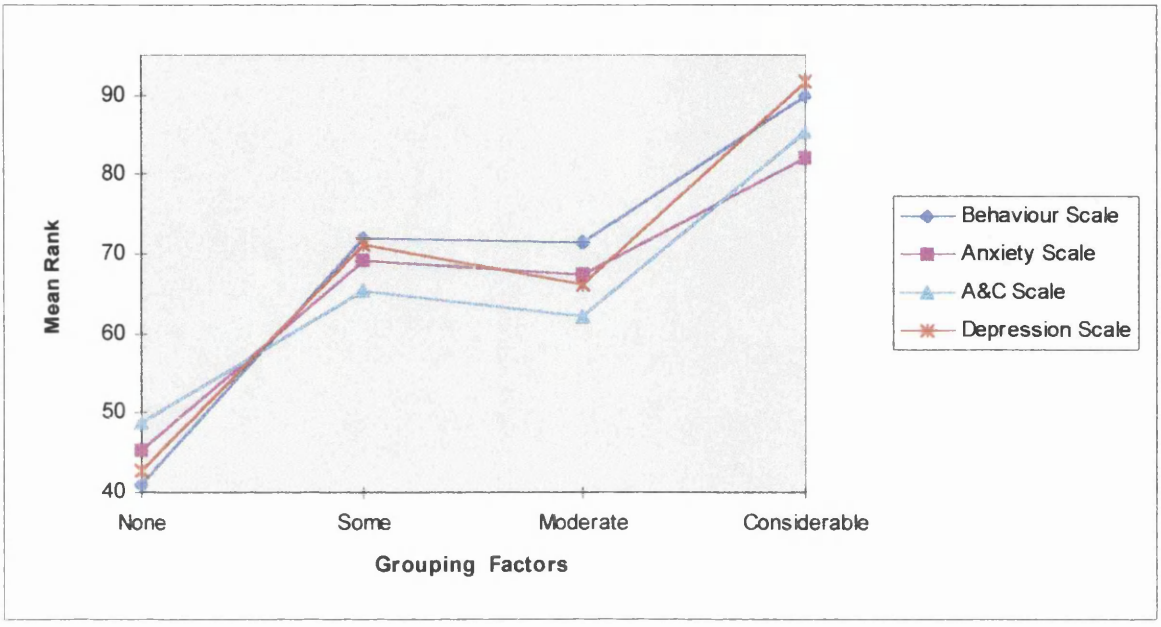


Figure 6: Comparison of Significant Results (by Kruskal Wallis Tests) on Questionnaire Measures By 'Number of Chronic Difficulties'



Unclear

Figure 7: Comparison of Significant Results (by Kruskal Wallis Tests) on Questionnaire Measures By 'Number of Life Events'

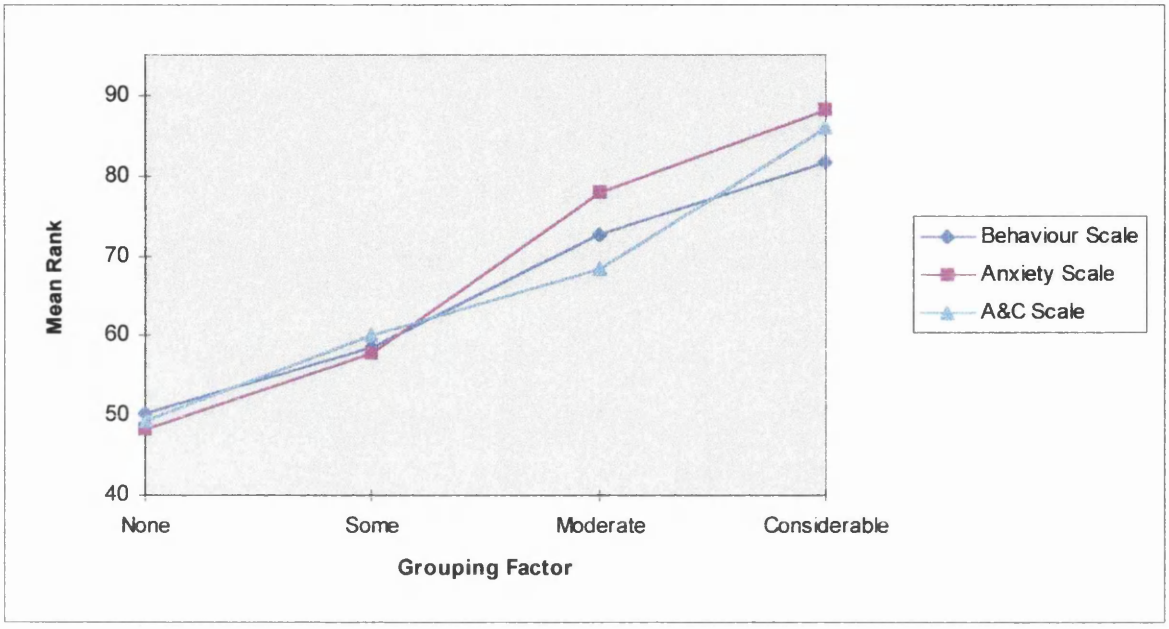


Figure 8: Comparison of Significant Results (by Kruskal Wallis Tests) on Questionnaire Measures By 'Level of Support at Home'

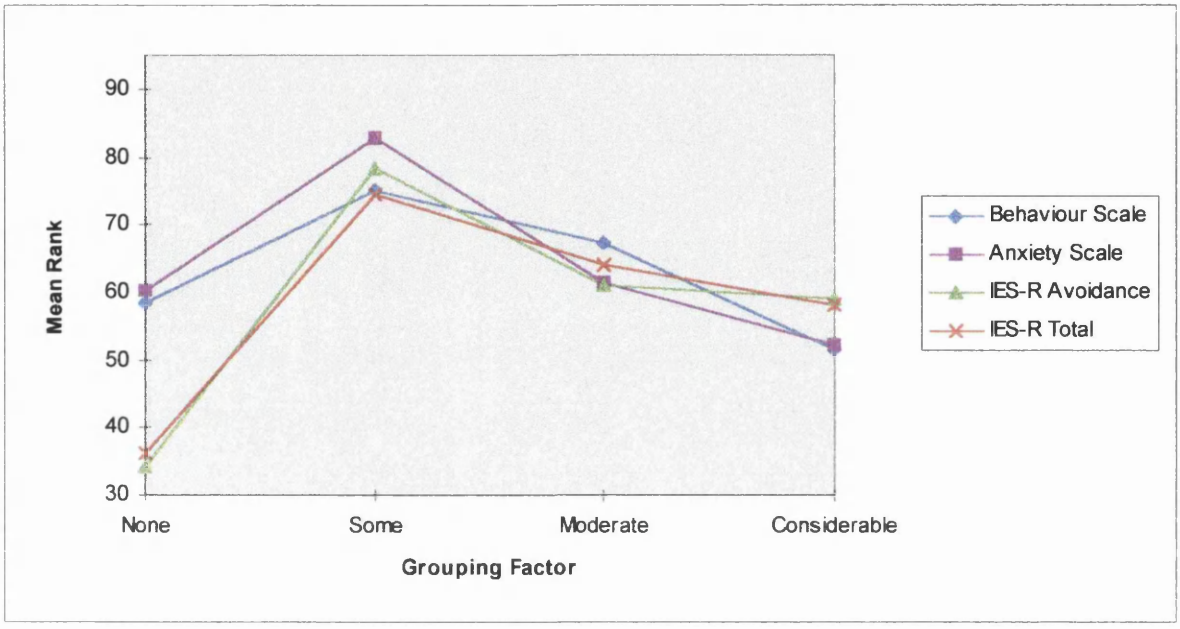


Table 4: Predictors of A&C Scale Results in Total Group

Logistic Regression Analysis							
Predictor Variable	***B***	***S.E.***	***Wald***	***D.F.***	***Sig.***	***R***	***Exp(B)***
Hours per week	-.065	.375	.030	1	.862	.000	.937
Training	.418	.226	3.42	1	.064	.129	1.52
Personal trauma in last 12 months	.526	.729	.521	1	.470	.000	1.69
Chronic difficulties	-.122	.443	.076	1	.783	.000	.885
Life Events	-.776	.444	3.06	1	.080	-.112	.460
Support at home	.169	.322	.273	1	.601	.000	1.18
Support at work	.172	.376	.209	1	.647	.000	1.19
Years work experience	-.113	.222	.260	1	.609	.000	.893
Years working with traumatised children	.497	.369	1.81	1	.179	.000	1.64
Previous treatment by a psychologist/ psychiatrist	1.04	.821	1.60	1	.206	.000	2.83
Constant	-2.51	2.99	.703	1	.402		

Figure 9: Number of Negative and Positive Comments made about Working with Traumatised Children

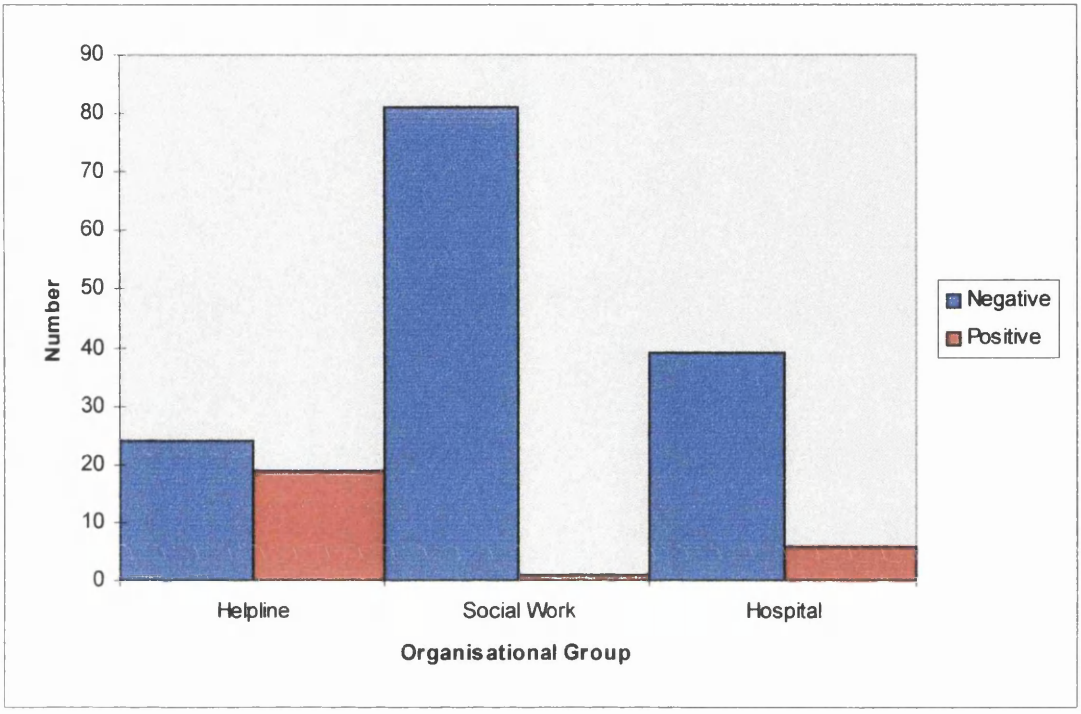
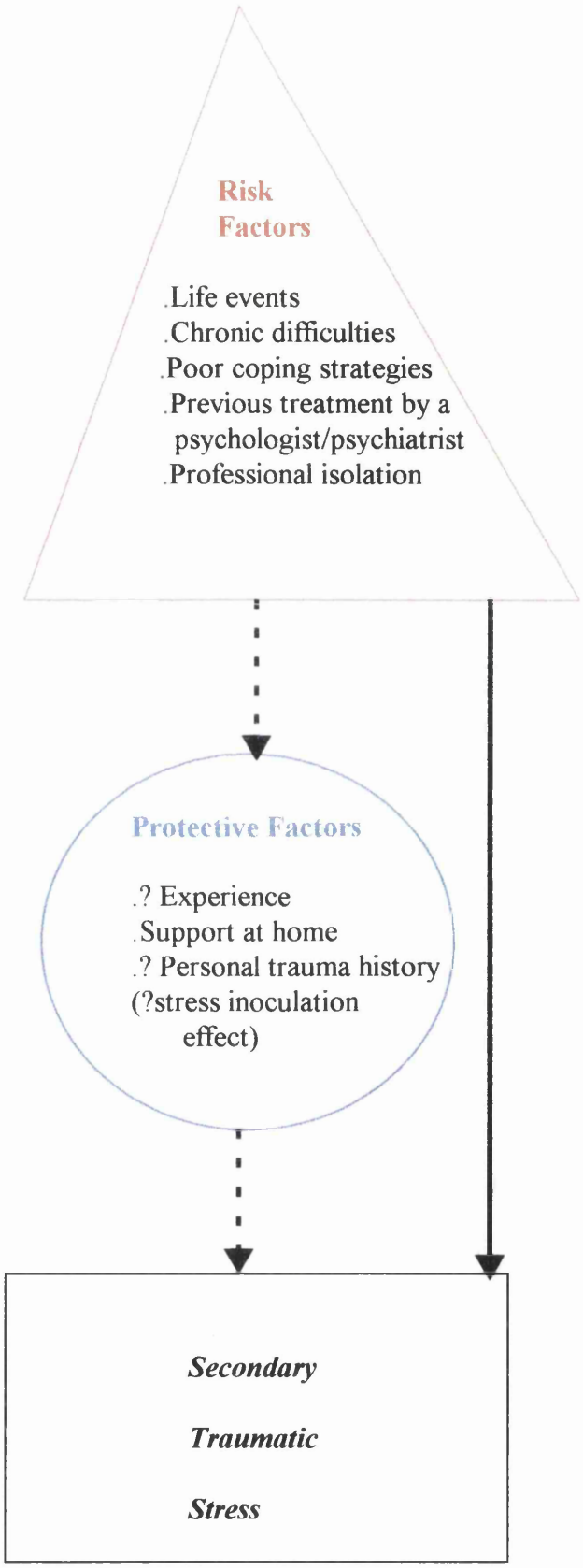


Figure 10: Risk & Protective Factors For STS



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Single Clinical Case Research Study 1 (Abstract)

Challenging Therapy: Cognitive-Behavioural Therapy (CBT) with a Client with Mild Mental Retardation

prepared for submission to the *American Journal on Mental Retardation*

ABSTRACT

Empirical evidence is now growing in favour of cognitive behavioural therapy (CBT) in the treatment of psychological problems for individuals with mental retardation (Stenfert Kroese, 1997). The current single case report documents the application of cognitive behavioural techniques (namely: self-monitoring, distraction, cognitive restructuring, relaxation training, visual prompting, and role play) with a client with mild mental retardation. A statistically significant reduction in the total number of behaviour problems reported by carers was found pre- and post-intervention. Some of the challenges of a cognitive behavioural approach with this client group are highlighted and the importance of carers in implementing psychological interventions with this population is discussed.

Single Clinical Case Research Study 2

A Rapid Exposure Treatment Approach To School Refusal (Abstract)

prepared for submission to the *Journal of the American Academy of Child & Adolescent Psychiatry*

A Rapid Exposure Treatment Approach To School Refusal

ABSTRACT

The present single case study describes the use of a behavioural approach in the treatment of school refusal in an adolescent male referred to a community adolescent psychiatric team. A multi-method assessment procedure was carried out and a rapid exposure (flooding) treatment programme implemented. The adolescent initially complied with the behavioural programme but relapsed once an expectation was put upon him to maintain progress. Reasons for the failure of the behavioural approach to maintain behaviour change, in contrast with successes documented within the literature, are discussed. Suggestions are made to enhance a behavioural management strategy for school refusal.

Keywords: school refusal, behavioural treatment, rapid exposure (flooding), maintenance

Single Clinical Case Research Study 3

Assessment & Treatment of ADHD in a Child with Chronic Illness

(Abstract)

prepared for submission to *Clinical Child Psychology and Psychiatry*

Assessment & Treatment of ADHD in a Child with Chronic Illness

ABSTRACT

The Child Behaviour Checklist (CBCL) is a commonly used rating scale of psychosocial functioning of children and has been posited as a useful tool for identifying cases of attention deficit hyperactivity disorder (ADHD) (Biederman et al, 1993). No previous reports in the literature have reported on the suitability of the CBCL in the assessment of ADHD in the context of chronic illness (namely, cystic fibrosis) or documented the treatment efficacy of a brief psychological intervention for children with ADHD and chronic/terminal illness. Multi-modal assessment and diagnosis of ADHD (incorporating the CBCL) plus a brief psychological intervention in a 7 year old child with cystic fibrosis led to a clinically significant reduction in behaviour problems reported by the child's teacher on the CBCL and to a verbally reported reduction in behaviour problems by the child's mother. Maternal reports of behaviour improvements post-intervention were not, however, reflected in CBCL measures. Possible causal explanations for the discrepancies found between maternal and teacher reports of behavioural problems using the CBCL and the effectiveness of the brief psychological intervention for the treatment of ADHD are discussed.

KEY WORDS: Cystic fibrosis, chronic illness, attention deficit-hyperactivity disorder, Child Behaviour Checklist (CBCL)

Appendix 1.1

Copy of 'Health Bulletin' Notes for Contributors

Notes for Contributors
Papers, articles and other contributions should be sent to the Editor, Health Bulletin, Scottish Office Department of Health, Room 143, St Andrew's House, Edinburgh EH1 3DE. They must be submitted exclusively for Health Bulletin. Acceptance is on the understanding that editorial revision may be necessary. All papers are reviewed by the Editor and by peer review, referees being drawn from a panel of appropriate professionals in the NHS in Scotland. No correspondence can be entered into about articles found unsuitable and returned to authors.

Material submitted for publication must be typewritten on one side of the paper only in double spacing and with adequate margins and each page should be numbered. The top typed copy should be submitted, with four other copies. All papers should be prefaced by a structured Abstract of about 250 words in length. It should normally contain 6 clearly headed sections entitled Objective, Design, Setting, Subjects, Results and Conclusion. The name, appointment, and place of work of the authors should be supplied on a separate title page. This same page should include the full postal address of one author, to whom correspondence and reprints will be directed. There should be adequate references to any relevant previous work on the subject: these references should appear at the end of the material on a separate page or pages, using the Vancouver style, which in the case of papers in journals includes:

Surname and initials of author(s)
Title of paper
Full name of Journal
Year published
Volume number
Opening and closing page numbers

Reference to books should similarly include author's name and initials, full title, edition (if necessary), place of publication, publisher's name, year, and if required volume number, chapter number or page number.

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Proofs
Contributors will receive one set of proofs. It should be read carefully for printer's errors, and any tables, figures and legends should be checked. Alterations should be kept to a minimum, and the proofs should be promptly returned.

Reprints
One hundred reprints will be supplied free of charge. A limited extra number (for which a charge will be made) may be ordered from the Editor when the proofs are returned.

Appendix 1.2

Structured Telephone Interview

1. Had the clinician sought consultation with a clinical child psychologist before this episode?
   a. Yes - Yorkhill community services
   b. Yes - Yorkhill hospital based services
   c. Yes - Clinical child psychology services other than Yorkhill
   d. No

2. How easy was it for the clinician to access the clinical child psychologist?
   a. Easy - the clinician was able to access the clinical child psychologist rapidly
   b. Acceptable - access was within an acceptable time frame
   c. Difficult - access was not within an acceptable time frame (if difficult, would it deter them from trying to consult with clinical child psychology again? Yes/No)

3. If consultation with the clinical child psychologist had not been available would the clinician have:
   a. made a formal referral to clinical child psychology and continued managing the case
   b. made a formal referral to clinical child psychology and closed the case
   c. made a formal referral to another service and continued managing the case (if so, to whom)
   d. made a formal referral to another service and closed the case (if so, to whom)
   e. sought advice from another source (if so, which one)
   f. continued to manage the case by themselves

4. Did the clinician feel the advice they were given was appropriate to the case concerned?
   a. Very appropriate
   b. Appropriate
   c. Inappropriate

5. Did the clinician feel they were listened to?
   a. Yes
   b. No

6. Did the clinician feel they were taken seriously?
   a. Yes
   b. No

7. Were the clinician's questions answered?
   a. Fully
   b. Partially
   c. Not at all

8. What was the outcome of the consultation?
   a. Formal referral to clinical child psychology
   b. Referral to another service (if so, which one?)
   c. Advice only
   d. Clinical child psychologist attending case discussion with/without formal referral to clinical child psychology
   e. Joint appointment with clinician & clinical child psychologist with/without formal referral to clinical child psychology

9. How useful did the clinician find the consultation opportunity?
   a. Very useful
   b. Useful
   c. Not useful

10. What specifically did the clinician find most useful about the consultation opportunity?
   a. Specific cognitive-behavioural advice
   b. Feeling supported by a colleague
   c. Opportunity to discuss issues surrounding the case
   d. Fresh insight into the case
   e. Other (specify...)

11. Was the length of the consultation:
   a. Too short
   b. About right
   c. Too long

12. Did the clinician find the advice given applicable to other cases?
   a. Highly applicable
   b. Applicable
   c. Inapplicable

13. Has the clinician used the consultation opportunity again?
   a. Yes
   b. No

14. Would the clinician use the consultation opportunity again?
   a. Yes
   b. No (if not, why not?)

15. How did the clinician learn about the opportunity to consult with the clinical child psychologist?
   a. Through a fellow community team member (different profession)
   b. Through a fellow professional (i.e. same profession)
   c. Through contact with Yorkhill hospital based clinical child psychology services
   d. Through contact with Yorkhill community based clinical child psychology services
   e. Other (specify...)

16. Any additional comments.....
.....
.....
.....
.....

Appendix 2.1

Copy of the 'Journal of Traumatic Stress' Instructions to Contributors

Instructions to Contributors

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

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

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

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

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

3. Type double-spaced on one side of 8½ x 11 inch or A4 white paper using generous margins on all sides and a font no smaller than 10-point, and submit the original and three copies (including copies of all illustrations and tables).

4. A title page is to be provided and should include the title of the article, author's name (no degrees), author's affiliation, acknowledgements, 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 form thereof. Also include the *word count*, the complete mailing address and telephone number for the corresponding author during the review process, and, if different, a name and address to appear in the article footnotes for correspondence after publication.

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

6. A list of 4-5 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.

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. Centre the title above the table, and type explanatory footnotes (indicated by superscript lowercase letters) below the table.

9. List references alphabetically at the end of the paper and refer to them in the text by name and year in parentheses. In the text, all 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 references should conform to strict APA style illustrated by the following examples (however, use indentation below):

Journal Article

Frederich, W.N., Urquiza, A.J., & Beikle, R.I. (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. 481-485) New York: Plenum Press.

10. Footnotes should be avoided. When there 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 1994 *Publication Manual* of the American Psychological Association (Fourth Edition)**, and it is suggested that contributors refer to this publication.

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

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Appendix 3.1

Main Questionnaire

SURVEY OF PROFESSIONALS WORKING WITH CHILDREN

Please indicate your consent to participate in this survey by placing a tick in the appropriate box below:

☐ YES - I have read the letter from the researcher explaining the purpose of the survey and consent to participate in the survey of professionals working with children.

☐ NO - I do not consent to participate in the survey of professionals working with children

All information contained within these questionnaires will be treated with the strictest confidentiality and will be assessed by the research psychologist only. No information will be passed on to your employer. Please circle or write in the relevant answer in the space provided.

BACKGROUND INFORMATION

Sex: Male/Female Age: ___ No. of children: ___ Occupation: _____
Marital Status: _____ Number of years training: ___ Number of years work experience: ___
Number of years training in the psychological effects of trauma: ___
Number of hours per week of: (a) general supervision: ___ (b) trauma-related supervision: ___
Number of years working with traumatised children: ___
Number of hours per week working with traumatised children: ___
What is the nature of the children's trauma:_____
Have you experienced personal trauma(s) within the last 12 months?: Yes/No
(If 'Yes' what was the nature of your personal trauma(s)? _____)
Have you experienced personal trauma(s) within your lifetime?: Yes/No
(If 'Yes' what was the nature of your personal trauma(s)? _____)
Have you had previous treatment by a psychologist/psychiatrist? Yes/No
Have you suffered chronic difficulties during the last 12 months which have effected you personally/ professionally (e.g. chronic illness, financial difficulties...)?:
None/ Some/ A moderate amount/ A considerable amount
Have you suffered any serious life events during the last 12 months which most people would consider stressful (e.g. divorce, bereavement...)?: None/ Some/ A moderate amount/ A considerable amount
Perceived level of social support you have at home:
None/ Some/ A moderate amount/A considerable amount
Perceived level of support you have at work: None/ Some/ A moderate amount/A considerable amount

BEHAVIOUR SCALE

Do you find yourself:

- talking excessively or talking less: Not at all/ Rarely/ Sometimes/ Often
- withdrawing from others company: Not at all/ Rarely/ Sometimes/ Often
- withdrawing from activities: Not at all/ Rarely/ Sometimes/ Often
- undereating or overeating: Not at all/ Rarely/ Sometimes/ Often
- having relationship problems: Not at all/ Rarely/ Sometimes/ Often
- having a decreased sexual appetite: Not at all/ Rarely/ Sometimes/ Often
- drinking alcohol excessively: Not at all/ Rarely/ Sometimes/ Often
- using drugs excessively: Not at all/ Rarely/ Sometimes/ Often
- feeling more vulnerable: Not at all/ Rarely/ Sometimes/ Often
- working late: Not at all/ Rarely/ Sometimes/ Often
- taking on too much work: Not at all/ Rarely/ Sometimes/ Often
- talking to yourself in a critical way: Not at all/ Rarely/ Sometimes/ Often
- needing more sick days: Not at all/ Rarely/ Sometimes/ Often
- thinking about a change in career direction: Not at all/ Rarely/ Sometimes/ Often
- avoiding hearing about other traumatic problems: Not at all/ Rarely/ Sometimes/ Often
- feeling more irritable: Not at all/ Rarely/ Sometimes/ Often
- feeling more impatient: Not at all/ Rarely/ Sometimes/ Often

SCHEMA QUESTIONS

- fearing your own children will be molested: Not at all/ Rarely/ Sometimes/ Often
- suspicious of other peoples motives: Not at all/ Rarely/ Sometimes/ Often
- distrustful of other adults who come into close contact with children: Not at all/ Rarely/ Sometimes/ Often
- despairing at your own helplessness in preventing child abuse: Not at all/ Rarely/ Sometimes/ Often
- restricting your own children's independence because of the risk of child abuse: Not at all/ Rarely/ Sometimes/ Often
- losing belief in the benevolence of other people or the world: Not at all/ Rarely/ Sometimes/ Often
- feeling isolated in your work: Not at all/ Rarely/ Sometimes/ Often
- preoccupied with why there is so much cruelty in the world and why adults perpetrate violence on children: Not at all/ Rarely/ Sometimes/ Often

INSTRUCTIONS: 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 your work with traumatised children.* If they did not occur during that time, please mark the "not at all" column.

	Not at all	*Rarely*	*Sometimes*	*Often*
1. I thought about it when I didn't mean to	☐	☐	☐	☐
2. I avoided letting myself get upset when I thought about it or was reminded of it	☐	☐	☐	☐
3. I tried to remove it from my memory	☐	☐	☐	☐
4. I had trouble falling asleep or staying asleep because of thoughts about it that came into my mind	☐	☐	☐	☐
5. I had waves of strong feeling about it	☐	☐	☐	☐
6. I had dreams about it	☐	☐	☐	☐
7. I stayed away from reminders of it	☐	☐	☐	☐
8. I felt as if it had not happened or it was not real	☐	☐	☐	☐
9. I tried not to talk about it	☐	☐	☐	☐
10. Pictures about it popped into my mind	☐	☐	☐	☐
11. Other things kept making me think about it	☐	☐	☐	☐
12. I was aware that I still had a lot of feelings about it, but I did not deal with them	☐	☐	☐	☐
13. I tried not to think about it	☐	☐	☐	☐
14. Any reminder brought back feelings about it	☐	☐	☐	☐
15. My feelings about it were rather numb	☐	☐	☐	☐

INSTRUCTIONS: Read each item and place a firm tick in the box opposite the reply which comes closest to how you have been feeling in the past week. Don't take too long over your replies: your immediate reaction to each item will probably be more accurate than a long thought out response.

1. I feel tense or 'wound up'
Most of the time ☐
A lot of the time ☐
From time to time, occasionally ☐
Not at all ☐

2. I still enjoy the things I used to enjoy
Definitely as much ☐
Not quite so much ☐
Only a little ☐
Hardly at all ☐

3. I get a sort of frightened feeling as if something awful is about to happen
Nearly all the time ☐
Very often ☐
Sometimes ☐
Not at all ☐

4. I can laugh and see the funny side of things
As much as I always could ☐
Not quite so much now ☐
Definitely not so much now ☐
Not at all ☐

5. Worrying thoughts go through my mind
A great deal of the time ☐
A lot of the time ☐
From time to time but not too often ☐
Only occasionally ☐

6. I feel cheerful
Not at all ☐
Not often ☐
Sometimes ☐
Most of the time ☐

7. I can sit at ease and feel relaxed
Definitely ☐
Usually ☐
Not often ☐
Not at all

8. I feel as if I am slowed down
Very often indeed ☐
Quite often ☐
Not very often ☐
Not at all ☐

9. I get a sort of frightened feeling like 'butterflies' in the stomach
Not at all ☐
Occasionally ☐
Quite often ☐
Very often ☐

10. I have lost interest in my appearance
Definitely ☐
I don't take as much care as I should ☐
I may not take quite as much care ☐
I take just as much care as ever ☐

11. I feel restless as if I have to be on the move
Very much indeed ☐
Quite a lot ☐
Not very much ☐
Not at all ☐

12. I look forward with enjoyment to things
As much as I ever did ☐
Rather less than I used to ☐
Definitely less then I used to ☐
Hardly at all ☐

13. I get sudden feelings of panic
Very definitely and quite badly ☐
Yes, but not too badly ☐
A little, but it doesn't worry me ☐
Not at all ☐

14. I can enjoy a good book or radio or TV programme
Often ☐
Sometimes ☐
Not often ☐
Not at all ☐

PTO

INSTRUCTIONS: 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 check each item and tick the box scale which you feel most closely matches your own beliefs about yourself and your world. Try to complete every item.

	Disagree Strongly	*Disagree*	*Disagree Somewhat*	*Agree Somewhat*	*Agree*	*Agree Strongly*
1. I can comfort myself when I'm in pain	☐	☐	☐	☐	☐	☐
2. I feel empty when I am alone	☐	☐	☐	☐	☐	☐
3. I enjoy my own company	☐	☐	☐	☐	☐	☐
4. People shouldn't place too much trust in their friends	☐	☐	☐	☐	☐	☐
5. I can't stand to be alone	☐	☐	☐	☐	☐	☐
6. For the most part, I can protect myself from harm	☐	☐	☐	☐	☐	☐
7. I am my own best friend	☐	☐	☐	☐	☐	☐
8. I look forward to the time I spend alone	☐	☐	☐	☐	☐	☐
9. Strong people don't need to ask others for help	☐	☐	☐	☐	☐	☐
10. Trusting other people is generally not very smart	☐	☐	☐	☐	☐	☐
11. I have sound judgement	☐	☐	☐	☐	☐	☐
12. People who trust too much are foolish	☐	☐	☐	☐	☐	☐
13. I feel confident in my decision making ability	☐	☐	☐	☐	☐	☐
14. I can usually size up situations pretty well	☐	☐	☐	☐	☐	☐
15. I don't feel like I deserve much	☐	☐	☐	☐	☐	☐
16. I have a lot of bad feelings about myself	☐	☐	☐	☐	☐	☐
17. You can't trust anyone	☐	☐	☐	☐	☐	☐
18. I feel good about myself most days	☐	☐	☐	☐	☐	☐
19. Mostly, I don't feel like I'm worth much	☐	☐	☐	☐	☐	☐
20. I often feel cut off and distant from other people	☐	☐	☐	☐	☐	☐
21. I don't experience much love from anyone	☐	☐	☐	☐	☐	☐
22. Even when I'm with other people, I feel alone	☐	☐	☐	☐	☐	☐
23. I can depend on my friends to be there when I need them	☐	☐	☐	☐	☐	☐
24. I feel out of touch with people	☐	☐	☐	☐	☐	☐
25. Most people are basically good at heart	☐	☐	☐	☐	☐	☐
26. Most people don't keep the promises they make	☐	☐	☐	☐	☐	☐
27. I feel bad about myself when I need other's help	☐	☐	☐	☐	☐	☐
28. I often doubt myself	☐	☐	☐	☐	☐	☐

Please provide your name and a contact telephone number if you would be willing to take part in a short follow-up telephone interview:

Name : _____
Convenient Telephone Number : _____
Convenient Contact Times : Day(s)_____
Time(s)_____

Thank-you for your co-operation.

Appendix 3.2

Letter to participants

Academic Centre
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH

[Insert date & address]

Dear Sir/Madam

Re. Survey of Professionals Working with Children

I am currently carrying out the above research study in part fulfilment of the Doctorate Course in Clinical Psychology at the University of Glasgow. The research aims to examine the potential impact on professionals and non-professionals of providing services to traumatised children.

I would be grateful if you would agree to participate in the research study by completing the enclosed questionnaire. Participation in the research study is voluntary and all responses are strictly confidential to the research psychologist and will not be divulged to your employer. Ethical approval of the project has been obtained from Greater Glasgow Community & Mental Health Services NHS Trust. I would be grateful if you could complete the enclosed questionnaires and return them to me directly at the Freepost address in the envelope provided. It is anticipated that about twenty minutes will be required to complete all questionnaires. If you are also agreeable to taking part in a follow-up telephone interview then please complete the opt-in form at the end of the questionnaires. Please feel free to contact me at the above address at any point for clarification of any issues relating to the project. A resource list of organisations that can be contacted for support and advice regarding professional/personal issues has been enclosed.

Thanking you in advance for your co-operation.

Yours sincerely

Joan Burns
Trainee Clinical Psychologist

ENC.

Appendix 3.3

Resource List:

Glasgow Marriage Counselling Service (27 Sandyford Place, Sauchiehall Street, Glasgow G3 7NB, Tel. 0141-248-5249) – provide a confidential counselling service for people who have difficulties and anxieties in their marriage or in other intimate personal relationships.

CRUSE Bereavement Care (Room 438/9, Baltic Chambers, 50 Wellington Street, Glasgow G2 6HJ, Tel. 0141-248-2199) – offer support, advice, and counselling to the bereaved.

Glasgow Council On Alcohol (9th Floor, Elmbank Chambers, 289 Bath Street, Glasgow G2 4JL, Tel. 0141-226-3883/226 4774) – provide a wide range of services centred on confidential and personal counselling tailored to meet the individual needs of clients in order to address problems associated with alcohol misuse.

Turning Point (The West Street Centre, 123 Calder Street, Glasgow G5 8BA, Tel. 0141-420-6777) – provide a range of qualitative services, supporting individuals with alcohol and/or drug problems.

One Plus: One Parent Families (55 Renfrew Street, Glasgow G2 3BD, Tel. 0141-333-1450) – provide advice and counselling for one parent families and individual/group work with children and young people.

Rape Crisis Centre, The (PO Box 53, Glasgow G2 1YR, Tel. 0141-331-1955) – provide a free and confidential support and information service to women and girls who have been raped or sexually assaulted, no matter what their age or when it happened.

Safe Strathclyde Resource Centre (The Old Fire Station, 347 Blythswood Court, Glasgow G2 7PH, Tel. 0141-226-4782) - - identify and investigate community safety issues and concerns.

Samaritans (210 West George Street, Glasgow G2 2PQ, Tel. 0141-248-4488) – provide a confidential, supportive befriending to those going through a crisis period.

Scottish Asian Action Committee (39 Napiershall Street, Glasgow G20 6EZ, Tel. 0141-341-0025) – provide confidential information and advice; further the interests of black and ethnic minority people.

Victim Support Strathclyde (10 Jocelyn Square, Glasgow G1 5JU, Tel. 0141-553-1726) – provide emotional and practical support to victims of crime.

Appendix 3.4

Questions for follow up telephone interviews:

1. What types of trauma are most distressing for you?

2. What is it about ...that affects your functioning ?

3. Have you seen people who were unable to function as a result of the type of work they are doing with traumatised children, and what happened?

4. How do you get yourself through rough spots? - question re. Coping strategies

5. How specifically does working with traumatised children interfere with your life - professionally and personally?

6. Has your outlook on life changed as a result of your work?

7. Do you have nightmares?: frequency____
content of nightmares: _____
_____
8. waking up in the middle of the night?: frequency____
9. trouble falling asleep?: frequency____
10. waking up early in the morning?: frequency____
11. do you startle easily at loud noises?: not at all/ sometimes/ often
12. do you repeatedly check windows and/or door locks in your home?:
not at all/ sometimes/ often
13. do you have difficulty remembering things?: not at all/ sometimes/ often
14. do disturbing thoughts sometimes come into your mind out of nowhere?:
not at all/ sometimes/ often
content of disturbing thoughts: _____
_____
15. do you ever have flashbacks to previously traumatic events?:
not at all/ sometimes/ often
content of flashbacks: _____
_____

16. have you lost interest in your job?: not at all/ moderately/ a considerable amount
17. have you considered taking a job in a different field?: yes/no
18. how much effort do you make to join in with others socially?:
none/ a moderate amount/ a considerable amount

How would you rate your own levels of : (subjective rating of anxiety & depression)
19. ANXIETY: not at all/moderately anxious/extremely anxious
20. DEPRESSION: not at all/moderately depressed/ extremely depressed

ALCOHOL/DRUG USE
21. how many days/month do you typically drink?: frequency____
22. how much do you typically drink at any one time?: 1-2/ 3-4/ 5-6/7-8/>8
23. do you have binges of heavy drinking? not at all/ sometimes/ often
24. what non-prescribed drugs do you regularly use?: _____
how often do you take these drugs?: frequency____

RELATIONSHIPS
25. do you have difficulties communicating with your partner?
not at all/sometimes/often
26. how supportive do you find the following groups of people:

	Very supportive	Supportive	Neutral	Unnsupportive	Very unsupportive
Family					
Colleagues					
Friends					
Neighbours					
Other: please state					

POSITIVE ASPECTS OF WORK:

27. What are the rewarding aspects of the work that you do?

_____

_____

_____

_____

_____

Appendix 4.1

Copy of the 'Journal of Traumatic Stress' Instructions to Contributors

Instructions to Contributors

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

Regular mail	*Overnight mail*
Dr. Dean G. Kilpatrick	Dr. Dean G. Kilpatrick
Medical University of South Carolina	Medical University of South Carolina
National Crime Victims Research and	National Crime Victims Research and
Treatment Centre	Treatment Centre
Department of Psychiatry and Behavioral	165 Cannon Street
Sciences, 171 Ashley Avenue	Third floor, Room OC310
Charleston, South Carolina 29425-0742	Charleston, South Carolina
	29403-5713

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

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

3. Type double-spaced on one side of 8½ x 11 inch or A4 white paper using generous margins on all sides and a font no smaller than 10-point, and submit the original and three copies (including copies of all illustrations and tables).

4. A title page is to be provided and should include the title of the article, author's name (no degrees), author's affiliation, acknowledgements, 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 form thereof. Also include the *word count*, the complete mailing address and telephone number for the corresponding author during the review process, and, if different, a name and address to appear in the article footnotes for correspondence after publication.

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

6. A list of 4-5 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.

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. Centre the title above the table, and type explanatory footnotes (indicated by superscript lowercase letters) below the table.

9. List references alphabetically at the end of the paper and refer to them in the text by name and year in parentheses. In the text, all 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 references should conform to strict APA style illustrated by the following examples (however, use indentation below):

Journal Article
Frederich, W.N., Urquiza, A.J., & Beikle, R.I. (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. 481-485) New York: Plenum Press.

10. Footnotes should be avoided. When there 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 1994 *Publication Manual* of the American Psychological Association (Fourth Edition),** and it is suggested that contributors refer to this publication.

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

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

Appendix 4.2

Participants' Demographic & Personal Background Details

		Total Group (N=119)	Helpline (n=42)	Social Work (n=39)	Hospital (n=38)
Sex:	Male	14.8%	10%	21.6%	13.2%
	Female	85.2%	90%	78.4%	86.8%
	MODE	Female	Female	Female	Female
Age:	20-25yrs	11.1%	14.6%	2.6%	16.2%
	26-30yrs	17.9%	17.1%	17.9%	18.9%
	31-35yrs	23.9%	14.6%	23.1%	35.1%
	36-40yrs	20.5%	22.0%	23.1%	16.2%
	41-45yrs	12.0%	9.8%	20.5%	5.4%
	46-50yrs	2.6%	2.4%	2.6%	2.7%
	51-55yrs	5.1%	4.9%	7.7%	2.7%
	56-60yrs	5.1%	9.8%	2.6%	2.7%
	>60yrs	1.7%	9.8%	0%	0%
	MEDIAN	31-35yrs	36-40yrs	36-40yrs	31-35yrs
No. of children:	0	49.1%	48.8%	42.4%	55.6%
	1	15.5%	17.1%	15.2%	13.9%
	2	28.2%	22%	33.3%	30.6%
	3	6.4%	4.8%	9.1%	0%
	4	0.9%	2.4%	0%	0%
	>4	0%	0%	0%	0%
	MEDIAN	1	1	1	0
Social support at home:					
	None	11.9%	9.8%	15.4%	10.5%
	Some	11.9%	12.2%	15.4%	7.9%
	Moderate amount	23.7%	22%	25.6%	23.7%
	Considerable amount	52.5%	56.1%	43.6%	57.9%
	MEDIAN	Considerable	Considerable	Moderate	Considerable
Previous treatment by a psychologist/psychiatrist:					
	Yes	11.5%	16.7%	11.4%	6.1%
	No	88.5%	83.3%	88.6%	93.9%
	MODE	No	No	No	No
Chronic difficulties in last 12 months:					
	None	47.9%	61%	25.6%	56.8%
	Some	31.6%	22%	48.7%	24.3%
	Moderate amount	13.7%	17%	12.8%	10.8%
	Considerable amount	6.8%	0%	12.8%	8.1%
	MEDIAN	Some	None	Some	None
Life events in last 12 months:					
	None	46.6%	42.5%	44.7%	52.6%
	Some	34.5%	42.5%	34.2%	26.3%
	Moderate amount	12.1%	12.5%	15.8%	7.9%
	Considerable amount	6.9%	2.5%	5.3%	13.2%
	MEDIAN	Some	Some	Some	None
Personal trauma in last 12 months:					
	Yes	39.8%	36.8%	44.7%	37.8%
	No	60.2%	63.2%	55.3%	63.2%
	MODE	No	No	No	No
Personal trauma in lifetime:					
	Yes	82%	81.6%	92.1%	71.4%
	No	18%	18.4%	7.9%	28.6%
	MODE	Yes	Yes	Yes	Yes

Appendix 4.3

Participants' Work Characteristics

		Total Group (N=119)	Helpline (n=42)	Social Work (n=39)	Hospital (n=38)
Number of years work experience:					
	< 1 year	7.7%	17.1%	2.6%	2.6%
	1-5 years	30.8%	39%	34.2%	18.4%
	6-10 years	20.5%	12.2%	34.2%	15.8%
	11-15 years	15.4%	7.3%	10.5%	28.9%
	16-20 years	15.4%	9.8%	13.2%	23.7%
	21-25 years	4.3%	7.3%	0%	5.3%
	26-30 years	2.6%	0%	5.3%	2.6%
	> 30 years	3.4%	7.3%	0%	2.6%
	MEDIAN	6-10 years	1-5 years	6-10 years	11-15 years
Number of years working with traumatised children:	< 1 year	19.6%	25.7%	5.4%	28.6%
	1-5 years	43%	57.1%	43.2%	28.6%
	6-10 years	20.6%	8.6%	29.7%	22.9%
	11-15 years	9.3%	2.9%	10.8%	14.3%
	16-20 years	4.7%	2.9%	8.1%	2.9%
	21-25 years	0%	0%	0%	0%
	26-30 years	0.9%	0%	2.7%	0%
	> 30 years	1.9%	2.9%	0%	2.9%
	MEDIAN	1-5 years	1-5 years	6-10 years	1-5 years
Hours per week (working with traumatised children):					
	< 5hours	52.8%	75.7%	47.4%	32.3%
	5-10hours	13.2%	13.5%	18.4%	6.5%
	> 10hours	34%	10.8%	34.2%	61.3%
	MEDIAN	< 5 hours	< 5 hours	5-10 hours	> 10 hours
Amount of training in the psychological effects of trauma:					
	None	38%	32.4%	34.3%	47.2%
	< 1 week	19.4%	5.4%	28.6%	25%
	1-2 weeks	8.3%	10.8%	5.7%	8.3%
	3-4 weeks	2.8%	5.4%	2.9%	0%
	> 4 weeks	31.5%	45.9%	28.6%	19.4%
	MEDIAN	< 1 week	3-4 weeks	< 1 week	< 1 week
Social support at work :					
	None	7.8%	7.5%	5.1%	10.8%
	Some	33.6%	17.5%	35.9%	48.6%
	Moderate amount	34.5%	37.5%	38.5%	27%
	Considerable amount	24.1%	37.5%	20.5%	13.5%
	MEDIAN	Moderate	Moderate	Moderate	Some

Appendix 4.4

Spearman Correlation Co-efficients Between Questionnaire Measures and Independent Variables

	Behavioural Scale	IES-R: Avoidance	IES-R: Intrusion	IES-R: Total	HAD: Anxiety	HAD: Depression	A&C Scale
Hours per week	.164	-.113	-.080	-.097	.048	-.019	-.055
Years working with traumatised children	.062	-.174	-.107	-.150	-.025	-.006	-.172
Years work experience	-.034	-.122	-.115	-.130	-.196*	-.048	-.120
Amount of training in psychological effects of trauma	-.044	.074	.104	.097	.011	-.114	-.028
Previous treatment by a psychologist/ psychiatrist	-.261*	-.074	-.048	-.065	-.151	-.144	-.195*
Personal trauma in lifetime	-.242*	-.147	.014	-.050	-.234*	-.226*	-.155
Personal trauma in last 12 months	-.212*	-.073	-.064	-.067	-.322**	-.270**	-.177
Chronic difficulties in last 12 months	.494**	.211*	.177	.201*	.373**	.446**	.283**
Life events in last 12 months	.273**	.238*	.185*	.205*	.347**	.344**	.287**
Amount of support at work	-.122	.097	.055	.081	.015	-.135	-.020
Amount of support at home	-.202*	.058	.011	.037	-.213*	-.194*	-.174

* **Correlation is significant at the .05 level (2-tailed).**

** **Correlation is significant at the .01 level (2-tailed).**

Appendix 4.5

Comparisons Of Questionnaire Results by Independent Variables

	Behavioural Scale n=117	***IES-R: Avoidance*** n=118	***IES-R: Intrusion*** n=118	***IES-R: Total*** n=118	***HAD: Anxiety*** n=118	***HAD: Depression*** n=118	***A&C Scale*** n=118
Mean	39.19	7.73	8.81	16.54	7.87	3.91	195.68
(S.D.)	(9.15)	(8.58)	(8.17)	(15.54)	(4.10)	(3.16)	(46.02)
Hours per week:							
X^2	2.85	3.08	1.15	1.86	.928	.153	.579
DF	2	2	2	2	2	2	2
Asymp.Sig.	.241	.214	.562	.395	.629	.926	.744
Years working:							
X^2	8.94	7.22	6.35	5.23	.982	3.04	8.38
DF	6	6	6	6	6	6	6
Asymp.Sig.	.177	.301	.386	.515	.986	.804	.211
Experience:							
X^2	16.22	11.37	5.91	9.09	14.42	13.16	14.58
DF	7	7	7	7	7	7	7
Asymp.Sig.	.023	.123	.550	.247	.044	.068	.042
Training:							
X^2	3.39	5.18	7.95	6.83	.839	9.46	6.85
DF	4	4	4	4	4	4	4
Asymp.Sig.	.495	.270	.094	.145	.933	.051	.144
Treatment:							
Mann Whitney U	291.5	479.0	504.5	487.0	402.0	410.0	354.5
Z	-2.65	-.751	-.486	-.664	-1.53	-1.46	-1.97
Asymp.Sig.	.008	.452	.627	.507	.126	.145	.049
Trauma-lifetime:							
Mann Whitney U	579.0	711.0	891.0	842.5	591.0	604.0	745.5
Z	-2.54	-1.55	-.147	-.520	-2.46	-2.37	-1.19
Asymp.Sig.	.011	.122	.883	.603	.014	.018	.231
Trauma-12mths:							
Mann Whitney U	1132	1380	1394.5	1389	938	1032	1193
Z	-2.23	-.766	-.675	-.706	-3.39	-2.85	-1.87
Asymp.Sig.	.026	.444	.500	.480	.001	.004	.062
Chronic:							
X^2	30.43	7.69	5.81	6.85	17.64	26.47	11.36
DF	3	3	3	3	3	3	3
Asymp.Sig.	.000	.053	.121	.077	.001	.000	.010
Life events:							
X^2	9.71	5.84	4.98	4.97	17.94	5.66	10.72
DF	3	3	3	3	3	3	3
Asymp.Sig.	.021	.119	.173	.174	.000	.129	.013
Support- work:							
X^2	5.29	1.59	1.00	.989	2.98	4.27	1.66
DF	3	3	3	3	3	3	3
Asymp.Sig.	.151	.661	.801	.801	.395	.234	.645
Support-home:							
X^2	7.87	12.47	7.26	9.94	9.54	5.27	6.51
DF	3	3	3	3	3	3	3
Asymp.Sig.	.049	.006	.064	.019	.023	.153	.089

Appendix 4.6

Follow-up Telephone Interview Data for Total Group and by Organisational Group & Responses To Open Ended Question On Main Questionnaire About The Effects Of Working With Traumatised Children

1. What types of trauma are most distressing for you?

	Helpline	Social Work	Hospital	Total Group
Sexual abuse	8 (72.7%)	5 (38.5%)	1 (11.1%)	14 (42.4%)
Abuse (undifferentiated)	0 (0%)	2 (15.4%)	3 (33.3%)	5 (15.2%)
Physical trauma	0 (0%)	0 (0%)	4 (44.4%)	4 (12.1%)
Bereavement separation/loss	0 (0%)	4 (30.8%)	0 (0%)	4 (12.1%)
Emotional abuse	1 (9.1%)	2 (15.4%)	0 (0%)	3 (9.1%)
Physical abuse	1 (9.1%)	0 (0%)	0 (0%)	1 (3.0%)
Pain/terminally ill	0 (0%)	0 (0%)	1 (11.1%)	1 (3.0%)
Bullying	1 (9.1%)	0 (0%)	0 (0%)	1 (3.0%)
Total	11 (100%)	13 (100%)	9 (100%)	33 (100%)

2. What is it about ...that affects your functioning?

	Helpline	Social Work	Hospital	Total Group
Impact on families	1 (8.3%)	2 (18.2%)	3 (30.0%)	6 (18.2%)
Adult betrayal/ responsibility to prevent harm occurred	0 (0%)	0 (0%)	5 (50.0%)	5 (15.2%)
Behaviour/feelings in child	1 (8.3%)	2 (18.2%)	2 (20.0%)	5 (15.2%)
Feelings in worker	3 (25.0%)	2 (18.2%)	0 (0%)	5 (15.2%)
Powerlessness of worker	1 (8.3%)	4 (36.4%)	0 (0%)	5 (15.2%)
Helplessness of child	4 (33.3%)	0 (0%)	0 (0%)	4 (12.1%)
Awareness of long term damage	2 (16.7%)	0 (0%)	0 (0%)	2 (6.1%)
Maliciousness on part of perpetrator	0 (0%)	1 (9.1%)	0 (0%)	1 (3.0%)
Total	12 (100%)	11 (100%)	10 (100%)	33 (100%)

3. Have you seen people who were unable to function as a result of the type of work they are doing with traumatised children, and what happened?

	Helpline	Social Work	Hospital	Total Group
YES	5 (50.0%)	9 (90.0%)	5 (55.6%)	19 (65.5%)
NO	5 (50.0%)	1 (10.0%)	4 (44.4%)	10 (34.5%)
Total	10 (100%)	10 (100%)	9 (100%)	29 (100%)

	Helpline	Social Work	Hospital	Total Group
Leave field/do different type of work	1 (25.0%)	6 (28.6%)	1 (12.5%)	8 (24.2%)
Upset/tearful	2 (50.0%)	2 (9.5%)	3 (37.5%)	7 (21.2%)
Stress	0 (0%)	3 (14.3%)	2 (25.0%)	5 (15.2%)
De-skilled/ Impact on work	0 (0%)	3 (14.3%)	2 (25.0%)	5 (15.2%)
Avoidance of appointments/ phone	0 (0%)	2 (9.5%)	0 (0%)	2 (6.1%)
Burnout	0 (0%)	2 (9.5%)	0 (0%)	2 (6.1%)
Need break	1 (25.0%)	1 (4.8%)	0 (0%)	2 (6.1%)
Withdrawn/ secretive	0 (0%)	1 (4.8%)	0 (0%)	1 (3.0%)
Impaired work relations	0 (0%)	1 (4.8%)	0 (0%)	1 (3.0%)
Total	4 (100%)	21 (100%)	8 (100%)	33 (100%)

4. How do you get yourself through rough spots?

	Helpline	Social Work	Hospital	Total Group
Use team/ debriefing	7 (50.0%)	4 (17.4%)	5 (45.5%)	16 (33.3%)
Compartmentalise /intellectualise	1 (7.1%)	2 (8.7%)	4 (36.4%)	7 (14.6%)
Exercise/ relaxation	3 (21.4%)	2 (8.7%)	0 (0%)	5 (10.4%)
Alcohol	0 (0%)	4 (17.4%)	0 (0%)	4 (8.3%)
Talking	1 (7.1%)	2 (8.7%)	0 (0%)	3 (6.25%)
Social life	1 (7.1%)	1 (4.3%)	0 (0%)	2 (4.2%)
Friends/family support	0 (0%)	1 (4.3%)	1 (9.1%)	2 (4.2%)
Writing	1 (7.1%)	1 (4.3%)	0 (0%)	2 (4.2%)
Time out/Go away	0 (0%)	2 (8.7%)	0 (0%)	2 (4.2%)
Humour	0 (0%)	1 (4.3%)	0 (0%)	1 (2.1%)
Protocol	0 (0%)	0 (0%)	1 (9.1%)	1 (2.1%)
Create balance	0 (0%)	1 (4.3%)	0 (0%)	1 (2.1%)
Shopping	0 (0%)	1 (4.3%)	0 (0%)	1 (2.1%)
Get angry (channels energy)	0 (0%)	1 (4.3%)	0 (0%)	1 (2.1%)
Total	14 (100%)	23 (100%)	11 (100%)	48 (100%)

5. How specifically does working with traumatised children interfere with your life - professionally & personally?

	Helpline	Social Work	Hospital	Total Group
Depression/ loss of interest/ tired	0 (0%)	3 (33.3%)	1 (100.0%)	4 (33.3%)
Less tolerant/ Cannot be bothered with the trivial	0 (0%)	2 (22.2%)	0 (0%)	2 (16.7%)
Irritability	0 (0%)	1 (11.1%)	0 (0%)	1 (8.3%)
Cynicism	1 (50.0%)	0 (0%)	0 (0%)	1 (8.3%)
Awareness of abuse	1 (50.0%)	0 (0%)	0 (0%)	1 (8.3%)
Awareness of damage can do	0 (0%)	1 (11.1%)	0 (0%)	1 (8.3%)
Apprehension about having children	0 (0%)	1 (11.1%)	0 (0%)	1 (8.3%)
Work impacted	0 (0%)	1 (11.1%)	0 (0%)	1 (8.3%)
Total	2 (100%)	9 (100%)	1 (100%)	12 (100%)

6. Has your outlook on life changed as a result of your work?

	Helpline	Social Work	Hospital	Total Group
More cynical	3 (16.7%)	5 (26.3%)	2 (25.0%)	10 (22.2%)
Greater appreciation of family/friends/ life	0 (0%)	3 (15.8%)	3 (37.5%)	6 (13.3%)
Less trusting	1 (5.6%)	2 (10.5%)	0 (0%)	3 (6.7%)
More awareness	4 (22.2%)	1 (5.3%)	0 (0%)	5 (11.1%)
More judgemental/ suspicious	3 (16.7%)	1 (5.3%)	1 (12.5%)	5 (11.1%)
More apprehensive/ cautious/alert	2 (11.1%)	1 (5.3%)	1 (12.5%)	4 (8.9%)
Harder/ less patience for the trivial	1 (5.6%)	2 (10.5%)	0 (0%)	3 (6.7%)
Greater anger	1 (5.6%)	1 (5.3%)	0 (0%)	2 (4.4%)
Less tolerant of others	0 (0%)	1 (5.3%)	0 (0%)	1 (2.2%)
More realistic expectations	1 (5.6%)	0 (0%)	1 (12.5%)	2 (4.4%)
Progress possible	0 (0%)	1 (5.3%)	0 (0%)	1 (2.2%)
Better listening skills	1 (5.6%)	0 (0%)	0 (0%)	1 (2.2%)
Less idealism	0 (0%)	1 (5.3%)	0 (0%)	1 (2.2%)
Total	18 (100%)	19 (100%)	8 (100%)	45 (10%)

7. Nightmares frequency?

	Helpline	Social Work	Hospital	Total Group
Not at all	8 (80.0%)	5 (50%)	5 (55.6%)	18 (62.1%)
Sometimes	2 (20.0%)	5 (50%)	4 (44.4%)	11 (37.9%)
Often	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	10 (100%)	10 (100%)	9 (100%)	29 (100%)

8. waking up in the middle of the night frequency?

	Helpline	Social Work	Hospital	Total Group
Not at all	8 (80.0%)	4 (40.0%)	2 (22.2%)	14 (48.3%)
Sometimes	1 (10.0%)	5 (50.0%)	5 (55.6%)	11 (37.9%)
Often	1 (10.0%)	1 (10.0%)	2 (22.2%)	4 (13.8%)
Total	10 (100%)	10 (100%)	9 (100%)	29 (100%)

9. trouble falling asleep frequency?

	Helpline	Social Work	Hospital	Total Group
Not at all	6 (60.0%)	6 (60.0%)	7 (77.8%)	19 (65.6%)
Sometimes	4 (40.0%)	3 (30.0%)	1 (11.1%)	8 (27.6%)
Often	0 (0%)	1 (10.0%)	1 (11.1%)	2 (6.9%)
Total	10 (100%)	10 (100%)	9 (100%)	29 (100%)

10. waking up early in the morning frequency?

	Helpline	Social Work	Hospital	Total Group
Not at all	9 (90.0%)	7 (60.0%)	3 (33.3%)	19 (65.6%)
Sometimes	1 (10.0%)	2 (20.0%)	6 (66.7%)	9 (31.0%)
Often	0 (0%)	1 (10.0%)	0 (0%)	1 (3.4%)
Total	10 (100%)	10 (100%)	9 (100%)	29 (100%)

11. do you startle easily at loud noises?

	Helpline	Social Work	Hospital	Total Group
Not at all	9 (90.0%)	7 (70.0%)	5 (55.6%)	21 (72.4%)
Sometimes	0 (0%)	2 (20.0%)	2 (22.2%)	4 (13.8%)
Often	1 (10.0%)	1 (10.0%)	2 (22.2%)	4 (13.8%)
Total	10 (100%)	10 (100%)	9 (100%)	29 (100%)

12. do you repeatedly check windows and/or door locks in your home?

	Helpline	Social Work	Hospital	Total Group
Not at all	9 (90.0%)	7 (70.0%)	5 (55.6%)	21 (72.4%)
Sometimes	0 (0%)	2 (20.0%)	2 (22.2%)	4 (13.8%)
Often	1 (10.0%)	1 (10.0%)	2 (22.2%)	4 (13.8%)
Total	10 (100%)	10 (100%)	9 (100%)	29 (100%)

13. do you have difficulty remembering things?

	Helpline	Social Work	Hospital	Total Group
Not at all	5 (50.0%)	4 (40.0%)	5 (55.6%)	14 (48.2%)
Sometimes	4 (40.0%)	4 (40.0%)	2 (22.2%)	10 (34.5%)
Often	1 (10.0%)	2 (20.0%)	2 (22.2%)	5 (17.2%)
Total	10 (100%)	10 (100%)	9 (100%)	29 (100%)

14. do disturbing thoughts sometimes come into your mind out of nowhere?

	Helpline	Social Work	Hospital	Total Group
Not at all	4 (36.3%)	3 (30.0%)	6 (66.7%)	13 (43.3%)
Sometimes	6 (54.5%)	6 (60.0%)	1 (11.1%)	13 (43.3%)
Often	1 (9.1%)	1 (10.0%	2 (22.2%)	4 (13.3%)
Total	11 (100%)	10 (100%)	9 (100%)	30 (100%)

	Helpline	Social Work	Hospital	Total Group
Case details	3 (42.9%)	5 (71.4%)	3 (75.0%)	11 (61.1%)
Thoughts about case in relation to own children/self/ other people	3 (42.9%)	2 (28.6%)	0 (0%)	5 (27.8%)
Thinking about violence/Dread feeling	1 (14.3%)	0 (0%)	1 (25.0%)	2 (11.1%)
Total	7 (100%)	7 (100%)	4 (100%)	18 (100%)

15. do you ever have flashbacks to previously traumatic events?

	Helpline	Social Work	Hospital	Total Group
Not at all	6 (60.0%)	7 (58.3%)	5 (55.6%)	18 (58.1%)
Sometimes	4 (40.0%)	5 (41.7%)	3 (33.3%)	12 (38.7%)
Often	0 (0%)	0 (0%)	1 (11.1%)	1 (3.2%)
Total	10 (100%)	12 (100%)	9 (100%)	31 (100%)

Personal trauma	2 (16.7%)
Related to case	10 (83.3%)
Total	12 (100%)

16. have you lost interest in your job?

	Helpline	Social Work	Hospital	Total Group
Not at all	8 (80.0%)	8 (80.0%)	7 (77.8%)	23 (79.3%)
Moderate	2 (20.0%)	1 (10.0%)	1 (11.1%)	4 (13.8%)
Considerable	0 (0%)	1 (10.0%)	1 (11.1%)	2 (6.9%)
Total	10 (100%)	10 (100%)	9 (100%)	29 (100%)

17. have you considered taking a job in a different/related field?

	Helpline	Social Work	Hospital	Total Group
Yes	0 (0%)	5 (50.0%)	5 (55.6%)	10 (34.5%)
No	10 (100%)	5 (50.0%)	4 (44.4%)	19 (65.5%)
Total	10 (100%)	10 (100%)	9 (100%)	29 (100%)

18. how much effort do you make to join in with others socially?

	Helpline	Social Work	Hospital	Total Group
Not at all	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Moderately	7 (63.6%)	6 (60.0%)	4 (44.4%)	17 (56.7%)
A considerable amount	4 (36.4%)	4 (40.0%)	5 (55.6%)	13 (43.3%)
Total	11 (100%)	10 (100%)	9 (100%)	30 (100%)

19/20. How would you rate your own levels of: (subjective rating of anxiety & depression)

ANXIETY

	Helpline	Social Work	Hospital	Total Group
Not at all	2 (20.0%)	3 (25.0%)	2 (22.2%)	7 (22.6%)
Moderately	8 (80.0%)	7 (58.3%)	6 (66.7%)	21 (67.7%)
Extremely	0 (0%)	2 (16.7%)	1 (11.1%)	3 (9.7%)
Total	10 (100%)	12 (100%)	9 (100%)	31 (100%)

DEPRESSION

	Helpline	Social Work	Hospital	Total Group
Not at all	7 (70.0%)	5 (45.5%)	6 (60.0%)	18 (58.1%)
Moderately	3 (30.0%)	6 (54.5%)	4 (40.0%)	13 (41.9%)
Extremely	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	10 (100%)	11 (100%)	10 (100%)	31 (100%)

21. how many days/month do you typically drink?

	Mean Number	Range
Helpline	4.8	0-25
Social Work	7.9	0-16
Hospital	8.4	0-30
Total Group	7.0	0-30

22.how much do you typically drink at any one time?

	Mode
Helpline	1-2 units
Social Work	3-4units
Hospital	3-4units
Total Group	3-4units

23. do you have binges of heavy drinking?

	Helpline	Social Work	Hospital	Total Group
Not at all	8 (80.0%)	8 (80.0%)	7 (77.8%)	23 (79.3%)
Sometimes	2 (20.0%)	1 (10.0%)	2 (22.2%)	5 (17.2%)
Often	0 (0%)	1 (10.0%)	0 (0%)	1 (3.4%)
Total	10 (100%)	10 (100%)	9 (100%)	29 (100%)

24. what non-prescribed drugs do you regularly use?

None	Cannabis	Homeopathic for stress
27	1(SocWk)	1(SocWk)

25. do you have difficulty communicating with your partner?

	Helpline	Social Work	Hospital	Total Group
Not at all	7 (70.0%)	5 (50.0%)	9 (100%)	21 (72.4%)
Sometimes	3 (30.0%)	4 (40.0%)	0 (0%)	7 (24.1%)
Often	0 (0%)	1 (10%)	0 (0%)	1 (3.4%)
Total	10 (100%)	10 (100%)	9 (100%)	29 (100%)

26. how supportive do you find the following groups of people?

	Helpline - Mode	Social Work - Mode	Hospital - Mode
Family	Neutral	Supportive	Very supportive
Colleagues	Very supportive - supportive	Very supportive	Supportive
Friends	Very supportive	Supportive	Very supportive
Neighbours	Neutral	Neutral	Neutral

27. What are the rewarding aspects of the work you do?

	Helpline	Social Work	Hospital	Total Group
Impact positively on peoples lives	9 (64.3%)	8 (66.7%)	9 (81.8%)	26 (70.3%)
Fun	2 (14.3%)	0 (0%)	1 (9.1%)	3 (8.1%)
Keeps you in touch	1 (7.1%)	1 (8.3%)	0 (0%)	2 (5.4%)
Financial	0 (0%)	2 (16.7%)	0 (0%)	2 (5.4%)
Self worth	1 (7.1%)	1 (8.3%)	0 (0%)	2 (5.4%)
Recognition from colleagues	0 (0%)	0 (0%)	1 (9.1%)	1 (2.7%)
Learning	1 (7.1%)	0 (0%)	0 (0%)	1 (2.7%)
Total	14 (100%)	12 (100%)	11 (100%)	37 (100%)

28. Any other comments?

a. NEGATIVE

	Helpline	Social Work	Hospital	Total Group
More support/ supervision	0 (0%)	8 (36.4%)	4 (40.0%)	12 (34.3%)
Hard/upsetting work	2 (66.7%)	0 (0%)	2 (20.0%)	4 (11.4%)
Working against organisation	0 (0%)	4 (18.2%)	0 (0%)	4 (11.4%)
Lack of resources	0 (0%)	3 (13.6%)	0 (0%)	3 (8.6%)
More positive feedback	0 (0%)	0 (0%)	2 (20.0%)	2 (5.7%)
More training (about trauma/ general)	0 (0%)	1 (4.5%)	1 (10.0%)	2 (5.7%)
Need mixed caseload	0 (0%)	2 (9.1%)	0 (0%)	2 (5.7%)
Some need counselled out	0 (0%)	1 (4.5%)	0 (0%)	1 (2.9%)
Raises awareness	1 (33.3%)	0 (0%)	0 (0%)	1 (2.9%)
Sleep disturbance	0 (0%)	1 (4.5%)	0 (0%)	1 (2.9%)
Disturbing thoughts	0 (0%)	1 (4.5%)	0 (0%)	1 (2.9%)
Stress related illness (colitis)	0 (0%)	1 (4.5%)	0 (0%)	1 (2.9%)
No sense of completion in job	0 (0%)	0 (0%)	1 (10.0%)	1 (2.9%)
Total	3 (100%)	22 (100%)	10 (100%)	35 (100%)

b. POSITIVE

	Helpline	Social Work	Hospital	Total Group
Enjoy work	0 (0%)	0 (0%)	1 (100%)	1 (33.3%)
Workplace supportive	1 (50.0%)	0 (0%)	0 (0%)	1 (33.3%)
Realise how fortunate are	1 (50.0%)	0 (0%)	0 (0%)	1 (33.3%)
Total	2 (100%)	0 (100%)	1 (100%)	3 (100%)

Negative Effects Of Working With Traumatised Children Reported By Staff On The Main Questionnaire And During Follow-up Telephone Interviews

	Helpline	Social Work	Hospital	Total
Upset/emotionally draining	4	6	13	23 (15.9%)
Tired/sad/depressed	2	9	4	15 (10.4%)
Stress	3	6	4	13 (9.0%)
Feelings of inadequacy/ helpless/ feeling overwhelmed	5	6	2	13 (9.0%)
Need more support/supervision	0	8	4	12 (8.3%)
Anxious/worry	0	9	2	11 (7.6%)
Frustrated/ angry	1	5	4	10 (6.9%)
Nightmares/loss of sleep	0	4	1	5 (3.5%0
Dwell on thoughts/unable to forget what have heard	3	2	0	5 (3.5%)
Working against organisation	0	4	0	4 (2.8%)
Lack of resources	0	3	0	3 (2.1%)
Distrustful of other adults/cynicism	1	2	0	3 (2.1%)
Awareness of abuse/damage can do	2	1	0	3 (2.1%)
Sexual dysfunction	1	1	0	2 (1.4%)
Numb/de-sensitised/ disconnected	0	2	0	2 (1.4%)
Loss of tolerance for the trivial	0	2	0	2 (1.4%)
Disgust with society	2	0	0	2 (1.4%)
Need more positive feedback	0	0	2	2 (1.4%)
More training (about trauma/general)	0	1	1	2 (1.4%)
Need mixed caseload	0	2	0	2 (1.4%)
Apprehension about having children of own	0	1	0	1 (0.69%)
Some need counselled out	0	1	0	1 (0.69%)
No sense of completion in job	0	0	1	1 (0.69%)
Work impacted	0	1	0	1 (0.69%)
Stress related illness (colitis)	0	1	0	1 (0.69%)
Flashbacks	0	0	1	1 (0.69%)
Sleep disturbance	0	1	0	1 (0.69%)
Irritability	0	1	0	1 (0.69%)
Disturbing thoughts	0	1	0	1 (0.69%)
"Survivor guilt"	0	1	0	1 (0.69%)

Positive Effects Of Working With Traumatised Children Reported By Staff On The Main Questionnaire & During Follow-up Telephone Interviews

	Helpline	Social Work	Hospital	Total Group
Heightened sensitivity and understanding	5	0	0	5 (19.2%)
Heightened awareness of effects of trauma/ childrens needs	4	0	0	4 (15.4%)
Increased skills	2	1	1	4 (15.4%)
More determined to do best work possible/protect child	3	0	1	4 (15.4%)
Personal fulfilment/ enjoy work	2	0	2	4 (15.4%)
Greater appreciation of own children	0	0	2	2 (7.7%)
Workplace supportive	1	0	0	1 (3.8%)
Realise how fortunate are	1	0	0	1 (3.8%)
More open re. Discussing feelings	1	0	0	1 (3.8%)

Appendix 4.7

Comparison of IES total distress levels in current study and other empirical studies

Study	Result
Current Study	*61% of total sample reported medium to high post-traumatic symptomatology. 38.1% of total sample fell into the high distress group (66.7% of social workers; 26.2% of helpline; and 21.6% of hospital staff)*
Dyregrov et al, 1996	67% of voluntary helpers & 44% of professional helpers belonged to the medium or high distress group. 25% of voluntary helpers & 13% of professional helpers fell into the high distress group.
Bryant & Harvey, 1996	17% of firefighters experiencing 'high' levels of post-traumatic stress related to fire-fighting duties.
Marmer et al, 1996	9% of emergency services personnel scoring within the 'medium to high' distress range on the IES as a consequence of critical incident exposure.
Raphael et al, 1984	About 20% of rescue workers experienced stress-specific symptomatology after a rail disaster.
McFarlane, 1988	30% of volunteer fire-fighters had PTSD 29 months post-disaster.
Foreman, 1989	About 33% police reported a moderate to high distress 6 months post-disaster.

Appendix 4.8

Comparison of IES sub-scale scores in current study and other empirical studies

	IES Intrusion Mean (SD)	*IES Avoidance* Mean (SD)	*IES Total* Mean (SD)
Current Sample	*8.81 (8.17)*	*7.73 (8.58)*	*16.54 (15.54)*
Trauma therapists without a trauma history (Pearlman & MacIan, 1995)	5.62 (3.7)	5.58 (4.2)	(not available)
ISU members of the South African Police (Kopel & Friedman, 1997)	8.7 (7.0)	15.7 (7.9)	24.4 (12.56)
Volunteer fire-fighters scores in relation to multiple trauma frequency (Bryant & Harvey, 1996)	7.32 (8.78)	5.88 (7.69)	13.23 (15.77)
Fire-fighters (McFarlane, 1992)	11.5 (9.6)	6.1 (7.4)	17.4 (15.3)
Professional disaster workers at 1 month post-disaster (Dyregrov et al, 1996)	8.3 (6.7)	4.6 (4.5)	12.9 (9.8)
Voluntary disaster workers at 1 month post-disaster (Dyregrov et al, 1996)	12.4 (6.3)	7.3 (5.2)	19.7 (9.7)
Disaster workers at 2 weeks post-disaster (Johnsen at al, 1997)	14.3 (6.6)	12.2 (6.6)	26.6 (11.6)