NOTE

This online version of the thesis may have different page formatting and pagination from the paper copy held in the University of Wollongong Library.

UNIVERSITY OF WOLLONGONG

COPYRIGHT WARNING

You may print or download ONE copy of this document for the purpose of your own research or study. The University does not authorise you to copy, communicate or otherwise make available electronically to any other person any copyright material contained on this site. You are reminded of the following:

Copyright owners are entitled to take legal action against persons who infringe their copyright. A reproduction of material that is protected by copyright may be a copyright infringement. A court may impose penalties and award damages in relation to offences and infringements relating to copyright material. Higher penalties may apply, and higher damages may be awarded, for offences and infringements involving the conversion of material into digital or electronic form.
THE ROLE OF VOLUNTEER COUNSELLORS IN THE PREVENTION OF PSYCHOLOGICAL TRAUMA: THE DEVELOPMENT OF THE ‘ORIENTING APPROACH’ TO TRAUMA COUNSELLING

A thesis submitted in partial fulfilment of the requirements for the award of the degree

DOCTOR OF PSYCHOLOGY (CLINICAL PSYCHOLOGY)

From

University of Wollongong

By


School of Psychology 2006
Acknowledgements

I wish to express my gratitude to my supervisors, Mitch Byrne and Frank Deane for their expert guidance and assistance in developing and evaluating this research. I thank Lifeline South Coast for the opportunity to develop and trial this intervention, and the Lifeline volunteers who participated in the research. I am forever grateful to: my partner Sarah Hemley for her support and understanding during the final, most trying stages of this research, and my dear friends Samantha Reis and Aaron Warner who have supported me through all stages of the project. Finally I wish to thank my parents, Colin and Cecily for their tireless encouragement and financial support through the many years of my studies. You have taught me the value of knowledge and the importance of helping others; to you I am most indebted.
Declaration

In signing this document I declare that this thesis has been entirely my own work and has not been submitted for the purpose of a degree to any other university or institution. The theoretical and research literature discussed has been referred to in the reference section of this thesis.

Andrew B. Phipps, June 2006
Abstract

Early interventions for trauma aim to reduce the likelihood of distress and impairment following exposure to a traumatic event. However, a growing body of research suggests that some popular early interventions have the potential to increase the risk of psychological sequelae. This risk may be increased when such interventions are delivered by practitioners with limited skill and training. This thesis discusses the development and training of the ‘Orienting Approach’ to Trauma Counselling (Phipps and Byrne, 2003). This early intervention was designed for use by volunteer counsellors. It is argued that the approach is a ‘no-harm’ intervention that can reduce the potential for distress and impairment of individuals who have been both directly and indirectly exposed to traumatic events. Eighty volunteer counsellors participated in a one-day training program. The capacity of volunteers to administer the approach was evaluated. Skill was assessed by participation in blind-rated role-plays both before and after training. Knowledge was assessed pre and post-training using a multiple choice questionnaire. This thesis also aimed to investigate variables which may affect counsellors’ ability to administer the approach. Since working with traumatised individuals has the potential to ‘vicariously’ traumatise counsellors, the influence of personal trauma experience on volunteers’ performance with the approach was explored. The results showed that volunteers have the capacity to learn and administer the Orienting Approach to Trauma Counselling. Measures of skill and knowledge increased significantly following training. Previous trauma experience did not affect performance. The results present promising empirical support for the use of this intervention by volunteers.
# Table of Contents

Summary 1

Chapter 1 – Secondary Traumatic Stress and Vicarious Trauma 6
1.1 – Overview 6
1.2 – What is Secondary and Vicarious Trauma? 6
1.3 – Symptoms of STS 8
1.4 – Impairment as a result of STS 9
1.5 – Prevalence of STS 11
1.6 – Predictors of STS 11
1.7 – Symptoms and impact of VT 12
1.8 – Predictors of VT 13
1.9 – Current Treatment Approaches 16

Chapter 2 – Secondary Traumatic Stress: Considerations for treatment 19
2.1 – Overview 19
2.2 – The problem of Identification 19
2.3 - Using Volunteers for a preventative intervention 20
2.4 – The capacities of volunteers and their organisations 23
2.5 – Towards an early intervention for STS 24
<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix F</td>
<td>Participant Information Sheet</td>
<td>194</td>
</tr>
<tr>
<td>Appendix G</td>
<td>Participant Consent Form</td>
<td>196</td>
</tr>
<tr>
<td>Appendix H</td>
<td>Participant Demographic Form</td>
<td>197</td>
</tr>
<tr>
<td>Appendix I</td>
<td>Multiple Choice Questionnaire (MCQ)</td>
<td>198</td>
</tr>
<tr>
<td>Appendix J</td>
<td>Role-Play Assessment, Vignette A – Researchers Instructions</td>
<td>201</td>
</tr>
<tr>
<td>Appendix K</td>
<td>Role-Play Assessment, Vignette B – Researchers Instructions</td>
<td>205</td>
</tr>
<tr>
<td>Appendix L</td>
<td>Role-Play Assessment, Vignette A – Participants Instructions</td>
<td>208</td>
</tr>
<tr>
<td>Appendix M</td>
<td>Role-Play Assessment, Vignette B – Participants Instructions</td>
<td>209</td>
</tr>
<tr>
<td>Appendix N</td>
<td>The ‘Orienting Approach’ Rating Scale for Clinicians</td>
<td>210</td>
</tr>
<tr>
<td></td>
<td>– Scoring Sheet</td>
<td></td>
</tr>
<tr>
<td>Appendix O</td>
<td>The ‘Orienting Approach’ Rating Scale for Clinicians</td>
<td>212</td>
</tr>
<tr>
<td></td>
<td>– Scoring Criteria</td>
<td></td>
</tr>
<tr>
<td>Appendix P</td>
<td>Reliability coefficients of the SLES and ProQOL in the current investigation</td>
<td>214</td>
</tr>
</tbody>
</table>
List of Tables

Table 1
Mitchell’s (1983) 7-Phase Debriefing Technique 34

Table 2
Orienting the Client (Phipps & Byrne, 2003) 52

Table 3
Characteristics of Participants ($n = 80$) 67

Table 4
Aspects of Knowledge assessed by the Multiple Choice Questionnaire 75

Table 5
Measures of Item Agreement ($n = 64$) 82

Table 6
Comparison of Scores for Vignette A and Vignette B at Pre-assessment 83

Table 7
Comparison of Scores for Vignette A and Vignette B at Post-assessment 84

Table 8
Means and Standard Deviations of Knowledge and Skill, Pre and Post-training 85

Table 9
Means and Standard Deviations of Training Group Skill at Pre and Post-training 86

Table 10
Scoring Criteria for Scale C 100
List of Figures

Figure 1. Exploratory model of the influence of trauma history and VT. 64
Figure 2. Correlations between predictor variables and performance. 88
Summary

Psychological trauma can be produced by indirect, as well as direct, exposure to a distressing event (Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996; Sexton, 1999). Indirect exposure typically occurs by gaining knowledge of the event after it has happened through anecdotal accounts or media communication. The term ‘Secondary Traumatic Stress’ (STS) refers to a stress reaction to such exposure (Motta, Joseph, Raphael, Suozzi, & Leiderman, 1997; Stamm, 1995). The symptom presentation of this phenomenon mimics that of Acute Stress Disorder (ASD) or Post Traumatic Stress Disorder (PTSD) (Herkov & Biemat, 1997). While the impairment that this reaction causes is often ‘subclinical’ (Lerias & Byrne, 2003), studies have shown that indirect exposure to particularly shocking traumatic events can lead to PTSD (Herkov & Biernat, 1997; Schlenger et al., 2002). Furthermore STS places individuals in a ‘high risk’ category for other anxiety and depressive disorders (Breslau, Davis, Peterson, & Schultz, 2000; Friedman et al., 2002). The prevalence of STS can be widespread, with rates as high as 35% in a community under threat of harm (Herkov & Biernat, 1997).

Despite the pervasiveness of this problem no appropriate model of intervention currently exists (Phipps & Byrne, 2003). Because of the relatively low level of acute distress, these individuals may be under-represented in clinical settings. Since mental health services are in high demand, priority must go to more severely impaired individuals (Meadows, Singh, Burgess, & Bobevski, 2002). As a result, the distress and impairment of STS may go unnoticed.
Given the potential for large numbers of people to experience STS and subsequently develop symptoms commensurate with ASD and PTSD, early detection and intervention appears warranted. Skilled practitioners presenting themselves to a community exposed to a traumatic incident would provide an opportunity to identify and assist those that may be affected. Early interventions for trauma do have the potential to reduce distress and lessen the chance of developing pathology (Rose & Bisson, 1998). However, since implementing such an intervention would place an enormous demand on professional resources, other avenues of service delivery need to be identified.

Volunteer counsellors provide an excellent resource for such early interventions. Volunteer counsellors possess skills that are under-utilised by health services (Velleman, 1992). However, the level of skill possessed by volunteer counsellors does limit them in the types of services they can provide. For example, while some treatments that incorporate thorough assessment and case management have been found to be effective in reducing the effects of trauma (Everly, Flannery, & Eyler, 2002), their administration requires expertise and infrastructure that is beyond the capacities of volunteer organisations. Furthermore, the types of intervention that volunteers have used in the past (e.g. single session psychological debriefing) have been found to be potentially dangerous to clients (Deahl, 2000).

Given the potential to exacerbate rather than reduce symptoms of trauma, early and brief interventions used by volunteer counsellors should first ‘do no harm’. A review of the literature on early and brief interventions for trauma reveals several key elements of therapy that are safe and potentially efficacious. From this, the ‘Orienting Approach’ to Trauma Counselling (OATC) was designed as a brief and early intervention for use by
volunteers (Phipps & Byrne, 2003). A key tenant of OATC is the avoidance of therapy
techniques that have previously shown to increase trauma symptoms. Instead, the
approach focuses on the reduction of arousal, psychoeducation, and the dissemination of
self-help information and referral options (Phipps & Byrne, 2003). OATC was designed
as a simple and minimal intervention to reduce the chance of counsellor error and risk of
harm to the client.

This thesis describes the development of OATC. OATC is a brief counselling
intervention, designed to be administered to victims of traumatic incidents. OATC is
designed to be administered shortly after a traumatic incident in order to reduce the
chance of developing psychological trauma at a pathological level. It is intended that
OATC be delivered by volunteer counsellors. It is argued that volunteer counsellors
provide a valuable resource with the skill-capacity to effectively administer this
intervention.

This thesis also describes an evaluation of volunteers’ ability to acquire skills
necessary to deliver OATC. A one day training program was developed to train volunteer
counsellors to administer OATC. Eighty volunteer counsellors participated in the training
program. Volunteers’ capacity to administer the intervention was investigated by
analysing change in volunteers’ knowledge and skill. Knowledge change was assessed
via a multiple choice questionnaire administered before and after training. Skill was
assessed by observing and rating video-taped role-plays conducted before and after
training. It was expected that measures of knowledge and skill would increase
significantly following participation in the training program.
Factors influencing skill performance with the approach was also investigated. Adequate performance in the delivery of this intervention is particularly important given the potential to do harm to this population (Deahl, 2000; Mayou, Ehlers, & Hobbs, 2000). Volunteer counsellors conducting an early intervention for trauma are particularly at risk of experiencing ‘Vicarious Trauma’ (Ghahramanlou & Brodbeck, 2000). Vicarious Trauma (VT) refers to a stress reaction that can occur with practitioners who work with victims of trauma (McCann & Pearlman, 1990). VT, while specific to trauma workers, is similar in many ways to ASD and PTSD (McCann & Pearlman, 1990). With VT, the counsellor experiences distressing recollections of incidents that clients have related to them (Pearlman & Mac Ian, 1995). The distress caused by VT often impairs the counsellors’ ability to deliver interventions properly (Sexton, 1999), which may put the client at-risk of harm. The influence of VT on counsellors’ performance with OATC was investigated. It was expected that VT would impair performance.

Some studies show that counsellors with a history of personal trauma are more likely to develop VT than those without a personal history of trauma (Ghahramanlou & Brodbeck, 2000; Pearlman & Mac Ian, 1995). Other studies have shown that personal trauma history does not affect the emergence of VT (Adams, Motto, & Harrington, 2001; Boscarino, Figley, & Adams, 2004). It is possible that inadequate and inconsistent assessment of trauma history is partially responsible for this disparity in the literature. The present study assessed personal trauma history using a measure of acute reactions in response to a wide variety of potentially traumatising events. The influence of a personal trauma history on the severity of VT is investigated. It was expected that personal trauma history would increase the severity of reported VT.
The effect of a personal trauma history on performance is also explored. Personal trauma history may impair performance as counsellors may begin to reexperience personal incidents when presented with stories of similar incidents during session.

The results of this study found that training resulted in significant improvements on all of the knowledge and skill scales. This suggests that volunteer counsellors do have the capacity to learn and administer the approach. While a history of personal trauma was related to the severity of VT in our population of volunteers, neither personal trauma history nor VT influenced performance with OATC. The absence of either personal trauma or VT as a moderator of OATC performance lends support for further investigation into the clinical effectiveness of OATC. These findings suggest that effective and adherent delivery is not impaired by the coping capacities of the counsellor. The adoption of OATC by volunteer counselling organisations has the potential to assist the community to cope with distressing events and reduce both the immediate and delayed demand placed on professional mental health services. It remains for future research to evaluate the potential benefits of this approach.