The role of volunteer counsellors in the prevention of psychological trauma: the development of the ‘orienting approach’ to trauma counselling

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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

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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.
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.
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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.
Chapter 1 – Secondary Traumatic Stress and Vicarious Trauma

1.1 – Overview

Chapter 1 introduces the concepts of Secondary Traumatic Stress and Vicarious Trauma. Similarities and distinguishing components are described. It is argued that Secondary Trauma, while often innocuous has the potential to cause clinically significant distress and impairment. Recent studies are reviewed, which demonstrate that the prevalence of Secondary Traumatic Stress is a growing concern. A lack of interventions and research addressing the treatment of this problem is also highlighted.

1.2 – What is Secondary and Vicarious Trauma?

Pathological reactions to trauma such as Acute Stress Disorder (ASD) and Post Traumatic Stress Disorder (PTSD) have been well documented (Harvey & Bryant, 1998, 1999). Such diagnoses may be warranted if the individual’s anxiety reaction occurs after being directly exposed to a significantly distressing event (DSM-IV-TR, 2000). Exposure may come as a result of being a victim of, directly witnessing, or having to intervene in one, or perhaps a number of distinct events (Scott & Stradling, 1994).

Individuals who have not been ‘directly’ exposed to a traumatic event have also been found to report similar symptomology such as intrusive recollections of the event and avoidance of reminders of the event. Numerous studies have demonstrated that listening to anecdotal accounts of traumatic events, or having knowledge of such events
can lead to debilitating psychological distress (Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996; Sexton, 1999).

Since its original conceptualisation (McCann & Pearlman, 1990) this phenomenon has received considerable attention. The terms Vicarious Trauma (VT), Secondary Traumatic Stress (STS), Empathic Strain and Compassion Fatigue have been used interchangeably (Sexton, 1999). All of these terms refer to a stress response, which may occur as a result of having gained explicit knowledge of a traumatic or distressing event (Lerias & Byrne, 2003). For the purposes of this thesis the terms STS and VT will refer to distinct syndromes. While the symptoms of STS and VT are essentially the same, the causes of these syndromes are different.

VT is regarded as a unique and common consequence of trauma work (McCann & Pearlman, 1990). McCann and Pearlman (1990) have defined vicarious traumatisation as:

...the transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with the clients’ trauma experiences...it reflects neither pathology in the therapist nor intentionally on the part of the survivor client. (p. 558).

VT is specific to the trauma therapist and may come as a result of being indirectly exposed to traumatic events in the context of the therapeutic relationship (Pearlman & Mac Ian, 1995). For example, trauma therapists may become plagued by images of perverse sexual assault that have been related to them by one of their clients. These images may become so distressing to the therapist that they exhibit trauma like symptoms such as hyper-arousal and avoidance of therapeutic work (McCann & Pearlman, 1990).
STS on the other hand is based on a diagnostic conceptualisation of ASD and PTSD (Pearlman & Saakvitne, 1995). STS can occur to anyone, outside the therapeutic relationship, who is indirectly exposed to an event that they find particularly distressing (Pearlman & Saakvitne, 1995). For example, Herkov and Biernat (1997) found that individuals who have learnt about the existence of a serial murderer in their community report distressing images and dreams of the event(s) as well as avoidance of outside activities.

1.3 – Symptoms of STS

Indirect exposure to traumatic events has the potential to cause distress to the individual. This distress is manifest in symptoms of psychological trauma. The symptoms of STS are essentially the same and mimic those of PTSD and ASD (Pearlman & Mac Ian, 1995). The core presentation of this reaction as described in DSM-IV-TR (2000) involves:

a) Reexperiencing the event through intrusive recollections or dreams.

b) Avoidance of thoughts, feelings, activities and material associated with the event. The individual may also be seen to avoid contact with other people, including emotional and intimate relationships.

c) Persistent symptoms of increased arousal such as insomnia, irritability, anger, difficulty concentrating and hypervigilance.

Indirect exposure does not create, within the observer, a first hand memory of the event. A person who has been indirectly exposed to a traumatic event can however experience intrusive recollections of the event (Murphy et al., 1999; Steed & Downing,
1998). It has been suggested that the process of being informed creates an ‘internal picture’, which can be activated when the individual is presented with specific reminders of the event (Steed & Downing, 1998).

1.4 – Impairment as a result of STS

Indirect exposure to traumatic events has the potential to cause impairment to the individual. Although the severity of symptomology varies between cases, impairment is often at a ‘sub-clinical’ level (Lerias & Byrne, 2003). This does not imply that the distress caused by STS is insignificant. Rather, indirect exposure is less likely to lead to a clinical diagnosis than direct exposure. This could be partly due to the nature of STS itself, as exposure occurs after the event. This delayed exposure thus lacks the necessary requirements to meet the current DSM-IV criteria. Criteria A for PTSD relates to the nature of exposure and states that:

…the person experienced, witnessed, or was confronted with an event or events that involved actual of threatened death or serious injury, or a threat to the physical integrity of others (DSM-IV-TR, 2000; p.467).

Such criteria does not lend itself easily to secondary exposure. Individuals have neither “experienced” nor “witnessed” the event themselves. A common definition of the word “confronted” would also exclude the population. To be “confronted” implies coming “face to face” with some adverse entity (Turner & Turner, 1989). In the present context there is no “face to face” exposure. It is likely that the authors of DSM-IV included this
term to allow the identification of individuals who are witnesses to the aftermath of an event (e.g., emergency personnel).

Since the current diagnostic approach to trauma does not allow for the inclusion of secondary exposure it is unlikely that these people will be identified in clinical settings. As a result this psychological distress often goes unnoticed (Brady, Guy, Poelstra, & Fletcher-Brokaw, 1999; Motta, Suozzi, & Joseph, 1994).

Some studies have shown that indirect exposure to particularly shocking traumatic events can lead to a full-blown PTSD syndrome (Herkov & Biernat, 1997; Schlenger et al., 2002). Studies on the impact of the September 11 terrorist attacks have shown rates of PTSD in the United States to rise above the usual point prevalence of 1-3% (Davidson, Hughes, Blazer, & George, 1991; Helzer, Robins, & McEvoy, 1987). One survey of non-New York residents estimated a rate of 4%, 1 to 2 months after the attacks (Schlenger et al., 2002), while another suggest PTSD rates as high as 8%, 4 to 6 months after the event (NORC, 2002). Herkov and Biernat (1997) studied the prevalence of PTSD symptoms in a community exposed to serial murder. They found that soon after the event (approximately 5 weeks) 14% of respondents met sufficient criteria for a PTSD diagnosis (Herkov & Biernat, 1997). When they followed-up 6 months later, 6% still had sufficient symptoms for PTSD.

Furthermore STS places individuals in a ‘high risk’ category for other pathology. Trauma symptoms have been found to be a reliable predictor of depression (Breslau et al., 2000), somatoform disorders (Roselind et al., 2002) and other anxiety disorders (Friedman et al., 2002).
1.5 – Prevalence of STS

The prevalence of STS in the community will differ greatly between individual incidents. Factors such as incident severity and the extent of media exposure will influence the extent of this problem (Lubit, Rovine, Defrancisci, & Eth, 2003; Putnam, 2002; Saylor, Cowart, Lipovsky, Jackson, & Finch, 2003). Studies of the general US population following September 11th found the prevalence of post traumatic stress symptoms to be as high as 17%, 2 months following the incident and 5.8%, 6 months after (Silver, Holman, McIntosh, Poulin, & Gil-Riva, 2002). However, more localized incidents with less widespread media attention should not be regarded as innocuous. Herkov and Biernet (1997) found rates of post-traumatic stress symptoms, not meeting full criteria for PTSD, to be as high as 35% in their community exposed to serial murder.

1.6 – Predictors of STS

Like pathological reactions to trauma, not everyone who is exposed to a distressing event will develop STS. Research shows that an acute reaction is more likely when the individual shares some emotional bond with those directly affected. This results in a higher incidence in families (Figley, 1998), nurses (Hartman, 1995) and psychotherapists (Brady et al., 1999) of the directly affected individual.

Sharing similarities with the direct victim(s) also increases the likelihood of developing STS. Those that live near the site where an incident occurred are more likely to be affected as they will perceive themselves to be at a higher risk of future harm
Following the September 11 attacks the severity and prevalence of trauma symptoms increased with residential proximity to the World Trade Centre site (NORC, 2002; Schlenger et al., 2002). In Herkov and Biernat's (1997) study the most severe pathology was present in those that shared some demographic similarity to the victims such as gender, ethnicity, age, and education.

Certain aspects of life history may also influence the onset of STS. Having a history of trauma, especially childhood trauma and abuse, has been shown to result in a greater incidence of traumatic stress when vicariously exposed (Breslau, Chilcoat, Kessler, & Davis, 1999; Brewin, Andrews, & Valentine, 2000). Individuals with an adverse mental health history are also more likely to experience psychological trauma after being exposed to a traumatic event (Brewin et al., 2000).

The individual’s ability to cope is also influenced by their current life situation. Concurrent life stress increases the chance of developing trauma symptoms (Brewin et al., 2000). Social support is likely to affect the coping resources of the individual. Stamm (1995) suggests that social support provides one of the most important buffers against the effects of indirect exposure on the individual.

1.7 – Symptoms and impact of VT

VT, like STS, is a traumatic reaction to an event experienced indirectly. The experience of VT however is limited to counsellors and therapists who become traumatised through listening to their clients distressing experiences (Phipps & Byrne, 2003). Furthermore,
this ‘condition’ tends to be the cumulative result of working with trauma victims rather than being limited to one specific event (Pearlman & Mac Ian, 1995). Some theorists have attempted to explain the process of traumatisation in the therapist. For example, information processing theorists propose that exposure to these traumatic stories cause certain schematic changes (Astin, 1997). These changes often affect the therapists view of the world as well as their perception of safety and trust in others (Astin, 1997; Hills, Iliffe, & Steed, 2000).

The symptom presentation of VT is similar to PTSD. The therapist reexperiences the event(s) that have been related by a client, exhibits avoidance, and experiences elevated arousal (Brady et al., 1999; Steed & Downing, 1998). A unique type of avoidance appears to be associated with traumatised psychotherapists. This is characterised by strong countertransference reactions to the directly exposed client as well as avoidance of contact with similar clients and therapeutic work in general (Figley, 1995; Pearlman & Saakvitne, 1995). These problems have also been found to generalise to the practitioners’ daily life. Practitioners will avoid intense interpersonal relationships and begin to perceive themselves as being at risk of harm (Hills et al., 2000; Saakvitne & Pearlman, 1996).

1.8 – Predictors of VT

Not every counsellor or therapist who is exposed to a traumatised client will develop VT. Certain aspects of the work and the individual will place some therapists particularly at risk. Exposure to traumatized clients is obviously one of the most important factors in the
development of VT. Therapists' with higher case-loads of sexually abused clients have shown significantly more trauma symptoms (Brady et al., 1999). There has also been evidence to suggest that younger therapists (Ghahramanlou & Brodbeck, 2000) and therapists with less experience (Pearlman & Mac Ian, 1995) are at greater risk.

It has also been suggested that certain personality variables are predictive of VT. While the influence of personality on the emergence VT has not yet received widespread attention in the literature, several studies have investigated the interaction between the personality construct ‘sense of coherence’ (Antonovsky, 1987), trauma work, and the experience of Vicarious Traumatisation. ‘Sense of coherence’ has been described as a personality variable, having three components: ‘Comprehensibility’ relates to one’s ability to understand their environment; ‘Manageability’ refers to the resources that one has to manage the challenges of the environment; ‘Meaningfulness’ relates to the extent to which the individual considers such challenges worthy of investment (Antonovsky, 1987). A greater ‘sense of coherence’ has been found to be associated with fewer negative changes and more positive changes for trauma therapists on a measure of ‘personal outlook’ as a result of trauma work (Linley, Joseph, & Konstantios, 2005).

Studies investigating the relationship between ‘sense of coherence’ and VT found that non-professional trauma counsellors who were higher on dimensions of ‘sense of coherence’, experienced lower levels of VT (Ortlepp & Friedman, 2001, 2002). In one of these studies, the researchers investigated a possible moderating role of ‘sense of coherence’ with counsellors’ exposure to trauma in the workplace (through clients’ recollections) and the experience of VT (Ortlepp & Friedman, 2001). ‘Sense of coherence’ was found to moderate the relationship between some work-related
experiences of trauma and the experience of VT, but this relationship was inconsistent (Ortlepp & Friedman, 2001). Thus, while it seems that personality variables influence the experience of VT, their moderating role with the stress of trauma work remains unclear.

As with STS, previous studies have shown that the presence of a traumatic life history can increase the likelihood of experiencing VT. Some studies have shown that therapists and trauma counsellors with higher rates of personal trauma tend to develop higher rates of VT (Ghahramanlou & Brodbeck, 2000; Pearlman & Mac Iain, 1995). Several explanations have been proposed to explain why this may occur. A pre-existing state of psychological trauma may be exacerbated by exposure to new traumatic material (Pearlman & Saakvitne, 1995). It is also possible that the traumatic stories of clients may remind the therapist of their own experiences, which may cause therapy to become distressing (Ghahramanlou & Brodbeck, 2000). This finding is reminiscent of the ‘scar hypothesis’ (Lewinsohn, Steinmertz, Larson, & Franklin, 1981). Although the research relates to depressed individuals (Shea et al., 1996; Zeiss & Lewinsohn, 1988), the scar hypothesis helps to explain why people who have experienced mental health problems in the past are more likely to experience mental health problems at a later date. It is proposed that the first episode causes relatively permanent personality changes which increase the individuals’ vulnerability to further episodes (Lewinsohn et al., 1981).

The finding that personal trauma predisposes the practitioner to VT has not been found in all studies (Adams et al., 2001; Boscarino et al., 2004; Schauben & Frazier, 1995). Ghahramanlou and Brodbeck (2000) suggest that this discrepancy could be related to the characteristics of the population being investigated. In the two studies that did not find a relationship between personal trauma history and VT, a sample of social workers
was used (Adams et al., 2001; Boscarino et al., 2004). In the Ghahramanlou & Brodbeck (2000) study that did find a relationship between trauma history and VT, a sample of volunteer counsellors was used. Ghahramanlou and Brodbeck (2000) argue that volunteer counsellors with a personal trauma history may be more at risk of developing VT than professional practitioners with a personal trauma history. They suggest that professional training and a greater theoretical understanding of acute stress and the trauma recovery process may act as a buffer to the emergence of VT (Ghahramanlou & Brodbeck, 2000).

1.9 – Current Treatment Approaches

Research addressing the treatment of STS is presently scarce. While treatment guidelines do exist for those who have been indirectly exposed to some traumatic material, they tend to target the treatment of trauma therapists ('vicarious traumatisation'). The specific nature of this treatment does not apply broadly to other victims of secondary exposure (e.g., a community exposed to violence) as these treatment strategies focus more on workplace management rather than the treatment of actual symptoms.

In the case of VT, some authors take an organisational perspective (Catheral, 1995; Rosenbloom, Pratt, & Pearlman, 1995). These approaches suggest that it is the organisations responsibility to care for the effected individual. In this context treatment becomes ongoing and part of the 'organisational culture'. This is achieved by employing a philosophy that emphasises peer support, open communication and group responsibility. In such an organisation VT is accepted as the normal and often unavoidable response to trauma work. Group members are educated in recognising the
signs of VT. The organisation is then responsible for ensuring that individual’s needs are met through ‘time off’ or by encouraging non-work activities. Care for the worker also involves monitoring caseloads to ensure trauma cases do not predominate (Sexton, 1999).

Most of the literature emphasises self-care as the primary treatment and means of prevention for VT in helpers. These approaches encourage the maintenance of self-care practices such as sustaining physical fitness, and an appropriate balance between work and non-work activities (Pearlman, 1995; Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996; Stamm, 1995). The most recent review identified over 30 useful self-help resources for those who had been indirectly exposed to trauma (O’Halloran & Linton, 2000). All of these focused on addressing this problem in helping professions. To date, no data has been presented which addresses the efficacy of these interventions.

As well as a lack of empirical support for VT interventions, applying these treatments to a general population is questionable when we consider that the reaction itself may be fundamentally different. It has been argued that the identification of VT in therapists is based more on a conceptualisation of ‘burnout’ than an actual trauma reaction (Betts-Adams, Motto, & Harrington, 2001). Fundamental differences exist between a helping population and a general population exposed to secondary trauma. For example, the frequency at which exposure occurs is very different. While a general population may be exposed only once to traumatic material, helping professions must accept this information as a necessary part of their role (Pearlman & Mac Ian, 1995). Because of this ongoing exposure, ‘treatment’ must focus more on management of lifestyle and coping with the work rather than immediate recovery (Stamm, 1995). Since
treatments for VT focus on self-care within the helping relationship and organisational management this cannot apply globally to other traumatic situations.

While there is ample literature regarding the concept of STS, there is a paucity of work relating to treatment. This thesis aims to identify an effective intervention strategy for individuals who have been indirectly exposed to traumatic incidents. Assisting this group poses some challenges. Firstly, the relatively low level of impairment will make this population ineligible for public mental health services. Also, this initial low level of impairment will make it unlikely that they will present themselves to health services, allowing the distress to go unnoticed. Finally, there exists no model of treatment or assistance that is relevant to this population. To address these problems the following chapters focus on identifying:

1. A population of ‘clinicians’ who are able to offer assistance.
2. A way of identifying individuals in the community who may be at risk of STS.
3. An efficacious approach to helping individuals who may experience STS.
Chapter 2 – Secondary Traumatic Stress: Considerations for treatment

2.1 – Overview

This chapter addresses the practical difficulties in identifying and assisting individuals who may be at risk of STS. An early intervention strategy is proposed as the optimal approach to identify those that may be at risk. Early intervention also provides an opportunity to prevent ongoing distress and impairment. It is argued that volunteer counsellors are an excellent resource for this purpose. The skills of volunteer counsellors and the capacities of their organisations are considered in working towards the design of an appropriate model of intervention.

2.2 – The problem of Identification

Secondary exposure may not result in immediate and acute distress, making it difficult to determine who will develop a problematic reaction. When a critical incident occurs, those who are indirectly exposed are less likely to suffer an acute reaction and those reactions are likely to be less severe than those who are directly exposed (NORC, 2002; Schlenger et al., 2002; Silver et al., 2002). However, as previously noted, STS has the potential to become chronic and puts the individual at greater risk of developing more debilitating psychopathology (Breslau et al., 1999; Herkov & Biemat, 1997; Schlenger et al., 2002).

Given that this distress and impairment is often initially low, these individuals are unlikely to receive any priority in professional services. Professional mental health
services in Australia are inundated by clients experiencing varying degree’s of distress and impairment (Meadows et al., 2002). As a result, those with more severe and immediately debilitating conditions will receive priority. Due to the initially low level of impairment they are also very unlikely to present to health services and hence their distress remains unnoticed.

Presenting to the site of an incident shortly after it has occurred does provide a way to identify individuals who may be at risk. The trauma reaction is a unique mental health phenomenon in that the “cause” of trauma can be clearly identified by one, or perhaps a number of, distinct event(s) (Scott & Stradling, 1994). This clear and distinct “cause” gives the clinicians the opportunity to offer their skills and services in an effort to prevent chronic psychopathology. If clinicians were able to present themselves in and around the site of the trauma this would allow the possibility to conduct preventative measures to reduce the chance of enduring pathology. Some early interventions for trauma have been found to be effective in reducing the onset of pathology (Rose & Bisson, 1998). However the problem of finding a group of practitioners who are able to provide such early intervention still exists.

2.3 - Using Volunteers for a preventative intervention

Volunteer counsellors are a potential resource for early and preventative interventions. Velleman (1992) argues that the use of volunteer counsellors in the community for certain mental health problems may be preferable to professional services. For example, lower degrees of stigma surrounding volunteer counsellors may increase victims
willingness to engage with such practitioners (Velleman, 1992). Thompson and Scott (1991) found that older adults (60 years or older) preferred the use of volunteer counsellors as opposed to professional counsellors.

Volunteer counsellors may indeed be more effective than professionals in the delivery of an early intervention for trauma. Raphael (2002) argues that the presence of a mental health professional during the early stages of trauma has the capacity to increase anxiety. Although the individual may not initially perceive their reaction to be maladaptive, the presence of this professional may provide evidence for them to believe otherwise (Raphael, 2002). The presence of a competent helper who is not seen as a member of the mental health profession may be beneficial without being perceived as intimidating.

Using volunteer counsellors reduces the burden on professional services. The demand on mental health services in Australia has led to recent shift towards encouraging professional practitioners who have not received formal mental health training to assume partial responsibility for their continued care (Hickie & Groom, 2002). While the demand for services continues to outweigh the supply, there exists a large pool of skilled para-professionals who are willing and able to provide certain services to the community without payment. By encouraging the use of volunteer counsellors for problems of lower level impairment we are enabling some of the burden to be taken from professional mental health services.

The use of volunteer counsellors for preventative therapy is particularly apt. Given that victims exposed to trauma will not necessarily become clinically impaired (Brewin et al., 2000), the use of professionals in this manner may be an inefficient use of
resources. Using volunteers to do preventative therapy allows professionals to attend to more severe and complex cases. Furthermore, preventing the emergence of severe pathology is also likely to lessen the need for later professional intervention.

Volunteer services also have the opportunity to seek out clients in the wake of a critical incident. Compared to professional providers these counsellors are often underutilized within the community (Velleman, 1992). This greater availability allows volunteers to respond after an incident has occurred.

The literature on volunteer counsellors emphasises a growing level of ‘professionalism’ in both the skills of counsellors and organisations to which they belong. While the majority of counsellors in these organisations are volunteers they are often managed by individuals with specialist training and experience in mental health (Hunot & Rosenbach, 1997). Many volunteer organisations have developed accredited programs where intensive training and supervision is provided on an ongoing basis (Hunot & Rosenbach, 1998). In contrast to other fields of volunteering, which have a high degree of turnover, volunteer counsellors maintain long term involvement with their organisation (Hunot & Rosenbach, 1997). They are also more likely to seek out additional training in the field of counselling and mental health (Hunot & Rosenbach, 1997).

Furthermore, comparative studies have shown volunteers to be comparable to professional practitioners in some domains. Volunteers achieve similar clinical outcomes with problems such as social adjustment, phobia, psychosis and obesity (Berman & Norton, 1985). They have also been found to be equally effective when conveying information to educate clients (Todres, 1990). Given the relatively low level of impairment, and providing that the intervention remains simple, we would expect
comparable success rates between professionals and volunteers when intervening at these early stages.

Volunteer and professional practitioners may be comparable in some domains. However, it is not the intention of this thesis to argue that these two groups are equally skilled and are likely to achieve similar outcomes. Studies have shown that graduate training in psychotherapy relates to enhanced clinical outcomes (Stein & Lambert, 1995). Also, it is not the intention of this thesis to argue for the ‘Dodo bird verdict’. This term, first appropriated by Rosenweig (1936), then popularised by Luborsky, Singer, and Luborsky (1975), refers to a finding that all psychotherapies achieve similar outcomes. This claim has refuted in the literature. Numerous studies have shown that certain therapies are more effective than others, and that certain problems are best addressed by specific types of therapies (Hunsley & Di Giulio, 2002). It is certainly clear that some therapies are more effective than others for addressing psychological trauma. This thesis does argue that volunteers possess skills that can be utilised to reduce distress and impairment following a traumatic incident. While volunteers do possess valuable skills, it is also important to acknowledge the limitations of this group of practitioners. These skills and limitations will be addressed in the following sections.

2.4 – The capacities of volunteers and their organisations

The skills and abilities of volunteers differ greatly between organisations. The training that volunteer counsellors receive is often highly specialised (Velleman, 1992). In contrast to professional fields such as psychology and social work, volunteer counsellors
are often trained in only one type of intervention. The literature highlights specialist volunteer fields such as advocate counselling (Sporakowski, McKeel, & Madden, 1993), drug and alcohol (Hunot & Rosenbach, 1997), geriatric counselling (Nagel, Newlin, & Cimbolic, 1988), sexual health counselling (Todres, 1990) and post-natal counselling (Alder & Truman, 2002).

Most counselling organisations adopt fairly simple and minimal models of service delivery. While some counselling organisations provide ongoing case management, most offer only one-off services (Golden, 1991; Velleman, 1992). Most organisations adopt a client centered model (Egan, 2002) with a focus on the communication of empathy and assistance with problem solving (Golden, 1991; Mc Lennan, 1985). While volunteer counsellors have not traditionally been seen as ‘clinicians’ with skills to ‘treat’ psychological disorders, it is assumed that the counsellors have well developed skills in empowering the client to initiate change in some aspect of their lives (Golden, 1991).

2.5 – Towards an early intervention for STS

In order to capitalise on the resource potential of volunteers, early intervention strategies for STS should be able to be implemented across a wide range of organisations. An optimal strategy would be appropriate for the minimum skills requirement of practitioners. In developing an early intervention strategy for STS it was assumed that organisations would be able to offer single session counselling at the trauma site. It was also assumed that the counsellors would possess a limited level of skill and would not
have received formal training in psychology, social work or other mental health profession.

The parameters within which the intervention was developed were that: the intervention must be brief and able to be delivered over a single session, and the duration of the session also should not extend beyond 1-2 hours. The development of the proposed early intervention for STS is described in the following chapters.
Chapter 3 – Psychological interventions for trauma

3.1 – Overview

Chapter 3 reviews current psychological interventions for trauma with a particular focus on early and brief interventions. Techniques that are incorporated into popular interventions for trauma including; relaxation, exposure, cognitive therapy and psycho-education are discussed. The use of these techniques in early interventions for trauma is then explored. These techniques and interventions are evaluated according to their appropriateness for an early intervention for volunteer counsellors. Several key strategies are identified which have the potential to reduce the psychological impact of traumatic events.

3.2 – Applying psychological treatments to STS

Although the nature of exposure and level of impairment between STS and PTSD/ASD are different, symptom presentation and course remain the same (Herkov & Biernat, 1997; Schlenger et al., 2002). This similarity allows us to draw on established treatments for ASD/PTSD as suitable considerations for an STS intervention.

When adapting psychological treatments to a model for volunteers, the appropriateness of these interventions must be considered. As previously discussed, volunteers have limited skills. Furthermore, some early interventions for trauma do have the potential to do harm to the client (Deahl, 2000; Mayou et al., 2000). This review of
psychological interventions for trauma considers the safety of these interventions given
the capacities of volunteer counsellors. The resulting intervention should, above all, do
no harm.

3.3 – Psychological Treatment of PTSD

Popular psychological approaches for the treatment of trauma tend to incorporate similar
techniques. Elements of relaxation, exposure therapy, cognitive therapy and psycho­
education are incorporated in most efficacious approaches to trauma (Resick & Calhoun,
2001). These techniques and the theory by which they produce change are discussed.

3.4 – Relaxation therapies

Relaxation, as a treatment element for PTSD, was first popularized by Michenbaum
(1985) when he introduced Stress Inoculation Training (SIT). Relaxation now forms an
important element of other popular approaches such as Cognitive Behavioral Therapy
(CBT) (Foa & Rothbaum, 1998), and Eye Movement Desensitization and Reprocessing
(EMDR) (Shapiro, 1995).

Relaxation involves teaching the client skills to lower autonomic arousal. Muscle
Relaxation (Jacobson, 1929) and Breathing Retraining (Craske & Barlow, 2001) are two
popular relaxation techniques. With Muscle Relaxation clients are taught to gain control
over the muscle tension in their body by systematically tensing and relaxing key muscle
groups (Jacobson, 1929). Breathing Retraining on the other hand involves teaching
clients to control their respiratory rate by slowing down their breathing (Craske & Barlow, 2001).

Relaxation, as a treatment for trauma, operates on the principle of ‘counter conditioning’ (Mazur, 1998). Traumatised individuals have been conditioned to experience fear and anxiety when they are presented with reminders of a traumatic event. With relaxation skills, the client is able to lessen autonomic arousal when exposed to these reminders. Relaxation enables the client to associate the pleasant feeling of relaxation with the feared stimulus. The conditioning of this pleasant feeling when exposed to the reminder decreases the need for avoidance.

Some studies have found that relaxation training alone is an effective treatment for PTSD. Studies investigating the comparative efficacy of relaxation training, EMDR and exposure therapy found that while exposure therapy appeared to produce greater reduction in PTSD symptoms, relaxation training was effective in reducing symptoms and did not differ from EMDR in terms of speed or efficacy (Taylor, 2003; Taylor et al., 2003). Marks et al., (1998) compared exposure therapy, cognitive restructuring, exposure combined with cognitive restructuring, and relaxation training. They found that while relaxation training alone was not effective as the other treatments, it did result in a significant reduction in PTSD symptomology (Marks et al., 1998).

3.5 – Exposure therapies

Exposure to the feared trauma-related stimulus forms an integral part of many treatments for trauma. Elements of exposure are incorporated into SIT (Michenbaum, 1985), CBT
Exposure, in the context of PTSD involves confronting the feared stimulus repeatedly, over an extended period of time until the capacity of the stimulus to produce anxiety is decreased. With Prolonged Exposure for example, the client repeatedly confronts the memory of the traumatic event (Foa et al., 1991). During the therapy sessions, clients describe the event aloud in the present tense. Principles of 'graded exposure' are used as the client progresses from minimal to maximum detail (Foa et al., 1991). The client relives the traumatic event repeatedly until anxiety is decreased. Using Prolonged Exposure, Foa et al., (1991) found significant reductions in PTSD symptomology following a period of 9 bi-weekly sessions.

An understanding of the mechanism by which exposure reduces PTSD symptomology requires a brief review of behavioral theories of PTSD (Becker, Skinner, Abel, Axelrod, & Cichon, 1984; Holmes & St. Lawrence, 1983). Such theories purport that PTSD is maintained though avoidance of various feared stimuli, including memories of the event. Classical conditioning is responsible for the initial association of fear with the once innocuous stimulus. Memories of the event are anxiety producing as they have become associated with the fear experienced at the time of the event. These memories are then avoided, which leads to a reduction in anxiety. These avoidance behaviors are negatively reinforced as the individual learns that avoidance reduces the conditioned emotional response (anxiety). This avoidance behavior maintains the anxiety as it
prevents an extinction of the link between the once innocuous stimulus (memories) and the aversive response (anxiety).

Exposure operates on the principle of ‘habituation’ or ‘desensitisation’ (Mazur, 1998). Desensitisation to a feared stimulus occurs when exposure to the stimulus no longer produces anxiety. Exposure therapies result in desensitisation as they break the association between the stimulus (e.g. memories of the event) and fear. When feared memories are recalled multiple times in a safe environment the association between the memories and anxiety is depleted. Importantly, for exposure to be effective, the individual must be exposed to the stimulus for long enough to allow desensitization to occur (Foa & Rothbaum, 1998). The individual must learn that exposure to the stimulus will not result in harm. Furthermore, effective exposure therapy also relies on repeated exposures over time (Foa et al., 1991). The association between safety and the feared stimulus must be reinforced over time.

3.6 – Cognitive therapies

Cognitive techniques form the basis of popular interventions for trauma such as SIT (Michenbaum, 1985), Cognitive Processing Therapy (CPT) (Resick & Schnicke, 1992), and CBT (Foa & Rothbaum, 1998). Cognitive therapies have been found to be highly effective in the treatment of PTSD (Marks et al., 1998; Resick & Schnicke, 1992).

Cognitive therapy is based on ‘Cognitive Theory’ (Beck, 1964; Ellis, 1962). Cognitive Theory assumes that emotions and behaviour are influenced by individuals’ perceptions of events. Negative emotional states are thought to be the result of unhelpful,
automatic attributions of events, or ‘negative automatic thoughts’. The occurrence of these negative automatic thoughts is believed to be influenced by more fundamental beliefs that the individual holds (Beck, 1964).

Cognitive therapy involves identifying and modifying unhelpful thinking or beliefs (Beck, 1995). The therapist uses various techniques to assist the client to actively challenge unhelpful thoughts, assumptions and beliefs while attempting to promote helpful ones (Beck, 1995). This process of changing thought patterns and adapting belief systems is known as ‘cognitive restructuring’ (Beck, 1995). The aim of cognitive restructuring is to change the way that individuals construe events in order to increase the likelihood of positive emotion and helpful behaviour.

3.7 – Psychoeducation

Psychoeducation is incorporated into most effective interventions for trauma such as Relaxation therapies (Michenbaum, 1985), Cognitive therapies (Resick & Calhoun, 2001), Exposure therapies (Foa et al., 1991), and effective early interventions such as Critical Incident Stress Management (Flannery, 2001). Psycho-education involves teaching clients about the nature and course of psychological disorders and symptoms. In the context of trauma for example, clients are often informed that it is ‘normal’ to; reexperience the event in some way, engage in avoidance behaviours, and experience unpleasant autonomic arousal following involvement in a traumatic event (Neuner, Shcauer, Klaschik, Karunakara, & Elbert, 2004).
Psychoeducation in psychological therapies forms the basis of some elements of cognitive restructuring (Craske & Barlow, 2001). Psychoeducation allows the client to appraise their psychological symptoms in a more accurate way. Individuals experiencing some anxiety disorders have a tendency to interpret psychological symptoms as ‘catastrophic’ or indicative of some severe and threatening condition (Craske & Barlow, 2001). For example, some individuals recovering from a traumatic incident may regard symptoms of reexperiencing as a sign that they are ‘going crazy’ (Ehlers, Mayou, & Bryant, 1998). Educating clients on the nature and reason for their symptoms promotes accurate construing of these symptoms and lessens the anxiety that these symptoms create (Craske & Barlow, 2001).

Although psychoeducation is incorporated in many effective treatments for PTSD, very few studies have evaluated the effectiveness of psycho-education alone in the treatment or prevention of psychological trauma. Poor methodology in those that have has prevented researchers from drawing definitive conclusions on role of psychoeducation in recovery (e.g., Staaehr, 2001). The results from studies of psychoeducation for other forms of psychopathology do support its use (Bloom, 1999). For example, a randomized controlled trial that tested the effectiveness of a brief psychoeducational intervention in reducing disability in cardiac patients experiencing benign palpitations found that participants were more physically active and less distressed when experiencing palpitations as a result of the psychoeducation (Mayou, Sprigings, Birkhead, & Price, 2002). This study suggests that psychoeducation alone can be effective in reducing unhelpful construing of anxiety symptoms. Furthermore, Rauch, Hembree, and Foa (2001) note that while early interventions for trauma have variable
effectiveness, psychoeducation is common to those that have shown to be effective in reducing PTSD symptomology.

3.8 – Preventative early interventions for trauma

Preventative measures for trauma aim to mitigate the psychological impact of traumatic events. Such preventative measures involve intervening soon after a traumatic event has occurred. A popular model of early intervention is ‘Psychological Debriefing’, which has received considerable attention in the literature over the past decade. Psychological Debriefing has two variants; ‘Critical Incident Stress Debriefing’ (CISD) (Mitchell, 1983), and ‘Critical Incident Stress Management’ (CISM) (Mitchell & Everly, 1997). Research into the effectiveness of these interventions in preventing the onset of traumatic symptoms has shown variable effectiveness. The following discussion outlines the debate surrounding early interventions for trauma and assesses the potential benefits of these interventions for the model proposed in this thesis.

3.9 – Critical Incident Stress Debriefing (CISD)

CISD was originally designed as a ‘stand alone’ procedure to assist ambulance personnel following a traumatic incident (Mitchell, 1983). The intervention is usually presented in a group setting with one or more facilitators. It is recommended that debriefing should take place within 48-72 hours after the incident in order to have the greatest preventative effect (Dygrov, 1997). The seven phase debriefing technique is summarised in Table 1.
CISD combines a number of techniques that are popular in the psychological treatment of PTSD. CISD includes a substantial psychoeducational component. The technique emphasises educating the individual in the symptoms and processes of trauma reactions (Bisson, McFarlane, & Rose, 2000). These reactions are normalized (Mitchell, 1983). Information is also provided about signs that might indicate this ‘normal’ response is becoming ‘abnormal’ (Mitchell, 1983).
CISD also incorporates elements of exposure therapy. Participants are asked to recall elements of the event in increasing detail. Participants are encouraged to begin with simple sequential descriptions of the event, proceeding to more comprehensive recollections of the event and their own experience (Mitchell, 1983). This strategy of imaginal exposure to increasingly more detailed recollections is similar to the technique of Prolonged Exposure (Foa et al., 1991).

### 3.10 – The effectiveness of CISD

Much debate exists as to the effectiveness of CISD. However, there does seem to be a growing body of evidence to suggest that CISD provides little benefit in the prevention of PTSD and can actually increase the risk of PTSD symptoms (McNally, Bryant, & Ehlers, 2003).

While several peer reviewed papers present evidence to support the use of the CISD, methodological flaws in this research question the validity of these findings. One study investigated the use of CISD on a population of emergency medical service personnel following their involvement in the 1992 Los Angeles riot (Wee, Mills, & Koehler, 1999). Most participants (72.9%) reported being attacked during the riot. 42 participants received CISD while 23 participants received no intervention. The researchers found that, 3 months after the riot, the debriefed participants reported significantly fewer PTSD symptoms. However, this study did not include a pre-intervention assessment of PTSD. It is possible that the CISD group were less distressed initially, which would decrease the probability that they would develop PTSD (McNally...
et al., 2003). Also, participants were not randomly allocated to treatment or control conditions. Participants were placed in the ‘control’ group after logistical constraints prevented them from receiving any intervention. While this study appears to present positive results in favor of CISD, a lack of randomisation as well as a lack of a pre-intervention assessment limits the validity of the findings.

Numerous other studies frequently cited in support of CISD show similar methodological flaws. Jenkins (1996) found that their CISD intervention group showed significantly less PTSD symptoms at one-month follow-up. However, this study used a retrospective assessment as their pre-intervention measure which asked participants to, “remember how you were feeling a week before the incident” (Jenkins, 1996; p.481). This method of assessment has been criticised as being highly susceptible to reconstructive memory bias (Devilly, Gist, & Cotton, In Press). Yule (1992), while showing a decreased rate of PTSD symptoms for the intervention group, had no random assignment and no pre-intervention assessment. Furthermore, the intervention employed in Yule’s (1992) study did not adhere to the practice of CISD. Instead it was based on cognitive behavioural methods (McNally et al., 2003). Chemtob, Thomas, Law, and Creminiter (1997) also found positive results of debriefing, but employed this intervention six months after the traumatic incident had occurred. With this lengthy delay, the intervention ceases to be a ‘preventative’ intervention for PTSD as any pathological reactions are likely to have already developed (McNally et al., 2003).

Devilly, Gist and Cotton (In Press) have commented on the difficulty in conducting valid debriefing research. In particular, they discuss the difficulty in conducting a Randomised Controlled Trial (RCT) where participants are randomly
allocated to an intervention or control group. These authors state that organisations, which manage potential participants, are often unwilling to impose an allocation process where certain individuals may be denied a potentially helpful service (Devilly et al., In Press). Consequently, samples from these non-RCT studies tend to be self-selected. It is possible that some of the negative results of debriefing are the result this self-selection. Those who elect to take part in the debriefing group may be more distressed, and less likely to benefit from the intervention (Devilly et al., In Press). It has certainly been suggested by several studies that higher initial distress in a CISD group is responsible for poorer outcomes when compared to the control group (Bisson, Jenkins, Alexander, & Bannister, 1997; Mayou et al., 2000).

While there appears some evidence to support the use of CISD, the evidence to refute its use seems much more compelling. Mayou, Ehlers and Hobbs (2000) conducted an RCT to examine the use of CISD with a population of motor vehicle accident survivors. One group of participants received CISD, which involved the administration of 1-hour individual debriefing as well as providing written information. Another group received treatment as usual. It was found that three years later the group who received the treatment had significantly worse psychiatric symptoms, travel anxiety, physical problems and poorer overall level of functioning than the group who did not receive the treatment.

Rose and Bisson (1998) reviewed Randomised Controlled Trials (RCT’s) of psychological debriefing. Of these studies six were selected for discussion on the basis of meeting criteria including: random assignment to experimental and control groups, using standardized/valid outcome measures, and delivery of a CISD intervention that matched
the description of Mitchell (1983). In two of the studies the treatment group significantly improved. In the remaining four studies, two showed no difference between groups while two showed an increase in psychiatric morbidity when exposed to the treatment. Thus, while CISD is a brief and early intervention it appears that evidence for its effectiveness is highly variable.

In a more recent ‘Cochrane review’, further evidence was presented to oppose the use of CISD (Rose, Bisson, Churchhill, & Wessely, 2002). This review discussed RCT’s where persons were administered a single session intervention following a traumatic event. The interventions discussed involved some form of emotional processing or ventilation, by recollection of the traumatic event (Rose et al., 2002). Studies included in this review were RCT’s with valid pre-post outcome data where the intervention was delivered within one month of the event. 15 trials were included in the review. In all of the studies reviewed, debriefing did not reduce psychological distress following the event and did not prevent the onset of PTSD compared to control (Rose et al., 2002). A reduction in PTSD symptomology was not reported at any follow-up period (1-4 months, 6-13 months or 3 years) (Rose et al., 2002). The two studies with the longest follow-up found adverse effects of the intervention (13 months: Bisson et al., 1997; 3 years: Mayou et al., 2000). However, Rose et al., (2002) did acknowledge that these negative results may have been influenced by large amount of attrition in Bisson et al., (1997), and ineffective randomisation in Mayou et al., (2000).

The Cochrane review of Rose et al., (2002) may present one of the most comprehensive and scientifically valid evaluations of CISD to date. However, this review has several limitations which limit the generalisability of the results. Firstly it does not
include any studies, where CISD was delivered as a group intervention. This is not surprising since this and other recent reviews have been unable to locate any RCT’s using group debriefing (Devilly et al., In Press; Rose et al., 2002). This is problematic since group debriefing is the most common type of debriefing used in community settings (Devilly et al., In Press). Also, this Cochrane review did not include studies that evaluated the effectiveness of CISD with the most common trauma situations, e.g., workplace trauma and mass casualty events (Devilly et al., In Press). Without adequate RCT’s including group debriefing and common trauma situations, it is difficult for researchers to make a definitive judgment as to the effectiveness of CISD.

It has been suggested that the effectiveness of CISD may depend on the initial severity of trauma symptoms. One RCT investigated the effect of debriefing with victims of acute burn trauma (Bisson et al., 1997). The treatment group showed significant increases on measures of depression, anxiety and trauma symptoms post intervention. However, the intervention groups initial ratings showed higher scores on trauma severity and greater exposure to previous trauma (Bisson et al., 1997). This suggests that the effectiveness of CISD may be affected by the individuals’ present level of functioning, and trauma history. Thus, a person who is significantly impaired after the traumatic event or has a history of trauma may not be suitable for this treatment. It has been suggested that suitability could be determined only via thorough clinical assessment (Bisson et al., 1997).

It appears that the effectiveness of debriefing may also be influenced by the skills of the facilitator. The literature has documented an overwhelming prevalence of debriefing facilitators who have had little or no formal training (Deahl, 2000). Deahl
(2000) argues that the negative results of CISD may be the result of inadequate delivery by underqualified practitioners. Most importantly, these practitioners lack the skills necessary to assess people for debriefing and provide appropriate assistance if the procedure inadvertently increases anxiety (Deahl, 2000).

Some investigators have suggested that the potential adverse affects of debriefing are a result of the element of exposure therapy (Bisson et al., 1997; Mayou et al., 2000). It is possible that intense imaginal exposure to distressing material may actually further traumatise the individual, exacerbating the symptoms of trauma (Bisson et al., 1997). Pitman et al. (1991) have commented on an exacerbation of symptoms when PTSD victims initially engage in exposure therapy. This complication can be managed in ongoing therapies as clients returning to therapy are engaged in further exposure, allowing the process of habituation to occur. However, with single session debriefing no further contact is made with the client. Habituation to the feared stimulus does not occur as the client does not engage in any further controlled and prolonged exposure. In single session debriefing, anxiety levels are raised and then the session comes to an abrupt end. This brief period of exposure may serve only to strengthen the relationship between the conditioned stimulus (e.g., the traumatic memory) and the aversive conditioned response. It is also argued that debriefing has the potential to increase symptoms of trauma as it interferes with individuals’ usual coping strategies (Bisson et al., 1997). Involvement in debriefing shortly after the incident does not allow individuals to engage in their ‘normal’ routine of anxiety reduction.

Group CISD has the additional complication of exposure to the traumatic material of others in the group. One of the problems with group debriefing is that the model
assumes that all participants have been exposed to the same experience (Mitchell, 1983). While participants may have been involved in the same event, their involvement in the event may differ substantially. In a debriefing of bank workers following a robbery for example, the experience and level of exposure of a bank teller who was threatened with a weapon is likely to differ substantially to another worker who was in a back room and effectively absent for the entire event. In a standard debriefing procedure, both of these individuals would be required to attend the same debriefing session (Mitchell, 1983). Since it is possible to experience psychological trauma through secondary exposure (McCann & Pearlman, 1990), listening to the distressing anecdotal accounts of others has the potential to cause further psychological trauma.

It appears that while psychological debriefing may have some preventative effect with certain populations it would not be suitable for use by volunteer counsellors for victims of STS. Since volunteer counsellors have not necessarily received formal training it is unlikely that they will possess the skills that Deahl (2000) argues are necessary to achieve positive results. Thus, debriefing based on the Mitchell (1983) model has the potential to be deleterious.

This literature presents some useful information towards the design of an early intervention for volunteer counsellors. It seems that single session, early interventions for trauma have the potential to do harm if they include elements of exposure therapy. Mayou, Ehlers and Hobbs (2000) showed that even when psychological debriefing is delivered individually it can increase the potential for distress and impairment. In order to minimize the risk harm, the proposed intervention should avoid elements of exposure therapy. However, elements of exposure therapy are not simply limited to structured
exposure therapies such as debriefing (Mitchell, 1983) or Prolonged Exposure (Foa et al., 1991). Client Centered counselling models (Egan, 2002), employed by many counselling organizations, focus on the active elicitation of details of the problem situation, and the clients thought/emotions associated with the situation. Thus, a counsellor working from a client centered model is likely to question a traumatised client about the event and their reaction to it. This technique is very similar to the exposure elements that are present in CISD. A counsellor using these basic counselling skills may be placing the client at risk of harm as they are facilitating imaginal exposure. In order to minimise the risk of harm it may be advantageous for counsellors to avoid such questioning. A model of brief intervention for trauma should focus on avoiding the active elicitation of trauma details.

3.11 – Critical Incident Stress Management (CISM)

There is evidence to suggest that debriefing should not be dismissed altogether. Instead, it is proposed that CISD be incorporated into Critical Incident Stress Management (CISM) (Mitchell & Everly, 1997). CISM involves three primary components:

1. Pre-Trauma Training: Stress Inoculation Training (Michenbaum, 1985).
2. Debriefing: Structured group based on Mitchell model of debriefing (1 session, 1.5 – 2 hours).
3. Individual Follow-Up: Subjects are assessed 1 month after incident. Ongoing difficulties are identified. Treatment, if needed, is based on a cognitive behavioural approach.
CISM is a much more comprehensive approach than single session debriefing. CISM incorporates Stress Inoculation Training, debriefing, and follow-up assessment and intervention into an ongoing model of care for individuals exposed to traumatic events. CISM was designed for individuals who have been identified as ‘high risk’ of exposure to traumatic events (e.g. soldiers, bank staff, emergency service personnel) (Mitchell & Everly, 1997). The pre-trauma training component is designed to provide the participant with anxiety coping skills before the event occurs (Mitchell & Everly, 1997). The provision of follow-up assists in the identification of individuals who may continue to experience distress and impairment. At this stage efficacious treatments such as CBT can be delivered if necessary (Mitchell & Everly, 1997).

3.12 – The effectiveness of CISM

Field research seems promising for CISM. One study compared the use of CISD and CISM on a population of bank workers exposed to critical incidents (Richards, 2001). This prospective study compared the rate of PTSD in the populations following two different armed robberies. After the first robbery, participants received CISD. After the second (later) robbery, participants received a more comprehensive CISM approach. It was found that the CISM group had significantly less trauma symptoms at 3-month and 12-month follow-up than the CISD group (Richards, 2001). While this study presents some reasons to optimistic about the potential of CISM to reduce trauma symptoms, it has received some criticism (e.g., McNally et al., 2003). Firstly, the study compared outcomes following different events. It may be that the first event, which received CISD,
was significantly more distressing than the latter. Also, there was no control group who received no intervention. Finally, there was no random allocation to treatment conditions. Given these limitations it is difficult to conclude that reductions in PTSD were attributable to either CISD or CISM as most individuals who are exposed to traumatic events will improve overtime without any intervention (McNally et al., 2003).

Several meta-analyses claim to demonstrate the preventative power of CISM. A review of eight CISM investigations revealed that, on average, individuals receiving CISM were significantly more likely to improve than those who did not (Everly et al., 2002). However, justifying the use of CISM on the basis of this review is problematic. Five of the eight articles reviewed refer to the use of the ‘Assaulted Staff Action Program’ (ASAP: Flannery, Hanson, Penk, Flannery, & Gallagher, 1995). ASAP is a program designed to assist staff in a psychiatric facility cope with aggressive patients. ASAP involves: training in aggression minimisation, coping strategies for staff, acute crisis intervention based on Mitchell (1983), private referral to a trauma therapist, and an incident review to assist staff to improve their responses to violent incidents (Flannery et al., 1995). It has been argued that using ASAP investigations to justify the use of CISM is problematic as ASAP is a distinct and dissimilar intervention to CISM (Devilly & Cotton, 2004). Furthermore, studies investigating ASAP use the occurrence of staff assaults as their outcome measure (Everly et al., 2002). This makes it difficult to generalise these results to a community population where the desired outcome is the reduction of psychological distress and symptoms of PTSD. Thus, while CISM may offer a more comprehensive and potentially more efficacious approach to trauma, further research is needed to justify the widespread use of this approach.
Regardless of the efficacy of CISM, the model is not an appropriate intervention for volunteer counsellors. Although CISM contains elements of brief and early intervention, pre-trauma training and individual follow-up make this treatment quite lengthy. It is not a single session intervention. Administration would require resources and infrastructure beyond the capabilities of most volunteer organizations. However, elements of CISM may be applicable to the treatment of traumatised individuals by volunteers.

The possible success of CISM may be attributed to the components that are absent in CISD. The two key components of CISM, which differ from CISD, are Stress Inoculation Training (SIT) and individual follow-up. While the limits of our single session intervention do not allow for the possibility of follow-up, elements of SIT may be appropriate for the proposed intervention. The following discussion evaluates the effectiveness of SIT and the feasibility of adapting SIT elements to an early intervention for volunteer counsellors.

3.13 - Stress Inoculation Training (SIT)

SIT was developed by Michenbaum (1985). SIT, as an early intervention for trauma is essentially a combination of relaxation and cognitive therapies (Richards, 2001). Common relaxation techniques taught in this approach are Muscle Relaxation (Jacobson, 1929) and Diaphragmatic Breathing Relaxation (Craske & Barlow, 2001). Such techniques are useful as a counter-measure for the general autonomic arousal associated with post-traumatic stress, as well a coping strategy when confronted with reminders of
the event (Foa et al., 1999). Common cognitive techniques taught in SIT are ‘thought stopping’ and ‘guided self-dialogue’ (Resick & Calhoun, 2001). Thought stopping is a technique to help to lessen distressing ruminating thoughts that clients may experience, while guided self dialogue is a technique to assist clients to reduce the maladaptive distressing internal dialogue (Michenbaum, 1985). Cognitive techniques in SIT for trauma also include psychoeducation (Resick & Calhoun, 2001).

SIT has been shown to be effective in reducing the symptoms of PTSD in female assault victims (Foa et al., 1999; Foa et al., 1991). When delivered over nine bi-weekly sessions SIT alone has been shown to be superior to supportive counselling (Foa et al., 1991) and equally effective as prolonged exposure and combined SIT/prolonged exposure (Foa et al., 1999).

Given that SIT aims at reducing rather than increasing arousal, it may be appropriate for use by volunteer counselling services. This is a relatively ‘safe’ therapy that does not appear to have a pronounced risk of iatrogenic effects.

The length of treatment required for SIT is a key limitation for its inclusion in a single session intervention. Eighteen sessions were administered in the Foa et al., (1991) study, which incorporated multiple relaxation and cognitive strategies. However, it is possible to incorporate some simple elements of SIT into a single session intervention for trauma. For example, diaphragmatic breathing relaxation is a relatively simple technique that is often only allocated one session for instruction in treatment manuals for anxiety conditions (Craske & Barlow, 2001). Breathing relaxation alone has been shown to be effective in anxiety treatments by reducing autonomic arousal (Garssen, de Ruiter, & van Dyck, 1992).
It may also be possible to incorporate some of the cognitive elements of SIT. Cognitive therapy techniques such as thought stopping and guided self dialogue are likely to be problematic. Thought stopping, while relatively simple to learn, can actually encourage avoidance if used incorrectly (Resick & Calhoun, 2001). Because there may be no opportunity to follow-up with the anticipated client group, the use of thought stopping may prevent the natural process of desensitization to distressing thoughts and recollections. Other techniques of cognitive therapy such as guided self dialogue and the challenging of unhelpful thoughts are also likely to be inappropriate. The successful use of these techniques requires a significant amount of training as well as time in therapy far beyond a one session limit (Beck, 1995; Foa & Rothbaum, 1998; Freiheit & Ocherholser, 1997). Cognitive techniques such as psychoeducation may be more applicable for our intervention.

Providing psychoeducation, by educating clients on the symptoms and course of trauma, may assist clients to avoid making inaccurate attributions regarding ‘normal’ reactions. In most cases a single session should provide enough time for adequate education. Mayou et al., (2002) delivered a single session psychoeducational intervention that aimed towards changing inaccurate symptom interpretations. These authors found that one session of psychoeducation resulted in significantly fewer inaccurate interpretations and significantly less anxiety in response to symptoms (Mayou et al., 2002). Psychoeducation may also benefit clients as it has been shown to play a key role in assisting clients to monitor their own symptoms to prevent relapse (Ekelund & Skule, 2004). Psychoeducation on trauma symptoms and indicators of emerging pathology may enable clients to recognise personal signs that further psychological assistance is
necessary. Psychoeducation is also a skill well within the capabilities of volunteers. Todress (1990) found that volunteers are as effective as professional mental health practitioners in communicating information to educate clients. Thus psycho-education appears to be a viable component for our intervention.

3.14 – Provision of written materials

The success of the SIT elements of relaxation and psychoeducation may be enhanced by the provision of written materials. Saunders, Driskell, Johnston, & Salas (1996) found that the benefits of SIT are increased with the number of training sessions. Written materials may provide a method of reinforcing information delivered during the active treatment phase. Research suggests that the majority of clients do refer back to written materials provided after the active treatment phase (Smith, Floyd, Scogin, & Jamison, 1997).

3.15 – Proposal for a preventative intervention for volunteers

While traditional early and brief interventions for trauma are not suitable for use by our volunteer population there does appear to be some useful elements of intervention that have come from the CISD/CISM literature. The avoidance of exposure techniques, including the elicitation of event details and reactions is likely to minimise the risk of harm to the client. Psychoeducation and normalisation regarding the trauma response is likely to prevent unhelpful construing of symptoms. Relaxation strategies are likely to
reduce autonomic arousal and provide a coping mechanism when confronted with distressing reminders. Written materials that include self-help information regarding signs of ineffective coping as well as referral options are likely to provide clients with some assistance if they develop clinically significant distress and impairment. In the following chapter these elements are incorporated into a model of early intervention that is appropriate for use by volunteer counsellors.
Chapter 4 – The ‘Orienting Approach’ to Trauma Counselling

4.1 – Overview

Chapter 4 describes the ‘Orienting Approach’ to Trauma Counselling (Phipps & Byrne, 2003). This is a brief and early intervention for trauma designed for use by volunteer counsellors. The elements of the intervention as well as the rationale for their use are described. The literature on effective dissemination strategies is briefly reviewed to assist in the design of an effective training program. This training program as well as a comprehensive description of the specific skills involved can be found in ‘The Orienting Approach – Training Manual’ (Phipps & Byrne, 2005), in Appendix A.

4.2 – The ‘Orienting Approach’

Research on existing interventions for trauma provides guidance on appropriate strategies to include in a brief and early intervention for trauma. These strategies relate to the avoidance of exposure techniques, the reduction of arousal and the provision of psycho-education.

The OATC is a model of crisis counselling for individuals exposed to trauma that can be administered over a single session. It is a one-to-one intervention designed to be delivered by volunteer counsellors. While the duration would depend on the level of need, it is estimated that sessions would not exceed 90 minutes. Such a counselling approach may be helpful at any stage of the trauma reaction but is designed for early
intervention, soon after the impact of the event. OATC is a theoretically ‘safe’ protocol, which emphasises support, normalisation, psychoeducation, relaxation and providing information on self-help strategies and referral options. These core components are summarised in Table 2.

4.3 – Support

The OATC involves providing support and empathy to the client, while refraining from the active elicitation of event details and reactions. Scott (2000) suggests that patience on the part of the counsellor will be needed as the client recounts the same story multiple times. A great amount of confusion is common as the individual struggles to make sense of their new reality (Shalev & Ursano, 2002). Soon after the event, clients may repeat the traumatic story multiple times in an effort to understand what has transpired (Shalev & Ursano, 2002). Helpers must be willing to tolerate the repetitiveness of these accounts. The warmth, understanding and acceptance of the counsellor can create a holding environment in which integration of this new material is possible (Scott, 2000). The presence of a stable and confident ‘other’ also provides a much-needed positive coping model (Scott, 2000). Thus, counsellors using OATC should be patient with clients if they wish to recount the story multiple times. Counsellors should also use ‘default’ skills for conveying empathy such as reflective listening.

Support should occur without encouraging or actively eliciting further detailed accounts of the event, or the clients’ reaction to the event. Such questioning encourages imaginal exposure to the event. It has been argued that such exposure in an single session
trauma intervention can increase the risk of enduring distress and impairment (Bisson et al., 1997; Mayou et al., 2000). To this end probing questions such as: “what did you see/hear”, “how did that make you feel”, or “what bothers you the most about the event”: are deemed inappropriate by the Orienting Approach.

Table 2

<table>
<thead>
<tr>
<th>Orienting the Client (Phipps &amp; Byrne, 2003)</th>
</tr>
</thead>
</table>

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4.4 – Language

The counsellor must be alert to the client’s choice of words and use these words themselves in discussion. It is not important for the client to use correct terminology (Scott, 2000). An individual who has recently been exposed to trauma may have an subconscious but intense perception of threat (Shalev & Ursano, 2002). As they struggle to make sense of what has happened they may ‘protect’ themselves by playing down the
event. For example, A woman whose sister has been brutally raped may describe her as being “attacked” (Scott, 2000). This is the sign of a temporary coping mechanism that should not be challenged at these early stages (Scott, 2000). Using language that is different to what has been communicated by the client has the potential to expose the client to further traumatic material. Such exposure may increase anxiety, leading to further risk of impairment (Bisson et al., 1997; Mayou et al., 2000).

4.5 – Normalisation

The OATC involves normalising the psychological response to trauma. Normalisation forms part of the psychoeducational component of OATC. Normalising individuals’ responses and symptoms is likely to lessen unhelpful construing that may lead to further anxiety. Clients may express concern over their immediate behaviour in response to the event or the trauma symptoms that have followed. In this case, counsellors should communicate that such reactions and symptoms are normal.

Clients’ psychological distress in response to the event should be normalised by the counsellor. When people are exposed to a traumatic event the ‘primary stress response’ can cause the individual to surrender, fight or be controlled by extreme fear (Shalev & Ursano, 2002). These responses are often so powerful that they take control of the person’s behaviour (Shalev & Ursano, 2002). People may act in a way that is previously unknown to them. Ordinarily timid people may find themselves risking their lives to save others. On the other hand, a person may find the event so distressing that they are paralysed with fear. It is likely that these memories will be distressing,
particularly if the actions are out of character. It is possible that those who are overcome with fear may experience extreme guilt (Shalev & Ursano, 2002). They may regard their ‘freezing’ or ‘fleeing’ as acts of cowardice.

It is important that these reactions are regarded as normal by the counsellor. It must be communicated clearly to the client that in these circumstances our control over our actions may be diminished. Psycho-education, with reference to the fight/flight response, would be useful. Normalising the individuals’ immediate response to an event minimises their tendency toward negative self attributions that lead to distress (Shalev & Ursano, 2002).

Client’s experiencing traumatic symptoms should be reassured that these symptoms are ‘normal’. Clients who are experiencing symptoms are often unsure of what is happening to them (Ehlers et al., 1998). Some clients may believe that they are ‘going mad’ as intrusive images and memories cause seemingly debilitating anxiety. Counsellors should be alert to this, as enduring symptoms have been found to be associated with those who negatively appraise these early experiences (Ehlers et al., 1998). While intrusive images, flashbacks and nightmares can be distressing they should be regarded as a normal aspect in the recovery process. The counsellor may wish to describe their symptoms as ‘a normal response to an abnormal situation’.

4.6 – Skills

On the basis of the effectiveness of SIT and other relaxation therapies in the treatment and prevention of psychological trauma (Foa et al., 1999; Foa et al., 1991; Marks et al.,
55
1998), OATC incorporates skills to assist clients to lower autonomic arousal. Clients should be taught a simple relaxation technique such as ‘diaphragmatic breathing’ (Craske & Barlow, 2001). Part of this strategy would involve the provision of a rationale for breathing relaxation with clients being encouraged to practice this technique daily. The provision of written materials would reinforce the rationale for this technique and the skills involved.

4.7 – Advice/Information

The provision of advice and information forms another part of the psychoeducational component of OATC. Accurate information regarding trauma and psychological recovery may assist clients to construe their symptoms accurately, avoiding unnecessary distress. The counsellor can also provide advice about self help strategies that can be used. Arming the client with this information may empower them to avoid the ‘normal’ reaction becoming ‘abnormal’. The provision of written information and referral options will also assist the client to recognise the signs of emerging pathology and seek out psychological assistance if needed. Advice and information is provided in the following ways:

1. Information about trauma symptoms: Information about common trauma reactions and symptoms should be conveyed to the client regardless of whether they are currently symptomatic. These should be communicated as part of the normal range of responses to trauma. If the client does begin to experience these symptoms excessive
worry may be avoided as the client will be better informed and less inclined to think they are ‘going crazy’.

2. **Information about recovery**: Information about the usual pattern of recovery from trauma should be communicated to the client. A clear communication of the signs that professional help may be needed should be communicated (eg. if distress extends beyond one month). This will assist clients’ to make a more informed decision as to the need to further professional help.

3. **Advice to maintain contact with others**: Counsellors should encourage the client to maintain contact with significant others. People who are exposed to trauma at some level may begin to question their sense of safety and trust in others (Pearlman & Saakvitne, 1995). Trauma victims may experience an increased sense of vulnerability in a world they no longer believe is predictable (Shalev & Ursano, 2002). Withdrawal may come as a result of decreased sense of trust in oneself and others (Pearlman & Saakvitne, 1995). As trauma victims often withdraw from personal relationships, they will need encouragement to keep in contact with significant others. Individuals who do maintain contact with others tend to show a quicker recovery, and fewer symptoms following a traumatic event (Brewin et al., 2000). If clients are able to maintain this contact they may be less likely to suffer acute distress and impairment (Brewin et al., 2000). The involvement of others also provides a secondary source to assist in help-seeking if needed.

4. **Advice to reduce life stress**: The counsellor should recommend that the client reduce stress in their lives for this period of recovery. Trauma victims with less life stress
tend to show a lower rate PTSD (Brewin et al., 2000). The counsellor may encourage the client, “not to push themselves too hard”, or “take too much on”.

5. **Written information:** Clients of volunteer organisations would benefit from a handout that covers symptoms, self-help strategies (including breathing relaxation) and referral options. This would reinforce information provided during the actual intervention phase as well as providing a source of referral information.

### 4.8 – Developing an effective training program for volunteers

One of the aims of this study is investigate the appropriateness of OATC for volunteer counsellors. Since the OATC has been designed with the intention for it to be broadly disseminated to volunteer counsellors, it is essential that volunteers be able to learn and administer the approach. A review of the literature on dissemination strategies provides useful information to assist in the development of an effective training strategy.

The dissemination literature suggests that the ‘gold standard’ in training involves the development of a training manual (Miller & Binder, 2002; Santacroce, Marcarelli, & Grey, 2004; Sholomskas et al., 2005). Manualised training approaches have previously shown to enhance intervention fidelity, over non-manualised approaches as they result in greater consistency and precision in the delivery of the training (Elliot & Mihalic, 2004; Miller & Binder, 2002).

One of the greatest challenges to ensuring effective training outcomes is the problem of absenteeism and drop out (Elliot & Mihalic, 2004). Attendance problems are
likely to be minimised if training is conducted in a single, rather than multiple session format.

The techniques that the facilitator employs in the training program also influence training outcomes. (Knowles, Holton, & Swanson, 1998). The literature suggests that didactic lecturing, while often necessary to communicate new information and concepts should not be used as the only method of training (Corder, 2002). Role-play activities that require the demonstration of therapy specific skills are regarded by many training researchers to be fundamental in acquisition and mastery of therapy skills and have previously shown to increase training fidelity (Elliot & Mihalic, 2004; Miller & Binder, 2002; Santacroce et al., 2004). Group discussion that aims towards solving common therapy problems also been found to be particularly useful in enhancing learning (Corder, 2002; Elliot & Mihalic, 2004; Miller & Binder, 2002).

This training program should focus on the core elements of OATC, including theory, aims and skills. In order to minimise absenteeism the training program should be delivered in a single session, one-day format. To maximise training outcomes the training manual should provide clear guidelines on the inclusion of group discussion, skills demonstration and role-play, in addition to didactic instruction.

This chapter has described the techniques involved in the OATC and explored important considerations in the development of an effective training strategy. The following chapters address the extent to which the approach can be quickly taught to volunteers. Factors which may impair these practitioners are also explored.
Chapter 5 – Trauma and its effect on trauma counsellors

5.1 – Overview

Variables which may affect counsellors’ ability to effectively deliver the approach are discussed. It is argued that vicarious traumatisation, being endemic to trauma counselling has the potential to affect performance with the approach, which may result in harm to clients. A rationale for the investigation of this and other trauma variables is presented.

5.2 – Variables that may influence effective delivery of the approach

In addition to investigating the capacity of volunteers to learn and administer OATC, this study also aims to evaluate the impact of certain variables on counsellors’ competency in the delivering the intervention properly and safely. The competent delivery of an early intervention for trauma is particularly important given the potential to do harm with this fragile population. One variable that is particularly relevant to this counsellor population is VT. VT is seen as endemic to trauma counselling and likely to affect all counsellors doing trauma work to some degree (McCann & Pearlman, 1990). Ghahramanlou and Brodbeck (2000) argue that volunteer counsellors who perform early interventions are particularly vulnerable to VT. These authors studied 89 volunteer sexual assault counsellors who provided assistance to clients shortly after the incident had occurred. Levels of psychological distress were above those reported for professional trauma therapists (Ghahramanlou & Brodbeck, 2000). These authors cited both the acute nature
of the work as well a comparative lack of training as being responsible for elevated VT. Early intervention may be particularly distressing for the counsellor as the work is conducted at a time when victims and families are often most distressed (Ghahramanlou & Brodbeck, 2000). Also, the one-off nature of this work allows no opportunity for the practitioner to know the eventual outcome (Ghahramanlou & Brodbeck, 2000). A comparative lack of training in trauma counselling may also place volunteers at risk greater risk of VT (Ghahramanlou & Brodbeck, 2000). An advanced theoretical understanding of trauma and the recovery process may provide professional practitioners with confidence that is necessary for the successful integration of this into the counselling experience (Ghahramanlou & Brodbeck, 2000). Professional clinicians, with a greater theoretical understanding of trauma, may be less affected by the distress of their clients as they may regard the clients' distress as temporary and part of the recovery process.

The impact of VT may extend to the quality of service delivered by clinicians. While some counsellors may only experience mild symptoms of trauma, others suffer severe disruptions in their personal and professional relationships (Figley, 1995). One of the key characteristics of VT is the development of intense countertransference reactions to trauma clients (Neumann & Gamble, 1995). These intense reactions are likely to inhibit the therapist's ability to work effectively with the client (Neumann & Gamble, 1995) Furthermore, the arousal and avoidance ‘symptoms’ associated with VT may inhibit therapist performance. Since anxiety has a negative effect on the performance of tasks requiring mental acuity (Aronen, Vuontela, Steenari, Salmi, & Carlson, 2005), VT may hamper the ability of therapists to attend to the task at hand and perform therapy skills.
Personal trauma history is a predictor of VT (Ghahramanlou & Brodbeck, 2000; Pearlman & Mac Ian, 1995) and may also impair counsellor performance in therapy. Although prior trauma experiences may also generate increased levels of empathy (Pearlman & Mac Ian, 1995), listening to traumatic accounts of clients may cause the therapist to reexperience some of their own personal trauma history. This reexperiencing leads to arousal and anxiety. Therapist performance may be affected as severe anxiety and arousal has a negative effect on performance (Aronen et al., 2005).

### 5.3 – The importance of effective delivery

While researchers and writers on VT have acknowledged the profound impact that this phenomenon can have on the therapist, to date no work has been done to investigate whether it impedes the skills development or competence of the counsellor.

The success of OATC relies on the ability of practitioners to adhere to the skills and tenants of the approach. Practitioners who do not adhere to the approach run the risk of exacerbating the trauma reaction. For example, actively engaging the client in exposure is likely to increase anxiety, which has shown to be harmful with single session interventions (Bisson et al., 1997; Mayou et al., 2000). The present study investigated the impact of VT and personal trauma history on counsellors’ performance with OATC.

### 5.4 – Assessing trauma history
Personal trauma history has not consistently predicted VT. While some studies suggest that a personal trauma history predisposes the clinician to higher levels of VT (Ghahramanlou & Brodbeck, 2000; Pearlman & Mac Ian, 1995), others suggest that a personal trauma history is unrelated to the occurrence of VT (Adams et al., 2001; Boscarino et al., 2004). One of the limitations of these studies may be the inconsistent and potentially inaccurate way that they assess personal trauma history. Pearlman and Mac Ian (1995) assessed trauma history by simply asking participants, “Do you have a trauma history?”. Participants who responded ‘yes’ were deemed as having a personal history of trauma. Ghahramanlou and Brodbeck (2000) assessed personal trauma history by asking, “Have you ever experienced any extremely stressful, life-threatening, or traumatic event such as serious physical injury, rape, assault, combat, or seeing someone badly hurt or killed?” Adams et al., (2001) asked a similar question but also gave participants the opportunity to write about an upsetting or traumatic incident they had experienced. Stories which involved exposure to either sexual violence or physical assault were denoted as being indicative of a trauma history (Adams et al., 2001).

Boscarino et al. (2004) assessed trauma history by enquiring about exposure to eight potentially traumatising events, then collapsed responses into an ordinal scale to reflect varying frequency of exposure.

This inconsistent finding in the relationship between trauma history and VT may be the result of the variety of methods used to assess trauma history. Not surprisingly these methods of assessment have resulted in vastly different frequencies in the occurrence of personal trauma history. Of the studies reviewed here the frequency of respondents having a trauma history ranged from 31.4% (Adams et al., 2001) to 81.8%
(Boscarino et al., 2004). Given this wide variation in the occurrence of a trauma history between studies it is not surprising that such studies had found incongruent evidence of the influence of this variable.

Measuring trauma history using techniques described in these studies may be problematic. Questions which ask simply about the existence of a trauma history or exposure to traumatic events are subjective and open to considerable interpretation. It is possible that some of these questions may be simply tapping into therapists’ exposure to traumatic events in therapy (vicarious traumatization). Also, definitions which rely on the “...experience [of] ... serious physical injury, rape, assault, combat” (Adams et al., 2001) excludes multiple events that are potentially traumatizing. Thus, trauma history may be more accurately assessed by an objective measure of involvement in a wide range of potentially traumatizing events. Furthermore, measuring ‘trauma history’ without reference to the occurrence any psychological phenomena may be overly inclusive. An individual’s experience of a potentially distressing event does not necessarily denote the occurrence of psychological trauma. The extent to which people find an event ‘traumatic’ is highly variable between individuals (Lerias & Byrne, 2003). Events are defined as personally ‘traumatic’ if the individuals’ reaction involves pronounced distress (Scott & Stradling, 1994). Therefore, the assessment of personal trauma history must consider the occurrence of distress in reaction to an event.

5.5 – A predictive model of trauma effects on the counsellor
The investigation of personal trauma history and VT on performance is largely exploratory in nature. Given the relative simplicity of OATC it may be that clinicians' anxiety and coping capacities do not affect their ability to deliver the prescribed approach. Furthermore, the nature of OATC may prevent the counsellor becoming exposed to traumatic material that may increase counsellor anxiety. Since the counsellor does not actively elicit event details from the client this may reduce the chance that the counsellor becomes distressed during the session. A nil effect of trauma variables on performance would certainly be the optimal outcome to support the widespread dissemination of the technique as it would seem to reduce the chance of negative outcomes for the client.

The potential impact of trauma history and VT on performance with the approach can be represented in a model (see Figure 1). In the first stage of the model it is anticipated that trauma history will predict higher levels of VT. In the second stage of the model the influence of VT on counsellors' ability to deliver the approach is explored. It is expected that VT will have a negative effect on performance. In the final stage of the model the effect of trauma history on performance is also explored. This final stage of the model is exploratory and hence no prediction on the effect of trauma history is made. It is not intended that Figure 1 imply a mediation model.

![Diagram](Figure 1. Exploratory model of the influence of trauma history and VT.)
5.6 – Research Summary

The present study aims to investigate whether a one day training program is able to significantly increase volunteers’ skills and knowledge in the Orienting Approach to Trauma Counselling. The study also aims to explore whether trainee variables were related to improvement in skills. Specifically, whether prior professional training in counselling leads to enhanced training outcomes. The influence of a personal history of trauma on the development of VT is explored. The impact of a trauma history and VT on OATC performance is also investigated.

5.7 – Hypotheses

The hypotheses for this study are as follows:

1. **Skills and knowledge will change significantly as a result of the training:** Measures of skill and knowledge will be significantly higher at post-training assessment than pre-training assessment.

2. **Trauma history will predict VT:** Participants with a greater incidence of distressing reactions to previous traumatic events will have more severe VT.

3. **VT will negatively affect performance:** Participants with more severe VT will attain lower skill scores following training than participants with less severe VT.
6.1 – Overview

This chapter describes the methods by which the current investigations were carried out. Participants were drawn from a volunteer counselling organisation and took part in a one-day training program on OATC. Skills and knowledge of OATC were assessed before and after training. Demographic variables, trauma history and VT were also assessed.

6.2 – Recruitment

Participants were drawn from four Lifeline centre’s in NSW, Australia. Lifeline is a charity organisation staffed mostly by volunteers who provide 24-hour telephone counselling. While all Lifeline centres provide a telephone counselling service, some provide face-to-face counselling and other mental health services. These services are operated by both mental health professionals and volunteers.

These centres were initially contacted by mail. They received an ‘Expression of Interest Letter’ (see Appendix B), an ‘Organisation Information Sheet’ (See Appendix C) and an article that described the rationale for and elements of OATC (Phipps & Byrne, 2003; see Appendix D). They were then contacted by telephone and training dates were negotiated with. Participating centres were sent a ‘Recruitment Flyer’ (Appendix E) and ‘Participant Information Sheets’ (Appendix F). The participating centres were responsible for recruitment at the site. Training was provided at no charge.
6.3 – Participants

A total of 80 people participated in the research. Table 3 summarises the demographic and background data on participants.

Table 3
Characteristics of Participants (n = 80)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Value</th>
</tr>
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<tbody>
<tr>
<td>Age (Years)</td>
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<td>Range</td>
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<td>71 (88.8%)</td>
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<tr>
<td>Male</td>
<td>9 (11.3%)</td>
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<tr>
<td>Education (Level)</td>
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<tr>
<td>Primary (at or below School Certificate)</td>
<td>10 (12.5%)</td>
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<td>Secondary (Higher School Certificate)</td>
<td>18 (22.5%)</td>
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<tr>
<td>Tertiary (completion of a university degree)</td>
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<tr>
<td>Counselling Training</td>
<td></td>
</tr>
<tr>
<td>Lifeline Only</td>
<td>26 (32.5%)</td>
</tr>
<tr>
<td>Additional non-tertiary (e.g., Tafe course)</td>
<td>20 (25.0%)</td>
</tr>
<tr>
<td>Tertiary</td>
<td>27 (33.8%)</td>
</tr>
<tr>
<td>Registered clinician</td>
<td>7 (8.8%)</td>
</tr>
<tr>
<td>Counsellor Type</td>
<td></td>
</tr>
<tr>
<td>Telephone only</td>
<td>55 (68.8%)</td>
</tr>
<tr>
<td>Face-to-face</td>
<td>25 (31.3%)</td>
</tr>
</tbody>
</table>
Table 3 shows that most participants were Female with a mean age of 48.8 years. Most participants had a tertiary level education with the attainment of a university degree (65.0%). This is commensurate with the general demographic of volunteers in the counselling services (Hunot & Rosenbach, 1997). All participants had at least completed the Lifeline telephone counsellor training with a large proportion (43%) having tertiary training in a relevant counselling field (e.g. Psychology/Social Work). Most Participants identified themselves as telephone counsellors only (68.8%).

6.4 – Pilot study

A pilot study was conducted prior to data collection with a sample of seven people. Participants in the pilot were aged between 32 and 73 with a mean age of 56.3 years (SD = 15.5). One participant was male, while six were female. Two had reached a primary level of education, while five had achieved a tertiary level of education. In regard to relevant training as a counsellor; one participant had received Lifeline training only, four had received additional non-tertiary training, one had received tertiary training, and one was a registered Clinical Psychologist. Two participants identified themselves as telephone counsellors only, while five also identified themselves as face-to-face counsellors. Total years of counselling experience ranged from 1 to 20 years with a mean of 7.6 years (SD = 6.2).

The purpose of this pilot study was to trial the training and assessment procedures. Trainees in this group were informed that their feedback would be requested at the completion of the session. An informal feedback session was conducted following
the post-assessment. The training program, assessment measures and assessment procedures were modified following the pilot. Data from this session was excluded from the main analysis.

The knowledge questionnaire, administered at both pre and post-assessment, was modified. The original knowledge questionnaire contained 10 questions. Results of the pilot study showed that four of these questions had potentially poor discriminant validity as all participants responded correctly to these items at both pre and post assessment. These questions were modified accordingly or removed from the questionnaire. Several participants found the wording in one of the questions confusing. The phrasing of this question was improved. Five additional questions were added to the measure, resulting in a 15-item final version of the knowledge questionnaire.

The training manual was modified. Results of the knowledge questionnaire showed that scoring on one question declined from pre to post-assessment. This question related to the likely impact of traumatic events. This item required participants to acknowledge that direct exposure is likely to result in more significant distress than indirect exposure. This decline in correct responses suggested that the training on this subject was confusing. The training manual was improved to ensure this information was communicated clearly.

The time allocated to subject areas was modified. Participants commented that too much time was spent on the introductory section, which explained the research procedures. Participants commented that the participant information sheet had already informed them of the procedures involved. The time allocated to this section was reduced.
Written instructions provided to participants prior to the role-play assessment were modified. Participants were given a sheet of paper which included information on the clients presenting problem. Participants commented that insufficient instruction was provided on the therapy context such as the amount of time that had passed since the traumatic event as well as where the client was receiving the service (e.g. over the telephone or face-to-face). These instructions were modified to clarify that the traumatic event had occurred three days previously and the client was being seen face-to-face, at a Lifeline Centre.

The first training role-play was modified. This role play involved a therapy situation where the 'client' was communicating various symptoms following a traumatic event. The role-play occurred in front of the group where one participant played the client and one participant played the therapist. The role of the therapist was to recognise trauma symptoms, in reference to a 'check-list', then discuss the observed symptoms with the rest of the group. Two of these role-plays occurred, one after the other. Participants commented that this method was too time consuming and excluded other group members from actively participating in the activity. This activity was modified so that one group member role-played the client, while the rest of the group listened and noted the symptoms. At the end of the role-play the symptoms and likely 'diagnosis' was discussed within the group.

The amount of time allocated to the role-play assessments was modified. For the pilot study, participants were allocated up to 5-minutes to demonstrate the skills in the role-play. After reviewing the tapes it was found that 5-minutes was generally enough time to demonstrate the skills. Participants commented that this was enough time but
more time would assist in lessening performance anxiety. It was found that seven 5-minute role-plays allowed time to spare in the one-hour allocated for data collection. Because of this the role-plays were increased to seven minutes. It was calculated that 7 minutes would allow the processing of 12 role-plays per-hour when 2 research assistants were employed.

The administration of pre-assessment questionnaires was modified. During the pilot, consent forms and questionnaires were administered and collected concurrently. This proved to be very time consuming and difficult for the facilitator if participants had questions about a measure or item. Following this, pre-assessment forms, including the consent from were stapled together and administered as a whole.

6.5 – Training Sessions

Participants were trained using the Orienting Approach to Trauma Counselling – Training Manual (Phipps & Byrne, 2005: appendix A). This manual is based on the ‘Orienting Approach to Trauma Counselling’ as presented in Phipps and Byrne (2003). These training sessions combine didactic lecturing, group discussion and demonstration/role play. The training manual is separated into three parts. In part 1: Introduction to Trauma, participants are introduced to the concept of psychological trauma following a traumatic incident. Skills to identify the signs and symptoms of psychological trauma are taught. Part 2: Early and brief interventions for trauma, focuses on research findings for existing early interventions. Participants are presented with research that suggests exposure techniques have the potential to do harm. In Part 3: The
‘Orienting Approach’ to Trauma Counselling, participants are trained in the skills and administration of OATC. These skills include; support without exposure, normalisation of reactions and symptoms, relaxation training and the provision of psycho-education and self-help information. These skills are demonstrated by facilitator and rehearsed by trainees.

Training sessions were conducted in small groups and led by a single facilitator. This facilitator was a registered Psychologist with post-graduate training in clinical psychology. All training sessions were conducted by the same facilitator. A total of eight training sessions were conducted, including the pilot session. The largest number of participants in any one training session was 13 while the smallest group consisted of 5 participants. The mean number of participants was 10. Each training session, including data collection and breaks, took a total of eight hours. One hour at the beginning and end of the session were allocated to data collection. One and a half hours were allocated to refreshment breaks and four and half hours were allocated to formal training.

6.6 – Procedure

Participants were asked to read the participant information sheet before attending training. Participants were allocated a participant number. Before any data was collected, the rationale and methods of the research were verbally explained to participants. Participants were then asked to complete the pre-training assessment forms. This battery of forms consisted of the Participant Consent Form (Appendix G), Participant Demographic form (Appendix H), Multiple Choice Questionnaire (MCQ; Appendix I),
Stressful Life Experiences Screening (Stamm et al., 1996), and Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales – Revision III (Stamm, 2002). These assessment measures were stapled together and always presented in this order.

Participants were then selected at random to take part in the pre-training role-play assessment. Participants were randomly allocated to one of two possible role-play vignettes (A or B). These vignettes were both examples of a significantly traumatised individual. The role-plays were designed to exhibit similar symptoms in different contexts. Research assistants role-played the client in these assessments. These research assistants were Registered Psychologists or Psychologists-in-training. All research assistants received identical training in the relevant procedures for data collection. Research assistants were given detailed information on the ‘character’ they were to portray and information they needed to communicate in order to ensure consistency (see Appendices J and K). Due to limited availability, a number of different confederates were used between training sessions (n = 7). Five minutes before the role-play assessment, participants were given background information on the role-play ‘client’ as well as brief instructions regarding what they were expected to do with the client (see Appendices L and M). These instructions summarised the basic techniques of the ‘Orienting Approach’. Instructions were provided in order to prompt any existing skills similar to those being trained. Participants were given seven minutes to demonstrate the relevant skills. These role-plays were video-taped and coded to identify participant number and vignette. Once data was collected participants took part in the actual training phase of the research.

When the training was complete, participants took part in the post-training assessment. Participants were again administered the MCQ and participated in the role-
play assessment. Order of participation in the role-play assessment was determined by random selection. Participants were allocated to the role-play that they had not participated in at pre-training, such that participants who were allocated to Vignette A at pre-training were allocated to Vignette B at post-training, and vice versa. Rotation of vignettes enabled minimisation of vignette specific practice effects.

Individual role-play segments were dubbed to Digital Video Disc (DVD) in random order. These segments were preceded by indicators of participant number and vignette (e.g., 56B). The condition within which the participant was performing (pre or post) was not revealed so that ratings of each role-play could be conducted with raters blind to whether it was a pre or post-training role-play.

Two independent raters were recruited to evaluate the video-tapes. These raters were fully registered Psychologists with post-graduate training in Clinical Psychology. These raters were trained to use the ‘Orienting Approach Rating Scale for Clinicians’ (see Appendix N) using practice video footage from the pilot session. Raters were trained until an agreement rate of over 90% was achieved. Once trained all data was blind rated with 49% of tapes co-rated to determine inter-rater reliability.

6.7 – Assessment Measures

Demographic information: A ‘Participant Demographic form’ was developed and used to gather information such as sex, age, education, years of experience and training (Appendix H).
Knowledge assessment: Knowledge was assessed with a 15-item Multiple Choice Questionnaire (MCQ; Appendix I). This questionnaire was specifically designed to test knowledge of information relevant to an understanding of psychological trauma and the delivery of OATC. A summary of the main aspects of knowledge assessed by the MCQ is found in Table 4. Performance on this measure was calculated by summing the number of correct responses to attain a total score out of fifteen.

Table 4
Aspects of Knowledge assessed by the Multiple Choice Questionnaire

1. Theoretical knowledge on the maintenance of trauma symptoms and anxiety.
2. Symptoms of trauma.
3. Theoretical understanding of the Orienting Approach in relation the dangers of increasing arousal.
4. Factors which put individuals at risk of psychological trauma following an incident.
5. Specific techniques and appropriate information giving in accordance with the Orienting Approach.

Skill assessment: The videotaped role-plays were assessed using the ‘Orienting Approach Rating Scale for Clinicians’ (see Appendix N). This 12 item measure was adapted from the ‘Medication Alliance & Cognitive Therapy Rating Scale for Psychosis’ (Byrne, Deane, Lambert, & Coombs, 2004). This is a checklist style measure which assesses the presence or absence of a particular skill. A point is awarded if the participant demonstrates that skill. Detailed criteria for the items were developed (see Appendix O). Waltz et al. (1993) argue that present/absent checklists for assessing therapy skills for research purposes are superior to rating scales that measure frequency or competence of a
skill as they are easier to use and likely to be more reliable as they minimise rater subjectivity. The 12 items comprise four scales:

1. **Support**: This scale is concerned with the counsellors’ ability to support the client without actively eliciting information about the event or the clients’ reaction.
2. **Normalisation**: This scale is concerned with the counsellors’ ability to normalise the clients’ reaction to the event and provide accurate information on the usual course of traumatic reactions.
3. **Relaxation**: This scale is concerned with the counsellors’ ability to provide: encouragement; the correct rationale for relaxation; and correct instruction for breathing relaxation.
4. **Advice/Information**: This scale is concerned with the counsellors’ ability to provide advice on maintaining contact with others and seeking further professional assistance if needed.

These scales contained 3 items each. Items on these scales were summed to obtain a score ranging from 0 to 3. A ‘performance’ measure was calculated by summing all skill-scale scores taken at the post-training assessment to obtain a score ranging from 0 to 12.

**Trauma History**: Trauma history was assessed using the Stressful Life Experiences Screening (SLES: Stamm et al., 1996). The SLES is a self-report scale with 20 statements describing common traumatic incidents, e.g., “As an adult I was forced to have unwanted sexual contact”. Three measures are obtained for each statement:

1. The extent to which the statement ‘Describes your Experience’ (0: Did not experience this – 10: exactly like my experiences).
2. The extent to which the incident was ‘Stressful Then’ (0: not at all stressful – 10: extremely stressful).
3. The extent to which the incident is ‘Stressful Now’ (0: not at all stressful – 10: extremely stressful).

The measure was designed as a screening instrument for life events which may have led to traumatic stress and is based on a DSM-IV conceptualisation of PTSD (Stamm et al., 1996). The instrument has shown adequate internal reliability with alpha coefficients reported as: Describes your Experience, (alpha .74); Stressfulness Then, (alpha .76); and Stressfulness Now, (alpha .62) (Stamm & Rudolph, 1996). The SLES has previously been used as an instrument to identify exposure to potentially traumatic events (Sprang, 1999, 2000), and as an instrument to quantify the clinical impact of such events (Weiser et al., 2001).

A trauma history score was obtained using the sum of responses to the ‘Stressfulness Then’ scale. Only the ‘Stressfulness Then’ scale was used because it provides the most accurate measure of previous exposure to events that have been traumatising. Including the ‘Describes your Experience’ scale would be confounding as it simply describes the extent to which the individual has been exposed to an event which may have the potential to cause trauma. Including the ‘Stressfulness Now’ scale would also be confounding as it describes a measure concomitant with current PTSD. The ‘Stressfulness Then’ scale has previously been reported independently by the authors of the measure to assess the immediate psychological impact of past traumatic events (Weiser et al., 2001). In the present study the ‘Stressfulness Then’ scale achieved an
alpha coefficient of .62. The alpha coefficients for the entire scale are reported in Appendix P.

**Vicarious Trauma**: A measure of VT was obtained with the Compassion Fatigue/Secondary Trauma subscale of the Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales – Revision III (Stamm, 2002). The ProQOL is a 30-item self-report measure. The measure is comprised of three scales: Compassion Satisfaction, Burnout, and Compassion Fatigue/Secondary Trauma. The Compassion Fatigue/Secondary Trauma scale assesses the phenomenon of VT as has been described in previous sections of this thesis. The scale relates specifically to trauma-like symptoms that have been influenced by the individual’s work. For example, item 14 states “I feel as though I am experiencing the trauma of someone I have helped”. Respondents are required to answer on a 6-point Likert scale, ranging from 0 = Never to 5 = Very Often, to indicate the extent to which the statement has applied to them over the last 30 days.

The reliability and construct validity of the measure is well established (Stamm, 2005). Reliability coefficients have been reported as: Compassion Satisfaction, (alpha .87); Burnout (alpha .72); and Compassion Fatigue/Secondary Trauma (alpha .80) (Stamm, 2005). The inter-scale correlations have previously been reported as ‘small’, with Compassion Fatigue/Secondary Traumatic Stress having 2% shared variance with Compassion Satisfaction and 21% shared variance with Burnout (Stamm, 2005). Compassion Satisfaction and Burnout also have 5% shared variance (Stamm, 2005). In the present study the Compassion Fatigue/Secondary Trauma scale achieved an alpha coefficient of .69. The alpha coefficients for the entire scale are reported in Appendix P.
Murphy and Davidshofer (2001) note that alpha coefficients above .60 are acceptable for assuming adequate internal reliability.
Chapter 7 – Results

7.1 – Overview

This chapter outlines the results of the statistical analyses conducted in this study. Following analyses of interrater reliability all skill items were retained in the analysis. The results show a significant difference on all skill and knowledge scales from pre to post-assessment. No differences in skill levels were found between different role-play vignettes or between levels of previous professional training. A history of psychological trauma predicted VT, but no significant relationship was found between trauma history or VT and performance with OATC.

7.2 – Statistical Analysis

Interrater reliability for the skill measure was determined by calculating Kappa statistics on individual items. Agreement between raters was further investigated using McNemar’s test of marginal homogeneity. Independent sample t-tests were conducted to investigate any effect of vignette on role-play performance. Changes in knowledge and skill from pre to post-test were investigated using matched pairs t-tests. A mixed ANOVA was used to investigate any difference in OATC skills between participants with professional training and participants with volunteer training only. Relationships between trauma history, VT and performance were investigated with Pearson’s correlations.
Regression analyses were then used to investigate the combined effect of trauma history and VT on performance.

7.3 – Data Screening

The distribution of the variables was checked in order to identify outliers and the presence of skewness and kurtosis for each variable. No outliers were identified and the scores on the variables showed no marked skewness or kurtosis. Distributions were normal and met the assumptions of the analyses.

A total of 80 people participated in the research. Demographic, trauma history and VT data was obtained for all participants. Data from the pilot session was excluded from the analysis as this data was used to refine the procedures and the measures (seven participants). Skill data was not obtained for a further eight participants at pre-assessment and seven participants at post assessment due to equipment failure. Full data was obtained for 65 participants.

7.4 – Interrater reliability

A total 131 seven-minute role-play assessments were recorded. Sixty-five participants took part in the pre-assessment, sixty-six in the post assessment. Sixty-four (49%) of these role-plays were selected at random and co-rated. Thirty-one (48%) were co-rated from the pre-training assessment while 33 (52%) were co-rated from the post-training assessment. Interrater reliability was calculated on individual items. Rate of agreement
was determined using Kappa statistics. Agreement between raters was also investigated with the McNemar test of Marginal Homogeneity. The McNemar test evaluates whether there is a significant difference between the scores of two raters on a dichotomous trait (Maxwell, 1970). Table 5 shows the agreement between raters expressed as a percentage as well as the Kappa and $p$ values (two-sided) for the McNemar test.

Table 5

<table>
<thead>
<tr>
<th>Item</th>
<th>Agreement (%)</th>
<th>Kappa</th>
<th>$p$ values for McNemar test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale A: Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>60 (94%)</td>
<td>.32**</td>
<td>.13</td>
</tr>
<tr>
<td>2</td>
<td>53 (83%)</td>
<td>.65**</td>
<td>.55</td>
</tr>
<tr>
<td>3</td>
<td>44 (69%)</td>
<td>.38*</td>
<td>.12</td>
</tr>
<tr>
<td>Scale B: Normalisation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>63 (98%)</td>
<td>.88**</td>
<td>1.0</td>
</tr>
<tr>
<td>2</td>
<td>56 (88%)</td>
<td>.75**</td>
<td>.29</td>
</tr>
<tr>
<td>3</td>
<td>57 (89%)</td>
<td>.30*</td>
<td>.13</td>
</tr>
<tr>
<td>Scale C: Relaxation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>63 (98%)</td>
<td>.96**</td>
<td>1.0</td>
</tr>
<tr>
<td>2</td>
<td>49 (77%)</td>
<td>.52**</td>
<td>.04</td>
</tr>
<tr>
<td>3</td>
<td>46 (72%)</td>
<td>.28*</td>
<td>.00</td>
</tr>
<tr>
<td>Scale D: Advice/Info.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>60 (94%)</td>
<td>.81**</td>
<td>.68</td>
</tr>
<tr>
<td>2</td>
<td>55 (86%)</td>
<td>.71**</td>
<td>.18</td>
</tr>
<tr>
<td>3</td>
<td>57 (89%)</td>
<td>.75**</td>
<td>.13</td>
</tr>
</tbody>
</table>

* $p < .05$
** $p < .001$

Kappa statistics show that the agreement between raters was significant for all items. Landis and Koch (1977) proposed the following guidelines for interpreting the strength of agreement for Kappa values: Poor (<0.00), Slight (0.00 – 0.20), Fair (0.21 –
0.40), Moderate (0.41 – 0.60), Substantial (0.61 – 0.80), Almost Perfect (0.81 – 1.00).

All Kappa values in the present investigation were at or above 'fair'. On the basis of these findings all items were retained in the analysis. However, McNemar’s statistics revealed some questionable agreement between raters. McNemar’s statistics were significant for items C2 and C3. This suggests that raters differed significantly on their responding to these items. This may place limitations on the conclusions that can be drawn from any change on scale C. These limitations are highlighted in the discussion section of this thesis.

7.5 – Tests of Vignette effects

Independent sample t-tests were conducted to see whether there was an effect of vignette on participants’ performance. Scores on Vignette A were compared to scores on Vignette B at pre-assessment (Table 6). There were no significant differences on any of the scales between the two vignettes.

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

<table>
<thead>
<tr>
<th>Scale</th>
<th>Vignette A (n = 38)</th>
<th>Vignette B (n = 27)</th>
<th>t</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale A (Support)</td>
<td>1.63 (0.75)</td>
<td>1.74 (0.71)</td>
<td>-.60</td>
<td>.56</td>
</tr>
<tr>
<td>Scale B (Normalisation)</td>
<td>1.11 (0.61)</td>
<td>1.04 (0.52)</td>
<td>.48</td>
<td>.64</td>
</tr>
<tr>
<td>Scale C (Relaxation)</td>
<td>0.71 (0.80)</td>
<td>0.59 (0.69)</td>
<td>.62</td>
<td>.54</td>
</tr>
<tr>
<td>Scale D (Advice/Info)</td>
<td>0.29 (0.57)</td>
<td>0.40 (0.50)</td>
<td>-.87</td>
<td>.39</td>
</tr>
</tbody>
</table>
Scores on each vignette were also compared at post-assessment (Table 7). There was no significant difference between vignettes at post-assessment. This suggests that the vignette's were equivalent with regard to difficulty and version of vignette was unlikely to be a confounder in the analyses.

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

<table>
<thead>
<tr>
<th>Scale</th>
<th>Vignette A (n = 28) M (SD)</th>
<th>Vignette B (n = 38) M (SD)</th>
<th>Sig. t (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale A (Support)</td>
<td>2.54 (0.69)</td>
<td>2.58 (0.60)</td>
<td>.27 .79</td>
</tr>
<tr>
<td>Scale B (Normalisation)</td>
<td>2.14 (0.65)</td>
<td>1.82 (0.69)</td>
<td>-1.95 .06</td>
</tr>
<tr>
<td>Scale C (Relaxation)</td>
<td>1.93 (0.98)</td>
<td>1.84 (0.92)</td>
<td>-.37 .71</td>
</tr>
<tr>
<td>Scale D (Advice/Info)</td>
<td>1.64 (0.95)</td>
<td>1.42 (1.06)</td>
<td>-.88 .38</td>
</tr>
</tbody>
</table>

7.6 – Training Effects

Pre and post-assessment scores were compared using paired sample t-tests to determine whether there was a significant change on skills and knowledge. Required significance was adjusted using the Bonferroni procedure. The original significance level of $p = .05$ was adjusted to $p = .01$ on the basis of the 5 planned comparisons ($0.05/5 = 0.01$). Table 8 shows the means and standard deviations of knowledge and skill before and after the training.

Table 8 shows that knowledge and skills improved over the course of training. A significant increase was observed on all scales from pre to post-training assessment.

Cohen’s $d$ statistics show effect sizes ranging from $d = 1.16$, to $d = 4.31$. Cohen (1992) provides the following conventions for the interpretation of effect sizes: Small, $d = .2;$
Medium, $d = .5$; Large, $d = .8$. Thus, the effect sizes obtained on all of these scales can be described as ‘large’.

Table 8

**Means and Standard Deviations of Knowledge and Skill, Pre and Post-training**

<table>
<thead>
<tr>
<th>Scale</th>
<th>n</th>
<th>Pre M (SD)</th>
<th>Post M (SD)</th>
<th>Effect Size ($d$)</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge Scale</td>
<td>73</td>
<td>7.51 (1.86)</td>
<td>13.16 (1.31)</td>
<td>4.31</td>
<td>26.23**</td>
</tr>
<tr>
<td>Skill Scales</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scale A (Support)</td>
<td>65</td>
<td>1.68 (0.73)</td>
<td>2.55 (0.64)</td>
<td>1.36</td>
<td>7.49**</td>
</tr>
<tr>
<td>Scale B (Normalisation)</td>
<td>65</td>
<td>1.08 (0.57)</td>
<td>1.93 (0.68)</td>
<td>1.25</td>
<td>7.58**</td>
</tr>
<tr>
<td>Scale C (Relaxation)</td>
<td>65</td>
<td>0.66 (0.76)</td>
<td>1.86 (0.93)</td>
<td>1.29</td>
<td>7.97**</td>
</tr>
<tr>
<td>Scale D (Advice/Info)</td>
<td>65</td>
<td>0.34 (0.54)</td>
<td>1.51 (1.01)</td>
<td>1.16</td>
<td>8.08**</td>
</tr>
</tbody>
</table>

**$p < 0.01$ (t-test, two-tailed)**

7.7 – **Effects of Previous Training**

While the significant skill changes from pre-assessment to post-assessment are promising, they are not sufficient to conclude that all volunteer counsellors have the capacity to learn and administer the approach. The high frequency of counsellors with tertiary qualifications in counselling-related pursuits (e.g. psychology/social work) potentially limits the generalisation of these results. Previous professional training may have contributed to skills acquisition.

In order to address the effects of prior training on improvements in knowledge and skills over the course of training, skill scores were compared between participants with professional training and those without professional training. A ‘total skill’ score was used in this comparison. This score was achieved by summing the individual skill
scales. Counsellors were divided into two groups depending on previous training: 'volunteer' training versus 'professional' training. Participants who had 'Lifeline training only' and participants who had 'Lifeline training plus additional non-tertiary training' were placed in the 'volunteer' training group. 'Additional non-tertiary' training, although beyond what would be necessary for a volunteer counsellor, was still classed as within the realm of volunteer training. Participation in additional training is typical within volunteer counselling organisations (Hunot & Rosenbach, 1997). Thirty-seven participants (57%) were placed in the volunteer training group. Participants who had a relevant counselling related degree (e.g., Psychology/Social Work) and participants who were registered clinicians were placed into the 'professional training' group. Twenty-eight participants (43%) were placed in the professional training group. Table 9 shows the means and standard deviations of these two groups at both pre and post assessment.

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Pre Mean (SD)</th>
<th>Post Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteer Training</td>
<td>37</td>
<td>3.57 (1.54)</td>
<td>7.86 (2.26)</td>
</tr>
<tr>
<td>Professional Training</td>
<td>28</td>
<td>4.00 (1.55)</td>
<td>7.85 (1.41)</td>
</tr>
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</table>

A 2 x 2 (Training Group x Time) mixed ANOVA was conducted where training group was the between-subjects factor and time (pre and post-assessment) was the within-subjects factor. The time by training group interaction was not significant, $F(1,63) = 0.51, p = 0.48$. This suggests that previous professional training did not differentially affect changes in total skill scores from pre to post-assessment. There was no significant
main effect for Training Group, $F(1, 63) = 0.46, p = .50$, but consistent with earlier paired t-tests there was a significant main effect for Time $F(1,63) = 173.36, p < 0.001$. This indicated that total skill scores improved from pre to post-assessment.

7.8 – Predictors of change: The effect of trauma history and VT on performance

Factors influencing OATC performance were investigated. A ‘performance’ score was obtained by summing all skill scales taken at post-assessment. A ‘trauma history’ score was obtained using the sum of responses to the ‘Stressfulness Then’ subscale of the SLES (Stamm et al., 1996). A ‘vicarious trauma’ measure was obtained using the sum of responses to the ‘Secondary Trauma’ subscale of the ProQOL (Stamm, 2002).

Firstly, the correlations between these variables were explored. One-tailed Pearson’s correlations were calculated for the relationship between trauma history and VT, and the relationship between VT and performance since predictions about the expected direction of the relationships were hypothesised. A two-tailed Pearson’s correlation was calculated for the exploratory investigation of the relationship between trauma history and performance. There was a significant positive correlation between trauma history and VT ($r = .27, n = 66, p = 0.008$). While the correlation between VT and performance did not reach significance, this correlation was in the predicted direction ($r = -.19, n = 66, p = 0.07$). A significant correlation was not found between trauma history and performance ($r = .06, n = 66, p = .64$). These results are illustrated in figure 2.
A hierarchical regression was also conducted to investigate how trauma history and VT influence performance. When using trauma history to predict performance the regression model failed to reach significance ($R^2 = .00; F_{(1,64)} = 0.22, p > .05$). When VT was added to the regression equation, there was no significant increase in the variance explained by the model ($R^2 = .04; F_{(2,63)} = 1.55, p > .05$). When using both trauma history and VT together to predict performance, the regression model failed to reach significance ($R^2 = .05; F_{(2,63)} = 1.55, p > .05$).

The results of these investigations show that skills and knowledge increased significantly from pre to post-assessment. This change occurred irrespective of levels of previous training. While it seems that there is a relationship between trauma history and the severity of VT, there does not seem to be a significant relationship between trauma history or VT and performance. The implications of these findings are discussed in the following chapter.
Chapter 8 – Discussion

8.1 – Overview

The ‘Orienting Approach’ to Trauma Counselling was developed as a brief and early intervention for individuals who have been both directly and indirectly exposed to traumatic events. The approach was designed specifically for use by volunteer counsellors. This study investigated the capacity of volunteer counsellors to learn and demonstrate skills in this approach. Participants’ knowledge and skills were assessed before and after participation in a one-day training program. The results of this study indicate that volunteer counsellors have the capacity to learn and deliver this approach. The results also indicate that previous trauma history and VT do not affect counsellors’ ability to deliver the approach. These results present some very promising support for the use of OATC by volunteers and suggest that further research to address the efficacy of OATC is warranted.

8.2 – The effect of the training program

This study found that measures of skill and knowledge in OATC increased significantly following participation in the one-day training program. Although the psychometric properties of The ‘Orienting Approach Rating Scale for Clinicians’ require results to be interpreted with caution, the significant changes on this measure present reason to be optimistic about the capacity of volunteer counsellors to learn and deliver this approach.
Importantly, performance on the skill scales at both pre and post-assessment was not affected by which vignette participants’ received or previous training. The lack of vignette effects suggests that these skills can be demonstrated equally across different trauma situations, increasing the generalisability of the results. The lack of effect of previous training shows that the ability to learn and demonstrate this approach is not dependent on previous professional training. Volunteers with the minimum requirements of training are able to deliver the approach with the same level of competence as those with more highly developed skills in psychological interventions. Effect sizes for change on all of the scales were ‘large’, as defined by Cohen’s benchmarks (Cohen, 1992). This adds further support for the success of the training program and suggests that these positive results could be maintained with an even smaller sample size.

The results show that scores on the MCQ increased significantly following participation in training. The effect size of this increase, at $d = 4.31$ is well above Cohen’s ‘large’ benchmark of $d = 0.8$ (Cohen, 1992). This suggests that volunteer counsellors are able to acquire knowledge necessary to deliver OATC. Perhaps the most important areas of knowledge change are those not targeted by the skill assessment. These areas relate to ‘Symptoms of trauma’ and ‘Factors which put individuals at risk of psychological trauma following an incident’, as described in Table 4. Change in knowledge of these areas not assessed by the role-plays is particularly important as it suggests that volunteers are able to recognise both the symptoms of trauma and signs that an individual may be at a higher risk of developing a pathological reaction.

Participants’ scores on the Support Scale (Scale A) increased significantly from pre to post-training, with a ‘large’ effect size of $d = 1.36$. The three items of this scale
required participants to: display patience with the client, refrain from actively eliciting
details of the event, and use the client’s own language/concepts. This scale related to
participants ability to provide support to the client while refraining from techniques that
may increase the clients arousal. This scale is particularly important to the ‘safety’ of the
approach as the items focus on ensuring that participants avoid techniques that have the
potential to be harmful to clients (Bisson et al., 2000; Mayou et al., 2000). Change on this
scale suggests that volunteers have the capacity to provide support to clients without
using techniques that have the potential to increase distress and impairment. These
changes are particularly supportive of the effectiveness of the training program when we
consider that the increased behaviors are often inconsistent counsellors previous training.
Client centered counselling involves the exploration of the client’s experience and
emotions (Egan, 2002). OATC training on the other hand aims to reduce these counsellor
behaviors in the context of early intervention trauma counselling. These results suggest
that the training program is able to change the use of these behaviors to suit the
counselling context and the needs of the client.

Participants’ scores on the Normalisation Scale (Scale B) increased significantly
from pre to post-training, with a ‘large’ effect size of $d = 1.25$. The three items of this
scale required participants to: communicate that the clients’ symptoms were a normal
reaction, communicate that the symptoms will abate, and give accurate information on
the likely course of the symptoms. These skills relate to the psychoeducational aspect of
OATC. Normalising this experience and providing information on trauma may promote
more accurate construing of any symptoms experienced. This is an important part of
minimizing long-term pathology as clients who evaluate their early symptoms negatively are at greater risk of PTSD (Ehlers et al., 1998).

Participants’ scores on the Relaxation Scale (Scale C) increased significantly from pre to post-training, with a ‘large’ effect size of $d = 1.29$. The items on this scale assess participants’ ability to; encourage the use of relaxation, provide a rationale for why relaxation is useful for anxiety, and provide correct instructions for the practice of breathing relaxation. This scale was originally designed to assess participants ability to teach skills to reduce arousal. Reducing arousal is a key component of OATC and is empirically supported in other treatment approaches for PTSD (Foa et al., 1999; Garssen et al., 1992). Unfortunately, the questionable interrater reliability of two of the three items, limit conclusions on skill change. Although a significant change did occur on this scale, it is possible that volunteer counsellors did not consistently provide a rationale and correct instruction for relaxation (this is discussed further in a later section of this chapter).

Participants’ scores on the Advice/Information scale (Scale D) increased significantly from pre to post-training, yielding a ‘large’ effect size of $d = 1.16$. The three items of this scale related to participants’ ability to: encourage the maintenance of contact with others, ensure that further assistance is available, and provide some recommendations regarding the signs that further assistance is needed. These skills relate to the self-help components of OATC. It is possible that these elements of the approach may lessen the impact of traumatic events as social support is an important buffer to the onset traumatic pathology (Brewin et al., 2000). Also, psychoeducation on the signs of
emerging pathology may enable clients to self-monitor their reaction and seek assistance of needed.

The results of this study indicate that volunteer counsellors have the capacity to learn and administer the Orienting Approach to Trauma Counselling. Participants in a one-day training program showed significant increases on all of the knowledge and skill scales. These results confirm Hypothesis 1. This finding suggests that volunteer counsellors are capable of delivering a theoretically safe intervention for trauma that may prevent the onset of pathology. Utilising this population may take some of the pressure from professional services, which do not always have the resources to be able to provide preventative measures. The provision of these preventative measures may also decrease the likelihood of long-term symptoms. This would reduce the need for the involvement of professional mental health services.

The design of the training program also suggests that OATC can be straightforwardly disseminated to practitioners. The manualisation of the training program allows these results to be replicated elsewhere as the program can be delivered by anyone with a background in clinical psychology or other similar profession. Since the training can be delivered in a single day it is likely to be relatively inexpensive and have minimal problems with attrition. Also, since it has been demonstrated that these skills can be acquired by practitioners with relatively low-level skill, practitioners with professional training or highly developed skill are likely to show similar post-training proficiency.

8.3 – Evaluating the affect of trauma history and VT
The results support part of the predicted model. It seems that a trauma history does predict VT. While the relationship between VT and performance was in the direction predicted, the negative effect of VT did not reach significance. Trauma history did not seem to affect performance directly. Figure 2 illustrates this trend.

The results of the study support Hypothesis 2 as trauma history was related to the severity of vicarious trauma. Participants with a greater incidence of distressing reactions to previous traumatic events tended to have more severe VT. This finding replicates the results of Ghahramanlou & Brodbeck (2000) and Pearlman & McKay (1995). However, it is contrary to the findings of Boscarino, Figley and Adams (2004), and Adams, Motto, and Harrington (2001). There are several possible explanations for this disparity. Firstly, the method of assessing trauma history in the current study is different to all previously cited studies. While the present study used a continuous measure which assessed involvement and severity in a range of potentially traumatising events, most previous studies have assessed trauma history categorically by enquiring about the existence of any trauma history. Previous sections of this thesis have argued that such a method of assessment is more susceptible to inaccuracies and open to considerable variation. Previous methods of assessment have not accounted for the wide variety of potentially traumatising events. Also, these previous methods have not assessed the occurrence of distress; a necessary criteria to denote an event as ‘traumatic’. In the present study, trauma history was assessed by obtaining a measure of distress in relation to a wide variety of potentially traumatising events. It is possible that the present measure provides a more accurate assessment of trauma history, resulting in support of the proposed hypotheses. It is also possible that characteristics of the population are responsible for
this disparity. Ghahramanlou and Brodbeck (2000) has argued that volunteer counsellors are at particular risk of developing VT. They suggest that professional training and a greater theoretical understanding of acute stress and the trauma recovery process may act as a buffer to the emergence of VT (Ghahramanlou & Brodbeck, 2000). This suggests that while trauma history may be a predisposing factor, its emergence may be moderated by factors such as professional training.

The relationship between trauma history and VT supports suggestions that the experience of pathological phenomena predisposes an individual to further pathology (Lewinsohn et al., 1981). While Pearlman and Saakvitne (1995) would explain this as a pre-existing state of psychological trauma being exacerbated by exposure to new traumatic material, Ghahramanlou and Brodbeck (2000) would suggest that therapy is particularly distressing for these individuals as the traumatic stories of clients remind the therapist of their own experiences.

This finding has implications for the management of counsellors doing trauma work. Since counsellors with a more extensive trauma history are more likely to experience elevated levels of VT, these counsellors may need to be provided with augmented assistance by organisations in order to help them to cope with trauma work. While enquiring about an individual’s trauma history may be inappropriate, education regarding the link between an individuals’ personal trauma history and the distress that they feel when working with victims of trauma may be helpful. Counselling organisations could educate their staff on the importance of supervision and self-care particularly for those with a trauma history. When provided with this information, counsellors with an
extensive trauma history may be able initiate self-help strategies (e.g., limiting their trauma case-load) in order to cope with the demands of trauma work.

The results of the study do not confirm the third hypothesis. Hypothesis 3 stated that VT will negatively influence performance. It was predicted that participants with more severe VT will score lower on the post-training skill assessment than participants with less severe VT. Figure 2 shows that while the correlation between VT and performance did not reach significance, the relationship was in the direction predicted. These results suggest that VT will not affect counsellors' performance with OATC.

There are several possibilities that may explain this finding. Firstly, it is possible that VT does not affect counselling skills. The distress caused by VT may be insufficient to impede the skills of the counsellor. It is also possible that the simplicity of OATC and/or its structured format leaves little room for error. If VT does have an effect on counselling work, these affects may be limited to more complex components of counselling such as increased negative countertransference. Another possibility is that the minimal and non-invasive nature of OATC protects the counsellor from exposure to potentially distressing material. Since the aim of therapy is to avoid actively exposing the client to distressing material, the emotional impact on the counsellor may also be minimal.

The finding that VT does not interfere with performance provides preliminary support for the safety of the Orienting Approach. These findings suggest that the coping capacities of the counsellor will not affect their ability to adhere to this approach. Adherence to OATC is particularly important as deviation from the theoretically safe tenants of the approach may result in harm to the client. Since performance is not
impaired by counsellors’ level of VT, this provides further support for the proposal that the Orienting Approach is a ‘no-harm’ intervention.

The final part of the proposed model involved the investigation of the effect of trauma history on performance. The results of the study suggest that trauma history does not affect performance in the Orienting Approach. The finding suggests that training either does not prompt reminders of personally traumatic events, or that if such reminders are occurring it does not seem to affect counsellors’ ability to deliver the approach competently.

8.4 – Limitations and future directions

The psychometric properties of the skill measure have important implications for the conclusions that can be drawn about changes in skill. Interrater reliability was questionable for two of the items in the Relaxation Scale. Conclusions about skill changes on this scale must be made with caution.

Kappa statistics showed that agreement between raters was significant for all items of the skill measure and that the strength of these Kappa values was at or above what Landis and Koch (1977) described as ‘fair’. On the basis of this finding all items were retained in the analysis. However, the use of Kappa values alone in evaluating agreement between raters has been criticised. Interpreting the strength of agreement using categories such as “Good”, “Fair” etc., is somewhat arbitrary and has the potential to be inaccurate (Maclure & Willet, 1987). Furthermore, the calculation of this statistic has the potential to yield low Kappa value despite relatively high agreement between raters.
(Ubersax, 1987). As a result, agreement between raters was also investigated with the McNemar test of Marginal Homogeneity. This test revealed that there was a significant difference between the scores of two raters on items C2 and C3. Of particular concern is item C3, which showed a highly significant difference between raters \( p < .01 \) in combination with the lowest reported Kappa value of .28. In contrast, the difference between raters for item C2 was only marginally significant \( p = .04 \), with a substantially higher Kappa value of .52.

Unfortunately, this inconsistency limits the conclusions that can be drawn about change on skills related to these items. These items related to the counsellors’ ability to: provide a rationale for the use of relaxation (C2), and provide correct instruction for breathing relaxation (C3). Since the raters could not adequately agree on whether this skill was demonstrated or not, we cannot confidently conclude that increased scores on Scale C reflect an increase in participant ability to demonstrate these skills.

It is unclear why raters showed inconsistency with these items. Table 10, taken from the scoring criteria given to raters (Appendix O), describes what the participant must demonstrate on Scale C items. Both of these items require the articulation of certain statements. In the case of item C2, the counsellor must articulate one of two simple rationale’s for relaxation. In the case of item C3, the participant must communicate the 3 main tenants of diaphragmatic breathing. In both of these examples, the decision to award or decline a point requires the observation of the presence or absence of these statements. It is possible that consistency may have been affected by low sound quality in some role-plays. What may have been audible to one rater may not have been audible to the other. This aspect is particularly hard to control given that the DVD’s were observed on
different equipment. However, this possibility does not explain why the rating of these particular items was less reliable than others as most items are judged on the presence or absence of brief statements. It is possible that one of the raters developed their own criteria which were either beyond or below the skills that the item requires. For example, one rater may have awarded points only if the participant gave a highly articulate rationale and actually demonstrated diaphragmatic breathing correctly to the client. This appears to be a likely cause as the contingency table shows that the difference between raters was consistent for both items; i.e., the frequency of correct responses given by Rater-1 was less than correct responses given by Rater-2 for both items. If this lack of reliability is the result of an inconsistent understanding of the criteria, it is probable that the 2-3 hours of training provided to raters was insufficient. Future research should address this inconsistency with a greater focus on the assessment of relaxation during rater training, providing more diverse examples of breathing relaxation during practice trials.

The research methodology employed by this investigation has several limitations. The lack of a control group that did not participate in the training, does not allow us to rule out the possibility that participants skills improved purely through practice effects. Participation in the role-play assessment may have prompted self-reflection in the counsellors’ performance, which could have lead to improvement at post-assessment. This is unlikely however as many of the skills, such as the avoidance of questions about the event and the clients’ reaction, are contrary to the ‘client centred’ counselling approach usually used by these participants. If they were to reflect on their performance and adjust their techniques accordingly, it is very unlikely that they would practice
techniques that were contrary to previous training, particularly when no instruction had been given to do so. However, it is quite possible that participation in the pre-training role-play increases outcomes at the post-training assessment, due to practice effects. Having taken part in this activity, counsellors participating in the training are able to reflect back on their earlier performance. This act of reflection, when provided with information on the ‘correct’ method may enable counsellors to better plan their behaviour in the future. It may be that this pre-training activity is an essential aspect of the training. Future research should evaluate the extent to which rehearsal prior to training improves performance post-training.

Table 10
*Scoring Criteria for Scale C*

**C. Relaxation**

1. **The counsellor encouraged relaxation**
   To achieve a score of 1 here, the counsellor must either introduce a new relaxation skill or prompt the client to use one that they are already familiar.

2. **The counsellor provided a rationale for relaxation.**
   To achieve a score of 1 here, the counsellor must convey relaxation as useful for either of the following reasons:
   1. Relaxation can be used when we are exposed to anxiety provoking situations – allowing us to cope with these situations better.
   2. Relaxation helps us cope with stress/anxiety in general.

3. **The counsellor provided correct instruction for breathing relaxation.**
   To achieve a score of 1 here, the counsellor must communicate the following things:
   1. Breathe in a 6-second cycle (three seconds in, three seconds out).
   2. Breathe from stomach/diaphragm (eg. “breath with stomach, not chest”, or “Stomach expands/contracts” etc.)
   3. Do not take unnecessarily deep breaths / take normal breath.
A further limitation of the present study is a lack of follow-up assessment in OATC skills. This lack of follow-up does not allow us to speculate on whether increases in skill are likely to be maintained. Future research should evaluate the maintenance of skills following participation (e.g., one month after training participation).

The method of skill evaluation has several limitations. The measurement of skill evaluation in a role-play setting limits the generalisability of these results. The evaluation of counsellor ‘competence’ may provide a more accurate indication of volunteer counsellors’ ability to deliver OATC in a real world setting. Evaluating competence involves the review video footage from actual counselling sessions by an ‘expert’ rater (Miller & Binder, 2002). This is a qualitative assessment of the adequacy with which the counsellor applies the techniques, taking into account various aspects of the sessions difficulty (Miller & Binder, 2002). To further evaluate the ability of volunteers to deliver the approach, future research should assess counsellor competence using OATC in actual counselling sessions.

Another limitation of the data collection procedures was the variation in the research assistants that facilitated the role-play assessments. Due to limited availability, a total of seven assistants were involved in the role-plays over the duration of the data collection. While research assistants received identical training, we could not control for natural variance in the way that assistants presented themselves in the role-plays. It is likely that this led to varying difficulty for the same role-play ‘character’. An optimal approach would be to have one assistant role-play the same ‘character’ for the duration of the research.
Although the finding that trauma history is related to VT has been replicated elsewhere, it is possible that the order in which the questionnaires were presented was partially responsible for the results obtained in this study. The trauma history measure (SLES) was always presented to participants before the VT measure (ProQOL). Participants with an extensive trauma history would have been primed to recall traumatic events in their lives when presented with the SLES. It is likely that this recall would have lead to elevated distress for those individuals. This distress may have increased their immediate perception of VT/Compassion Fatigue when asked to rate the personal effect of working with other individuals with a trauma history. Future research should attempt to control for this possible confounder by reversing administering of these questionnaires or administering them on separate occasions.

The effects of VT on post-assessment performance suggest that further investigations may be warranted. Although VT did not significantly hamper participants’ competence the results suggested that VT may be having some effect on learning or performance of skills. It could be that this intervention is too simple to detect variance. Future research should investigate the impact of VT on more advanced interventions (e.g., psychotherapies for PTSD). Future research may also investigate the effect of VT on performance with a population of practitioners already doing specific trauma work. It may be that VT in our population was not severe enough to significantly impair counselling skills. Our population had relatively low VT (Mean = 9.4, SD = 4.8) compared to the average score on this measure (M = 13, SD = 6; Stamm, 2005). A population with more severe VT may have significantly more impaired skills. It is also possible that the criterion that was chosen to evaluate performance was too simple to
detect variance in performance. More advanced criteria, such as the assessment of ‘competence’, may detect variance that our present/absent checklist could not. Future research should investigate the effect of VT severity on competence with a population of trauma therapists.

The effect of VT on competence needs also to be investigated in an actual therapy context. It is possible that counsellors VT ‘symptoms’ are not severe enough during sessions to effect competence. This could be the result of the ‘role-play’ context. The situation and emotion being communicated by the confederate is fictional. This may prevent the emergence of strong reactions in the counsellor as they know the situation and suffering is fictional. ‘Real life’ situations and emotions may be more likely to provide strong countertransference reactions, which are often associated with VT (Neumann & Gamble, 1995).

A further limitation of this study is a lack of extensive psychometric data to support the use of the SLES and ProQOL. There is currently no test-retest reliability data on either of these instruments (Stamm, 2005; Stamm et al., 1996). Although these instruments have some validity data (Stamm, 2005; Stamm & Rudolph, 1996), further investigations need to be performed before definitive conclusions can be drawn on the results of these measures. Also, the psychometric properties of both measures have yet to be endorsed by the peer-reviewed literature. The psychometric properties of the SLES, while appearing adequate, have only been reported in a book chapter, edited by the author (Stamm et al., 1996) and a non-published preliminary report (Stamm & Rudolph, 1996). Similarly, the psychometric properties of the ProQOL have only been presented in a non-peer-reviewed publication (Stamm, 2005). Future research should investigate the effects
of trauma history and VT on competence using additional trauma history and VT measures such as: the Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979), in the case of trauma history; and the Traumatic Stress Institute Belief Scale (Pearlman & Mac Ian, 1995), in the case of VT.

Future research should investigate the influence of professional training on the emergence of VT. This study supported previous findings that a trauma history predisposes volunteers to VT. These findings were not replicated with professional practitioners however (Boscarino et al., 2004). It is possible that professional training may help individuals with a pronounced trauma history avoid the onset of VT (Adams et al., 2001; Ghahramanlou & Brodbeck, 2000).

While it appears that OATC should, at the very least do no harm’, future research should investigate clinical outcomes in a ‘real-world’ setting. It is a possibility that any intervention may cause an increase rather than decrease in symptoms. This has certainly been suggested with other early interventions for trauma such as CISD (Mayou et al., 2000). While it is very unlikely, given the non-invasive techniques used in this approach, the possibility to do-harm with any intervention should be considered. The capacity of the approach to reduce distress and long-term impairment must be evaluated before widespread use can take place.

8.5 – Conclusion

The Orienting Approach to Trauma counselling was developed to assist individuals who have been both indirectly and directly exposed to traumatic incidents. The approach is an
alternative to popular early interventions that have been shown to exacerbate the psychological effects of trauma. Unlike psychological debriefing, the approach excludes elements of counselling that have the potential to increase the distress of the client. Instead, OATC focuses on theoretically ‘safe’ and potentially helpful aspects such as relaxation, psychoeducation, and providing information on self-help strategies and referral options. This study has shown that volunteer counsellors have the ability to learn and administer the technique. Since OATC appears to be appropriate for this underutilised population of practitioners, the intervention makes it possible to provide a service to individuals whose suffering would otherwise go unnoticed. The dissemination of the approach is likely to be straightforward as training is manualised and limited to a one-day session. While the approach appears to be theoretically sound there is a need to investigate its capacity to reduce the psychological sequelae of traumatic incidents. The finding that performance is not affected by the counsellors’ trauma experiences does provide some promising support for the approach as a ‘no-harm’ intervention. Should future empirical data support the use of OATC, then the widespread dissemination of the approach is likely to assist many individuals who would otherwise not receive assistance, and reduce the need for them to seek professional services.
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Appendix A

The Orienting Approach to Trauma Counselling

Training Manual

Andrew B. Phipps & Mitchell K. Byrne

Produced in part of a research collaboration between the Illawarra Institute for Mental Health, University of Wollongong and Lifeline South Coast (NSW)

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Training Guidelines

The authors make the following recommendations when training the ‘Orienting Approach’ to trauma counselling.

1. The trainer or facilitator should be suitably qualified and experienced. Due to the complexity of post-traumatic reactions to trauma as well as the potential to exacerbate the trauma reaction the facilitator should be a qualified Psychologist or Clinical Psychologist with experience in mental health and trauma.

2. Group sizes should be limited to a maximum of 12 per group. It has been the experience of the authors that the optimal group size is 8-10 participants.

3. Adequate arrangements should be made for participants who may become distressed throughout the course of the training. Usual procedures and mechanisms that the organisation employs for practitioners who become distressed during the course of practice should be sufficient.

4. It is not intended for this manual to be a complete resource for facilitators. It is strongly recommended that facilitators familiarise themselves with all the suggested reading provided.

5. One full 8-hour day should be allocated to training which includes evaluation. The following time allocation should me used as a guide:

<table>
<thead>
<tr>
<th>Section</th>
<th>Suggested time allocation</th>
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<tbody>
<tr>
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<td>30 Minutes</td>
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<tr>
<td>Part 1</td>
<td>90 Minutes</td>
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<tr>
<td>Morning Tea Break</td>
<td>30 Minutes</td>
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<td>Part 2</td>
<td>30 Minutes</td>
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<td>Lunch Break</td>
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<td>Part 3</td>
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<tr>
<td>Evaluation</td>
<td>60-90 Minutes</td>
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</tbody>
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Suggested readings

Background to the ‘Orienting Approach’


Predictors and Course of Trauma


Secondary Traumatic Stress/Vicarious Trauma


Psychological Debriefing


The ‘Orienting Approach’ to Trauma Counselling Workshop

A crisis intervention model for critical incidents

Andrew B. Phipps & Mitchell K. Byrne

Objective: To welcome the group and provide some brief background information to the model.

Instruction: The following points should be communicated to the group.

Introductions
• Thank trainees for coming.
• Introduce self and other individuals involved in the training day.
• Explain role of named supervisors and their input.

What the ‘Orienting Approach’ is designed for?
• This model has been developed specifically for use by volunteer counsellors.
• The model is designed to be used shortly (within one week) of a traumatic incident.
• The model is designed to be used by counsellors who go out into the community and help those exposed to trauma. Essentially this is a team of counsellors that presents to the cite of the incident.

Background to the research and affiliates
• Funded by Lifeline South Coast (NSW).
• Lifeline South Coast (NSW) has been interested in developing its capacity to help individuals in the community who have been exposed to traumatic incidents.
• Lifeline approached the iiMH seeking input on the best way to help individuals who had been exposed to trauma in the community. The iiMH is an affiliate of the Psychology Department, University of Wollongong.
Introduction to the training

- Format: A full day with 2 breaks.
- Will give you Skills to Identify, Counsel and Refer someone who has been traumatised.

Objective: To instil confidence that skills taught will be relevant.

Instruction: Outline the following points

Format of the day
- The training program will take a full day we will have one short tea break and one lunch break (approx 1 hour).
- Break Times: 11.30 (20 mins) and 1pm (1 hour).

What the training aims to give participants
- Skills to help someone who has been exposed to a traumatic or significantly distressing incident.
- Identify someone who has been exposed to a traumatic incident. This involves becoming familiar with the signs and symptoms.
- Counsel someone who has been exposed to a distressing or traumatic incident. Some of the concepts and ideas may be different to training and practice that you have already undertaken. Since people who have just been exposed to a traumatic event have a specific set of needs, we must learn some specific helping strategies.
- Refer someone who has been exposed to a traumatic incident. This involves becoming aware of some of the signs that a client may need to be referred on for further help.
The Model

- A challenge for any counsellor.
- Many skills you will already be familiar with.
- Uses existing skills that have been packaged to give you a sense of how best to help.
- Based on 25 years of research.
- Please ask questions.

Objective: To instil confidence that skills taught will be achievable and based on ‘best practice’

Instruction: Outline the following points

Will it be too hard?
- Some of the aspects of what we are doing may be challenging but many of the skills you will already be aware of.
- None of the skills in this training are new by any means.
- What is new is the way that they have been packaged. They are a group of skills that have been brought together to give you a good sense of how best to help someone who has been exposed to a traumatic incident.

Is it effective?
- The ‘Orienting Approach’ is based on the information gathered from about 25 years of research into trauma and trauma counselling. We will be presenting some of that research so you will understand why we are doing what we are doing and so that you will believe in what we are doing.

Your input and questions are valued
- Please feel free to ask questions at any stage of the day. It’s best that we deal with concerns or problems as a group as they come up.
- Please feel free to add any of your own suggestions or discuss your own experiences of counselling.
Getting to know each other

- Name.
- Role at lifeline.
- Duration of service.
- Current skills and knowledge in trauma counselling.
- What you hope to achieve from the training.

Objective: To obtain information on what people would like to gain from the training; in an effort to try to meet those expectations and clarify what expectations are not able to be met.

Instruction:
- Go around the room and ask individuals to introduce themselves, declare experience and training, and inform of what they would like to achieve.
- Write their objectives on the board and indicate that we will try to meet as many of these as possible.
- Clarify any objectives that are requested that will clearly not be met.
Disclosure of personal experiences

- We have all experienced traumatic events.
- Talking about these events can be distressing.
- The training involves role-play activities. Please use the scenario’s provided and not your own experiences.
- Listening to traumatic events can also be distressing.
- If you do become distressed, please let us know.
- If needed contact the support counsellor on duty.

Objective: To normalise the experience of vicarious trauma for counsellors and to outline procedures if participants become distressed throughout the day.

Instruction: Outline the following points.

Normalising Trauma: The world is a place where bad things happen and we are often involved or come into contact with these bad things. These tragic or awful things often happen to us and we are affected for quite a while afterwards.

Role-playing trauma: We will be doing a lot of role-plays. As you would know, discussing traumatic personal experiences is not very pleasant. Most people become distressed. It is normal to become distress when talking about traumatic events or listening to traumatic events.

For today I ask that you don’t use your own personal experiences in role-plays. We will have many different scenario’s for you to choose from so please use those. Also I ask that you try not to use scenario’s that many closely resemble situations in your own life.

If you do become distressed

Because trauma is about tragic things happening to people I will need give examples of these tragic things and discuss their effects on people involved. Although all these examples are fictional, listening to some of them may be upsetting.

If you do become distressed: Please do what you need to do. If you feel that you want to take a break while we go ahead please do so. I do ask however that if you feel that you need to leave altogether please come and talk to me or one of the other facilitators first. The reason I ask this is that I would like to make sure your OK and to make sure that there is someone that can follow-up with you later to see how you are going.

If you do become upset by any of the material discussed today please feel free to come up to myself either during the breaks or at the end of the workshop. Otherwise please follow the same procedures that you would if you became upset while counselling.
Group Rules

- Treat all information discussed within the group as confidential.
- Do not use your own traumatic experiences in role-plays.
- Please respect other group members.
- Please avoid giving advice or counselling.
- If you do become distressed please let us know sooner rather than later.

**Objective:** To outline group rules so participants feel safe enough to disclose any experiences they wish to.

**Instruction:** The facilitator should explain to the group that these rules have been arrived at through previous groups. They are dictated to save time. They are not exhaustive however. Facilitator should encourage the group to add any that they feel are important.
Overview

- Part 1 - Introduction to Trauma: To provide participants with skills to identify trauma.
- Part 2 - Early and brief interventions for trauma: To provide participants with information that will help them to ‘do no harm’.
- Part 3 - The ‘Orienting approach’ to trauma counselling: To provide skills to enable participants to best help a traumatised person.

Objective: to outline the training content of the day.

Instruction: Outline the three parts of the training.

Part 1: This section takes about 1 to 1.5 hours and should conclude with morning tea. This section covers presentation and diagnostic issues. Skills for identifying trauma are taught.

Part 2: This section takes about 45 mins to 1 hour and should conclude with lunch. This section focuses on outlining the debate over Critical Incident Stress Debriefing (CISD). This section provides justification for the model that we are proposing (covered in part 3).

Part 3: This section takes about 2 to 2.5 hours and concludes the day. Part three is the major skills component of the day where participants learn about the model and practice the skills.
Part 1: Introduction to Trauma

- Aim: To provide participants with skills to identify trauma
- Objectives:
  1) Gain an understanding of the trauma reaction
  2) Become familiar with the symptoms of trauma
  3) Gain an appreciation for the range of possible causes of the trauma reaction

Objective: Outline the contents of Part 1.

Instruction: Explain that part 1 of the training is designed to provide participants with the following.

- Basic overview of what it is and what causes trauma.
- More specific information on the actual symptoms to help you identify this reaction.
- Information that will help you appreciate the types and ranges of events that are able to cause such a reaction.
What is trauma: example of Terry

- Terry is a 54-year-old farmer who was working with his son fixing the cutting blades of a harvester. An accident occurred where Terry's son had his arm trapped between the blades. His son was in incredible pain while he was stuck between the blades for over 1 hour. Terry was unable to do anything to help his son other than call an ambulance. He felt helpless while he waited for the ambulance to arrive. Terry's son ended up loosing his arm. During the time that followed Terry was unable to return to work. Images of his son, trapped in the harvester, kept appearing in his mind. When this happened he felt extremely anxious and helpless (similar to how he felt when the actual incident occurred). These images were so distressing to him that he would do anything to avoid thinking about the incident. He avoided doing work in the farm because working with the equipment reminded him of the incident. He had trouble sleeping at night because he was so 'stressed'. He sometimes woke during the night because of nightmares about it happening again.

**Objective**: To provide an practical example of a traumatic incident and reaction that can be referred back to when outlining symptoms of trauma.

**Instruction**: This slide can be read verbatim to the trainees.
What is Trauma?

- A reaction that may occur after being exposed to some type of distressing event(s).
- Person becomes anxious, particularly when they come into contact with reminders of the event.
- The anxiety is unpleasant so they learn to avoid reminders of the event.
- ‘Reexperience’ the event through unpleasant memories or nightmares.

Objective: To outline the four necessary criterion of trauma. This is a broad introduction only.

Instruction: Outline the following information.

Point 1: Trauma is a distressing psychological reaction. For the psychological reaction to be classified as ‘trauma’, the reaction must be precipitated by an event that is perceived by the person to be significantly distressing. These stressful events can take many forms. Some common examples may be; sexual assault, war or a very bad car accident.

Point 2: The reaction that the person experiences can be described as ‘anxiety’. The affected person becomes quite anxious, particularly when they come into contact with reminders of the event.

Point 3: The anxiety they experience is very unpleasant and so they learn to avoid reminders of the event. When the person escapes the reminder they often feel a little better (less anxious).

Point 4: They also tend to re-experience this event through unpleasant memories or nightmares.
What are the symptoms of Trauma?

- **Reexperiencing**: The event is reexperienced through intrusive and distressing memories or dreams.
- **Avoidance**: The individual avoids thoughts and activities associated with the event.
- **Arousal**: Persistent symptoms of increased arousal such as insomnia, irritability, anger and difficulty concentrating.

**Objective**: To outline the 3 signs or symptoms of psychological trauma which are elaborated on in later slides.

**Instruction**: The facilitator should read these points and also add a few other trauma symptoms that exist under these clusters.
Reexperiencing

- Distressing thoughts or images of the event.
- Dreams and nightmares of the event.
- Acting or feeling that the event is happening again (Flashbacks).
- Emotional distress (becoming fearful or upset) when reminded of the event.
- Unpleasant physical reactions when reminded of the event (e.g., Shaking, sweating, heart pounding, gastro-intestinal discomfort).
- What were Terry's symptoms of reexperiencing?

Objective: To provide some concrete examples of 'Reexperiencing' symptoms. Both Clinical and non-clinical.

Instruction: This slide provides examples of reexperiencing symptoms, as per DSM-IV. The facilitator should explain these examples to the trainees. Facilitator should communicate that this type of reexperiencing is usually 'distressing' and 'unpleasant'.

Instruction: Describe a Non-Clinical example of reexperiencing - Reexperiencing is not just remembering the event, while it does involve memories it also has an element of feeling the same way as when the event happened.

Eg. Driving in car and hear song that you were listening to when you broke up with a partner- immediately feel sad and you re-experience the event to some extent.

Eg. You go to the dentist and hear a drill, you automatically remember and reexperience pain to some extent.

Instruction: Prompt the trainees to come up with other examples of reexperiencing, either in personal life or from counselling.

Instruction: Prompt the trainees to recognise Terry's reexperiencing symptoms: Reliving the event (Images that kept coming to mind, Also experiencing nightmares).
Avoidance

- Avoiding thinking or talking about the event.
- Avoiding activities, places or people that produce reminders of the event.
- Avoiding contact or relationships with others.
- Being unable to remember important aspects of the event.
- What are Terry’s symptoms of Avoidance?

**Objective:** To provide some concrete examples of avoidance symptoms and to describe the function of avoidance.

**Instruction:** Go through the slide points with reference to the following points that explain the function of avoidance as protective and to avoid psychological distress.

• The event, and the reexperiencing of it, is very unpleasant. So people actively work to avoid anything that will make them think about the event again.

• People avoid places associated with the event because they fear that the event will happen again (eg. Same street as a assault).

• People avoid contact with others for several reasons; Relationships are associated with emotions and they may not want to be more stressed out than they already are, They may not trust people anymore, or others may be a reminder of the event.

**Instruction:** Prompt the trainees to recognise Terry’s avoidance symptoms (Avoided thinking about the accident and avoided work and farm related equipment).
Arousal

- Difficulty falling or staying asleep
- Irritability or anger
- Difficulty concentrating
- Feeling constantly on edge or restless
- Being easily startled or frightened (Jumpy)
- What are Terry’s symptoms of arousal?

**Objective:** To provide some concrete examples of arousal symptoms.

**Instruction:** These simple anxiety symptoms can simply be read verbatim to the group. Facilitator should also describe how distress is often prompted by exposure to reminders of the traumatic event(s).

**Instruction:** Prompt the trainees to recognise Terry’s arousal symptoms (Had trouble sleeping as he was so stressed).
Dissociation (or “Shock”)

- A common ‘Avoidance’ symptom in trauma.
- Particularly common at the point of the incident.
- Being unaware of or unresponsive to the world around you.
- Lack of emotion (‘flat’).
- Similar to ‘Being in a daze’
- A more severe version of a common human experience.
- Did Terry have any dissociative symptoms?

Objective: To provide some concrete examples of dissociative symptoms. Both clinical and non-clinical.

Instruction: Mention all slide points with reference to the following points:
- This symptom is particularly common during the early stages of a trauma reaction - at the time of the event or shortly after.
- This has also been referred to as, “being in shock”.
- Dissociation = In some way being unaware or unresponsive of the world around you.
- Has been described as a ‘protective’ mechanism – To protect the psyche from the reality of how cruel and unsafe the world is.

Instruction: Describe dissociation as a more severe version of a ‘normal’ human experience.
- Dissociation is normal and it happens to everyone. Throughout today’s workshop you will become dissociated at various times. It is normal for your attention to drift.
- Can anyone think of personal example?

Instruction: Prompt the trainees to recognise Terry’s dissociative symptoms (possibly feelings of helplessness).
Why do we experience the symptoms of trauma?

- Trauma is a type of anxiety
- We experience anxiety when we come into contact with things that we fear.
- When we withdraw from things that we fear we feel better (No more anxiety).
- Because this feels good we learn to do it again next time (perpetuates avoidance).

**Objective:** to introduce the participants to a cognitive-behavioural explanation of trauma/anxiety and the ‘cycle of avoidance’.

**Instruction:** The facilitator may wish to explain these concepts with reference to the following points.

- Trauma is a type of anxiety. When we ask, “Why do we experience trauma”, we are really asking why do we experience anxiety.
- We will use the example of a simple and common phobia (of spiders).
- For many of us, somewhere along the line we have learnt to fear spiders. There may be many explanations as why we have learnt to fear them, perhaps we have modelled this from our parents or maybe we have been bitten at some stage. They are ‘bad’ so we fear them. When we come into contact with spiders we experience anxiety. Anxiety is unpleasant. Because anxiety unpleasant and spiders are the cause of this we avoid them (either run away or kill them). When they are no longer around us we feel significantly better (no more anxiety). As a result of this process we learn that if we get away from them we will feel better (no more anxiety). Since we have learnt that, “if you get away from spiders you will feel better”, we are likely to avoid them in the future.
Objective: To provide participants with a simple way of recognising trauma symptoms (with reference to a check-list).

Instruction: Hand out this measure and briefly discuss the cluster of symptoms.
Activity 1: Trauma Symptom Role Play

- Aim: To enhance skills in observing and identifying trauma symptoms in the client.
- Materials: Trauma Symptom Checklist
- Two Volunteers: To role play clients.
- Clients: read the scenarios and tell the counsellors what happened and how they have been feeling.
- Counsellors listen to the client and identify the symptoms using the checklist (tick boxes as they apply).

Objective: To give participants the opportunity to identify the symptoms of trauma.

Instructions:
- Two volunteers should read the ‘Role play activity 1’ vignettes and relate their story to the group.
- Each participant should have a copy of the trauma symptoms checklist.
- Counsellors do not ask questions. Your role is simply to listen and mark down the symptoms that they have observed.
- When each individual vignette has been conveyed by the role-players, discuss the symptoms recognised in a group.
  - When counselling Tony, what trauma symptoms did you pick up on and what was the evidence for this in the role-play?
  - When counselling Kathy, what trauma symptoms did you pick up on and what was the evidence for this in the role-play?
What events can cause a traumatic reaction?

- Trauma is caused by an event, which the person interprets as life threatening or a threat to how they understand the world. Trauma usually results when people feel that they are at risk, and that the world is uncontrollable and unpredictable.
- What are some examples of possible events?
- What about if you were not involved, or you were not a direct witness to the event?

Objective: To give participants an appreciation for the range of possible events that can cause a traumatic reaction.

Instructions: Read the definition provided and discuss possible events that could cause a traumatic reaction. The purpose of this is to introduce the concept of Secondary Traumatic Stress. To become traumatised you don’t necessarily need to be involved in the event or see the event. The facilitator may wish to use examples such as the 9/11 incident to describe the influence events on the greater community (remember: Reexperience, Avoidance, Arousal).
Example: Jennifer

- Jennifer lives alone in a one bedroom flat. She had become quite close with her neighbour Katherine who lived across the way; they were good friends that enjoyed each other’s company. One evening when Jennifer came home she learnt that Katherine had been sexually assaulted in her flat. As you would imagine Jennifer became very distressed. She could not help but imagine Katherine being attacked. The images that she created in her mind were very upsetting. She began to think that she would probably be the next victim so she had new locks put on her doors. She began having difficulty sleeping as she kept waking-up at the slightest noise in the building. She did not talk to Katherine for months after the event. Every time she went to call Katherine or knock on her door she felt extremely ‘nervous’ so then decided not to talk to her.

Objective: To give participants a practical example of STS. (note: This slide may be left out if the group already seems to have a clear understanding of secondary reactions)

Instructions: Read the vignette verbatim and request the group identify trauma symptoms.

Reexperiencing: Creating an image of the event in her mind
Avoidance: Talking to Katherine.
Arousal: Having difficulty sleeping.
Who else may experience trauma?

- The effect of traumatic incidents are wide reaching. They have an impact on people besides those directly involved.
- Counsellors become traumatised by the stories that they hear.
- How does a counsellor re-experience and avoid?

**Objective:** To introduce the participant to the concept of Vicarious Trauma (The effect of trauma work on the counsellor).

**Instructions:** Discuss the following points.

- Listening to people’s traumatic stories can traumatise counsellors.
- This is quite a normal response and comes as a result of empathically engaging with the client. It does not mean that the counsellor has a disorder as such. This, in many cases of counselling, is simply unavoidable.
- Symptoms may be expressed as;
  - **Re-experience:** Go over the call in mind, think about it at home and become distressed. Worry about the client.
  - **Avoidance:** withdrawal from personal relationships; as well begin to dislike their clients and counselling work in general. Stop coming into work. Some people call it ‘burn out’.
  - **Arousal:** Request input from the group on how they feel ‘aroused’ as a result of the work they do.
Characteristics of ‘Vicarious Trauma’ or ‘Secondary Trauma’

- More likely with people who share an emotional bond with those directly affected.
- More likely if we live in the same area as we perceive ourselves to be at risk.
- Serial murder: Those who live in the same area and those who share some demographic similarity (eg. Age, gender etc.) are effected the greatest.
- The distress and impairment experienced by those who are indirectly affected is usually LESS severe.

Objective: Introduce participants to the predictors of Secondary Trauma. Important to recognise individuals that may be more likely to experience and provide a context for the ‘Trauma intervention team’

Instructions: Discuss this slide in reference to the following points.

• Not everyone who is exposed to a distressing event will develop traumatic stress. An acute reaction is more likely when the individual shares some emotional bond with those directly affected. This results in a higher incidence in families, nurses and counsellors of the directly effected individual.

• If we are in some way similar to the victim(s) we are more likely to develop a traumatic response.

• In an American community exposed to serial murder, significant increases were found in trauma symptoms. The most severe symptoms were found in those that shared some demographic similarity to the victims (eg. Gender, Ethnicity, Age, Education).

• In the event of serial murder the people who are affected the most are those who live in the area where the events are occurring. This is because they think they are now at a greater risk.
Part 2: Early and brief interventions for trauma

- **Aim:** To provide participants with information that will help them to ‘do no harm’.
- **Objectives:**
  - Become familiar with the concept and aim of a brief and early intervention.
  - Gain an understanding of Critical Incident Stress Debriefing (CISD) and the controversy surrounding it.
  - Become familiar with the concept and dangers of exposure therapy.

**Objective:** Outline the contents of Part 2.

**Instruction:** Explain that part 2 of the training is designed to provide participants with the reasoning and rationale for the ‘Orienting Approach’. A brief explanation that it is possible to do more harm than good when intervening early may be sufficient.
What is an ‘early’ and ‘brief’ intervention?

- **Early** = Within one week
- **Brief** = One session only
- **Intervention** = something that we do to help someone (eg. counselling)
- People will respond with distress to traumatic events. Early interventions aim to prevent the ‘normal’ response becoming ‘abnormal’

**Objective:** Define what is meant by ‘early’ and ‘brief’ intervention and describe the aim of such interventions.

**Instruction:** Discuss slide points as well as the following.
- It is widely accepted that an individual exposed to a traumatic event will experience some degree of stress response.
- Early interventions aim to prevent the ‘normal’ stress response from becoming ‘abnormal’.
- Intervening early can help the person avoid long-term suffering of trauma.
Critical Incident Stress Debriefing (CISD)

- A popular treatment that is sometimes given directly after the traumatic event (48-72 hours).
- A ‘once off’ treatment in a group setting.
- Group members are encouraged to talk about what they saw, heard etc and how they feel/felt.

Objective: Describe the elements and practice of CISD.

Instruction: Discuss slide with reference to the following.

• The most popular model of early and brief intervention is CISD or Psychological Debriefing.
• CISD was originally designed for ambulance personnel as a ‘stand alone’ procedure following a traumatic incident.
• The intervention is usually presented in a group setting with one or more facilitators.
• Debriefing takes place immediately after the event (within 48-72 hours).
• The aim is to get a group of people together who were involved in the event and talk about it. Group members are encouraged to talk about what they saw, heard etc and how they feel/felt.
Is CISD Effective?

- Critical Incident Stress Debriefing **DOES NOT WORK.**
- Several studies have demonstrated that CISD actually makes people worse. Thus they experience more trauma if they participate in these groups.

**Objective:** To establish the research findings that psychological debriefing is not effective.

**Instruction:** Discuss research findings. Facilitators may wish to refer to this excerpt from Phipps & Byrne (2003)

Much debate exists as to the effectiveness of CISD. Mayou, Ehlers and Hobbs (2000) examined the use of CISD with a population of motor vehicle accident survivors. The treatment involved the administration of 1-hour individual debriefing as well as providing written information. It was found that three years later the group who received the treatment had significantly worse psychiatric symptoms, travel anxiety, physical problems and poorer overall level of functioning than the group who did not receive the treatment.

Rose and Bisson (1998) reviewed Randomised Controlled Trials (RCT’s) of psychological debriefing. Of these studies six were selected for discussion. In 2 of the studies the treatment group significantly improved. In the remaining four studies, two showed no difference between groups while 2 showed an increase in psychiatric morbidity when exposed to the treatment. Thus, while CISD is a brief and early intervention it appears that evidence for its effectiveness is highly variable.
Why might CISD do harm?

- People are being exposed to extra trauma material that they were previously unaware.
- Debriefing is 'exposure therapy' gone wrong.
- People are exposed again, their anxiety rises, and then left to their own devices.
- They are unable to learn that there is nothing to fear so their fear and avoidance is reinforced.
- Talking about and listening to stressful events causes anxiety. Extra anxiety at the early stages may interfere with normal coping mechanisms.

Objective: To establish a consensus that prompted exposure to traumatic material has the potential to do harm.

Instruction: Outline this slide as well as the following points.

- Listening to others accounts is traumatising. People are exposed to other things that they may not have witnessed (more traumatic information to go home with). When people participate in CISD they are actually traumatised twice, therefore they are worse off.

- Debriefing is exposure therapy gone wrong. Explain the rationale and procedure of exposure therapy in reference to the spider example. THE KEY TO SUCCESSFUL EXPOSURE THERAPY IS EXPOSING THE PERSON TO THE THING THAT THEY FEAR LONG ENOUGH FOR THEM TO LEARN THAT THERE IS NOTHING TO FEAR.

- When people participate in CISD groups they are exposed to the thing that they fear (Thoughts and reminders of the event). They are encouraged to talk about the event, bring up all the feared memories and then listen to the traumatic memories of other people. This causes them anxiety – then the group ends. They go home in an anxious state. There is no time for them to learn that there is nothing to fear from the memories. So they still cause a great deal of anxiety.

- Even when debriefing is done individually (they have only their on memories), the intervention does more harm than good. Talking about and listening to stressful events causes’ anxiety. This anxiety may inhibit the individual’s ability to employ their normal coping mechanisms.
Relaxation Training

- Certain types of relaxation skills have shown to be effective in the treatment of trauma symptoms.
- Lowering arousal can help people to manage anxiety. This helps people to stop avoiding the things that they are fearful of.
- Relaxation does not expose people to the trauma and hence will DO NO HARM.

**Objective:** To provide one possible alternative to debriefing that has some empirical support. This is important as we draw on this in the ‘Orienting Approach’.

**Instruction:** Discuss this slide in reference to the following points.

- Teaching skills to lower arousal when exposed to traumatic material has been found to be effective. Anxiety/arousal is managed by using these skills. When used during exposure to the feared stimulus – anxiety is reduced and avoidance is not as necessary.
- Since we are decreasing rather than increasing arousal we can DO NO HARM. The inherent problems of CISD do not apply to relaxation. CISD is potentially detrimental because anxiety levels are raised. Exposure therapies require follow-up to ensure that adequate habituation has occurred. The aim of relaxation however is to lower levels of anxiety. This is a ‘safe’ therapy that does not require follow-up as a result of the intervention.
Part 3: The ‘Orienting approach’ to trauma counselling

• Aim: To provide skills to enable participants to best help a traumatised person.
• Objectives:
  - Become familiar with the approach.
  - Rehearse and demonstrate relevant skills.

Objective: Outline the contents of Part 3.

Instruction: A brief statement indicating that this is the section where we learn how to counsel the traumatised individual is sufficient here.
Format of the approach

- It is appropriate for use at any stage of the trauma recovery process but designed as an early intervention
- Can be delivered over a single session.
- Designed for use in a face-to-face setting but many skills are equally effective over the phone.

Objective: Provide participants with a context within which the 'Orienting Approach' is to be delivered.

Instruction: Outline the following points.
- This model was designed to be used face to face, one-to-one. Designed to be used as a disaster/incident response model.
- The 'orienting' approach is a model of early intervention crisis counselling for trauma. It would benefit individuals exposed to trauma at varying levels (e.g. personal assault to media coverage).
- It can be administered over one session only. The duration would depend on the level of need. It is estimated however that the session would not exceed 90 minutes. It can be helpful at any stage of the trauma reaction but is designed for early intervention, soon after the impact of the event.
The ‘Orienting’ Approach

1 **Support**: Listen to their story
2 **Normalisation**: A ‘normal response to an abnormal situation’.
3 **Skills**: Relaxation skills
4 **Advice/Information**: - Self-help information
   - Referral Options
   • ‘Orienting’: Supporting the person and then pointing them in the right direction.

**Objective**: Provide participants with an outline to the model.

**Instruction**: Outline the following points.

- There are 5 core components of this model.
1. The counsellor counsels the individual without actively trying to get them to relive the traumatic incident.
2. The counsellor conveys to the client that what they are experiencing at this point is a ‘normal’ reaction.
3. The counsellor teaches the client some skills to reduce their anxiety.
4. The counsellor gives the client some self-help information that they can refer back to.
5. The counsellor makes some judgement as to the need for referral.
- The term ‘Orienting’ has been used to describe the model as we are simply trying to supporting the client and point them in the right direction. The main tenant of the approach is to ‘do no harm’. We are less concerned with notions of ‘treatment’ or improvement. Our focus is to support and provide information to help the person help themselves.
Support

- Patience is needed if the client recounts the story multiple times. Must be able to tolerate repetitiveness of the clients account.
- Repetitiveness is a sign that the client is struggling to make sense of their ‘new world’. This support will allow client to integrate the new material.
- They may not want to talk about it: This is OK and you should not encourage them to talk about it.

Objective: Convey the importance of allowing the individual to talk as little or as much as they like.

Instruction: Outline the following points.

• Patience on the part of the counsellor will be needed as the client recounts the same story multiple times. Helpers must be willing to tolerate the repetitiveness of these accounts. Do not interrupt the client or attempt to ‘move them on’.
• A great amount of confusion is common as the individual struggles to make sense of their new reality. Soon after the event clients may repeat the traumatic story multiple times in an effort to understand what has transpired. The warmth, understanding and acceptance of the counsellor can create a holding environment in which integration of this new material is possible. The presence of a stable and confidant other also provides a much-needed positive coping model.
• It is more likely however that the client will want to talk less rather than more. If this is the case do not encourage them to talk. Just allow them to go at their own pace.
Support but do not expose

- Do not ask for details of the event itself. This maybe harmful exposure that is likely to increase their distress.
- Key Skill: Do not ask open ended questions in regard to the event itself or their reaction to it.
  - eg. “Tell me what happened”
  - “How did you feel when they were hitting you?”
  - “What did they look like?”
- Do not discourage them however if they wish to relive the event.

Objective: To convince participants that exposure to traumatic material has the potential to do harm. Also discuss how to avoid unnecessary exposure.

Instruction: This is a very important part of the intervention. Communicating these points effectively will take some time. Facilitators should considerable time on this slide discussing and answering questions. This aspect of the intervention is quite difficult considering it is contrary to the way that many of the participants have been taught to practice counselling. Client centred counselling, the model employed by the majority of volunteer counselling organizations, focuses on the clients experience and associated emotions. The model of counselling that most Lifeline centre’s subscribe to involves exploring the situation and the event.

- Facilitators may wish to model for the group correct and incorrect methods of reflective listening within this model:

  The correct way:
  Client: “I just can’t get the sight of the burning building out of my head”.
  Counsellor: “Sounds like your having trouble getting the burning building out of your head”.

  The wrong way:
  Client: “I just can’t get the sight of the burning building out of my head”.
  Counsellor: “What does the burning building look like, tell me what you see”

- One very important element is how the session begins. Counsellors will often start with a statement such as, “Tell me what brings you here”. Facilitators should encourage discussion over this and try to come to a reasonable way of beginning a session eg. “Is there anything you would like to talk about?”
Language

• Be attentive to the clients use of words and use them yourself.
• Traumatised clients use words that allow them to cope with what has happened.
• Using words other than what the client has used is likely to expand their exposure to the incident (similar to group debriefing).
• Key skill: do not reframe what the client is saying and be wary of paraphrasing. Just use the clients own words to let them know that they have been heard.

Objective: Convey the importance of using the clients own language as a method of avoiding unnecessary exposure.

Instruction: Outline the slide. Facilitators may wish to use some of the examples that follow.

• The client has chosen to use these words for a reason. Probably because they are less distressing to use. Do not substitute the clients words for your own. The use of language that the client has not used will only expand their exposure to the incident. Its similar to re-traumatising. They will only distress the client.

• For example, A woman whose sister has been brutally raped may describe her as being “attacked”. This is the sign of a temporary coping mechanism that should not be challenged at these early stages.

• Facilitators may wish demonstrate this aspect of the intervention with reference to the following or similar example.

  The right way:
  Client: “I looked back and the fire was really going, I was shit-scared”.
  Counsellor: “So you were shit-scared when you looked back”.

  The wrong way:
  Client: “I looked back and the fire was really going, I was shit-scared”.
  Counsellor: “Sounds like you were petrified when you looked back to see a blazing inferno”.

• The point of this particular example is that, although the word ‘Shit-scared’ may be offensive to some, for our client is safe. If we changed it, we are introducing new feelings and a new experience to the client’s recollections of the event. This new experience may be far more frightening.

• Therefore: use the client’s words no matter how inappropriate they may seem to you.
Group Activity

- Using these statements practice your reflective listening. Be sure to remember not to ask open ended questions that encourage the person to talk about the event and use the person's own language.
- John, who was mugged on his way home from work, talks about his experience.
- "I feel like the whole world has changed, like I'm no longer safe"
- "You can't imagine how helpless you feel when you can't even walk down your own street anymore"
- "I hate those guys, I hate them. They have turned me into a bloody ball of tension and fear".

Objective: To practice appropriate listening skills for this intervention model.

Instruction: The facilitator plays the part of the client. One or more group members have the job of responding to these statements. The ideal response is a shorter version of the statement delivered. The statement should not contain any words that have not been communicated by client and have the potential to further expose the individual to traumatic material.
Normalising: Tell them that their reactions/symptoms are normal

- **Reaction to the event:** A person may flee in terror or be paralysed with fear. They may regard their ‘freezing’ or ‘fleeing’ as acts of cowardice.
- It is important that these reactions are regarded as normal by the counsellor.
- In a dangerous situation we are programmed to:
  1. Fight: to protect ourselves
  2. Flee: to escape the danger
  3. Freeze: So that we are not noticed.

**Objective:** Convey the message that individuals react in different ways to traumatic and distressing events and these reactions are sometimes out the individuals control.

**Instruction:** This point refers specifically to the individuals reaction at the time of the event. The facilitator may choose to refer to the concept of ‘Fight/Flight’ to convey this information. The following information may be of use.

- When people are exposed to a traumatic event the ‘primary stress response’ can cause the individual to surrender, fight or be controlled by extreme fear. These responses are often so powerful that they take control of the person’s behaviour. People may act in a way that is previously unknown to them. Ordinarily timid people may find themselves risking their lives to save others. On the other hand, a person may find the event so distressing that they are paralysed with fear. It is likely that these memories will be distressing, particularly if the actions are out of character. It is possible that those who are overcome with fear may experience extreme guilt. They may regard their ‘freezing’ or ‘fleeing’ as acts of cowardice.

- When this mechanism kicks in we are programmed to:
  - Fight: to protect ourselves.
  - Flee (‘flight’): to escape the danger.
  - Freeze: So we are not noticed.

- It is important that these reactions are regarded as normal by the counsellor. It must be communicated clearly to the client that in these circumstances our control over our actions may be diminished.
Group activity: Normalise John’s experience

• How would you respond to John, if his response to the mugging was to:

1. Fight
2. Flee
3. Freeze

Objective: Give participants the opportunity to normalise a client's direct reaction to an event.

Instruction: The facilitator plays the part of the client and conveys the following information.

1. **Fight**: John fought back when the boys were mugging him. This only encouraged the boys to beat him up some more. He now feels like a fool for doing this. He thinks he should have just let them take his money.

2. **Flee**: John ran away when the boys were attempting to rob him. He now feels like a coward as they were much younger than he. He feels that he could have defended himself.

3. **Freeze**: John was with his friend Craig at the time. After the muggers had secured John’s belongings they moved onto Craig. Craig began fighting with muggers but John simply stood there watching, he felt helpless to do anything. He felt like he was just ‘frozen’ to the spot. The muggers made quite a mess of Craig. John now feels very guilty that he did nothing to help his friend.

• Ideally the group participants should provide a normalising response which eases the feelings of guilt/stupidity. The Participants response should communicate that the clients behaviour was not totally within their control.
Normalising

- **Symptoms:** Clients who are experiencing symptoms may be unsure of what is happening to them. This causes more anxiety.
- Intrusive images, flashbacks and nightmares should be regarded as a normal aspect in the recovery process.
- Describe their symptoms as 'a normal response to an abnormal situation'.

**Objective:** Train participants to normalise symptoms of trauma.

**Instruction:** convey information on the slide with reference to the following.

- While intrusive images, flashbacks and nightmares can be distressing they should be regarded as a normal aspect in the recovery process.
- The way that clients evaluate their symptoms will influence the impact that they have. As many clients will have never experienced severe reexperiencing symptoms before, they will be unsure of what is happening. Some clients may believe that they are 'going mad' (experiencing psychotic symptoms). This is likely to cause further anxiety. Counsellors should be alert to this, as enduring symptoms have been found to be associated with those who negatively appraise these early symptoms.
- Counsellors should normalise any current symptoms. The counsellor may wish to describe their symptoms as 'a normal response to an abnormal situation'.
Relaxation Skills

- Relaxation decreases arousal.
- When relaxation is used in feared situations we will experience less anxiety.
- If we can stay in a situation and not experience anxiety we learn that the situation is not harmful and we will no longer need to avoid that situation.

**Objective:** To provide a brief rationale for relaxation.

**Instruction:** Explain the rationale for relaxation in the context of Anxiety/Trauma

* (Use spider example). Relaxation helps us to reduce anxiety. When we are confronted with something that we fear we experience anxiety. If we can reduce anxiety, when in contact with the feared thing, we will not need to run away. If we don’t need to run away we will be able to learn that it cannot harm us. Then its ability to make us anxious is reduced.

**Purpose of relaxation in the context of trauma:**

- To reduce levels of arousal in general (symptom of trauma)
- To reduce anxiety when remembering the event (usually anxiety provoking).

- To reduce stress/anxiety in specific situations (i.e. when confronted with reminders of the event, eg. Walking down street that you were assaulted). If anxiety is reduced in these specific situations the individual will no longer avoid these situations.
Breathing Relaxation

- Breathing should be done in a 6-second cycle. That is, inhale for 3 seconds, exhale for three seconds. Use the second hand of a watch to count 3-seconds.
- Breathe from the diaphragm. This means that the stomach area (or abdomen) expands more than the chest. Breathing using the chest causes more tension in the body.
- Do not take unnecessarily deep breaths. This only increases your oxygen uptake, which provides more fuel for your body to operate faster (anxiety). Instruct the person to breath as they normally would, but concentrate on keeping the breathing slow and steady.
- Group activity: Train each other to do this.

Objective: To train participants in a simple method of relaxation.

Instruction: Train participants in this relaxation technique. When participants are reasonable proficient themselves they should role play training another person in the group. The following information may also be of use.

• The aim of breathing relaxation is to learn to regulate and slow down the breathing rate. This in-turn slows down the body.
• Breathing should be done in a 6-second cycle. That is, inhale for 3 seconds, exhale for three seconds.
• Use the second hand of a watch to judge the duration of 3-seconds. This is very important because breathing must be slowed down and people who are distressed find this difficult.
• Breathe from the diaphragm. This means that the stomach expands and not the chest. Breathing using the chest causes more tension in the body.
• Do not take unnecessarily deep breaths. This only increases your oxygen uptake, which provides more fuel for your body to operate faster (anxiety). Instruct the person to breath as they normally would but concentrate to keep it slow and steady. Changing the rate of your breathing may result in needing to take several deep breaths until the rate is stabilised.

Activity: Participants should practice training each other to do this technique.
Relaxation: Questions/Instructions for clients

- What have you used in the past?
- Provide a rationale for relaxation – To reduce anxiety in feared situations and arousal in general.
- Encourage daily practice.
- Encourage eventual use when 'reexpereincing' in feared situations.

Objective: To give the participants specific prompts that they should use with clients in regard to relaxation.

Instruction: Outline the following points:
- Counsellors should enquire about existing relaxation skills or practices, eg. “What types of things have you done in the past in order to relax”.
- Counsellors should encourage clients to use any existing skills.
- Counsellors should provide the client with a rationale for relaxation. This does not need to be a complicated CBT explanation of the benefits and theory. Simply communicate that relaxation helps us cope because; it reduces anxiety/arousal in general, and can be used in specific situations when we become particularly distressed.
- Relaxation is a skill and needs to be practiced in order to gain optimal benefit. Optimum frequency of practice is twice daily for 10 minutes.
- Relaxation can be useful when exposed to situations that cause excessive and unreasonable anxiety eg, when reminded of the traumatic event.
Advice/Information

- The counsellor provides an excellent opportunity to convey information that allows the client to avoid the 'normal' reaction becoming 'abnormal'.
- **Encourage contact with others**: As trauma victims often withdraw from personal relationships, they will need encouragement to keep in contact with significant others. If people maintain their contact with others they are more likely to recover quickly.

**Objective**: To present sensible and safe advice to provide to clients.

**Instruction**: Outline the following points:

• Probably the most useful advice that can be provided at the early stages is to maintain contact with other people.

• People who are exposed to trauma at some level may begin to question their sense of safety and trust in others. Trauma victims may experience an increased sense of vulnerability in a world they no longer believe is predictable. Withdrawal may come as a result of decreased sense of trust in oneself and others. Withdrawal however only reinforces this sense of distrust as they are never able to learn that that world is 'more or less' safe.

• As trauma victims often withdraw from personal relationships, they will need encouragement to keep in contact with significant others. The maintenance of estrangement from others is associated with poor prognosis for recovery.
Advice/Information cont.

- **Information about Trauma**: If the client is not yet experiencing symptoms the counsellor may need to prepare the client by discussing common symptoms of the trauma reaction. This will help the person know what to expect.
- They will know that they are not 'going crazy'.
- **Outline**: Reexperiencing, Avoidance and Arousal and give examples to illustrate.
- **Reduce life stress**: will help the person cope.

**Objective**: Alert participants of the need to outline the trauma symptoms that may be experienced.

**Instruction**: Outline the following points:

- Information about the symptoms of trauma that may be expected is likely to help the individual.
- Regardless of whether the individual is currently experiencing symptoms the counsellor will need to describe to the client the symptoms that they may experience in the future. This does not need to be a complicated explanation of all the symptoms that are possible. The counsellor needs only to describe some common symptoms from the three clusters; Reexperiencing, avoidance, arousal.
- Again these should be proposed as 'normal' reactions.
- The onset of symptoms varies between individuals. It is essential that the counsellor outline common reactions to trauma so the client is able to identify these in the future.
- Another piece of advice that may be useful is to advise the client to reduce stress in their lives. This may only be relevant if the client has described a stressful life already.
Advice: Recovery

- Be optimistic about recovery and give information on the usual pattern of recovery.
- Most people feel much better within a few days of the event.
- A proportion of people continue to experience symptoms a few weeks after.
- A small percentage of people continue to experience symptoms a month after the event.
- Reassure the client that if they are one of this small percentage, effective treatments are available.

Objective: Convey information to assist participants to provide accurate recovery information.

Instruction: Outline slide points and instruct participants that they should be telling clients that simply;

• Most people feel much better within a few days of the event.
• A proportion of people continue to experience symptoms weeks or months later.
• If you do continue to experience symptoms or continue to struggle there is a variety of very effective help that can be accessed.
• Medications from a doctor as well different types of counselling (usually provided by a psychologist) have been found to be very successful in assisting individuals who continue to struggle with the effects of traumatic events.
**Objective:** To provide a help seeking timeframe.

**Instruction:** Outline the slide with the aim to enable participants to suggest to clients when they may need further help.
Risk factors of further disability

- **Previous Trauma:** Having a history of trauma (especially childhood trauma and abuse; has been shown to result in a greater incidence of traumatic stress, even when vicariously exposed.
- **History of psychological problems:** Individuals with a personal or family history of mental health problems may find it more difficult to cope after becoming aware of some traumatic event.
- **Current Stress:** Life stress increases the chance of developing trauma symptoms.
- **Social support:** Social support is likely to affect the coping resources of the individual. Social support provides one of the most important buffers against the effects of trauma.

**Objective:** To provide participants with information that will help them to identify clients that are at a higher risk of developing a traumatic reaction.

**Instruction:** The information provided in these slides are self-explanatory. The following information may assist facilitators.

- It is not appropriate to ask clients about all of these risk factors as enquiring about previous trauma, history of psychological problems and current life stressors has the potential to increase arousal. It is appropriate however, and indeed important to enquire about existing social supports.
- Regardless of current symptoms, the counsellor will need to make some judgement as to the risk of a long term problem developing. If the person does describe some of these risk factors, they have a greater need for referral.
Final Activity: Role play a full session

- Break into pairs and use the vignettes that we used earlier.
- Take 10-15 minutes each
- Try to demonstrate all of the skills.
- After the role play: The client provides both positive and constructive feedback to the counsellor. The client identifies three ways in which they are different to the client that they just portrayed.

Objective: To give participants the opportunity to practice the model in full.

Instruction: Provide instruction as per slide. This activity uses the group vignettes that were introduced towards the beginning of the day.
Trauma Reaction Checklist for Volunteer Counsellors (TRC)

Adapted from the Diagnostic and Statistical Manual of Mental Disorders (4th Edition) - Text Revision

This instrument is recommended for use in identifying victims of trauma. A client who meets all of the criteria below should be offered referral to an ongoing counselling or mental health agency. This tool will be most accurate in predicting prolonged impairment when used two days after the traumatic event has occurred.

☐ The person experienced an event that involved actual or threatened harm to self or others.

☐ The person responded to the event with fear, helplessness or horror.

☐ The person is still reexperiencing the event in one or more of the following ways:
  - Thoughts or images of the event.
  - Dreams of the event.
  - Acting or feeling that the event is happening again (Flashbacks).
  - Emotional distress (becoming fearful or upset) when reminded of the event.
  - Unpleasant physical reactions when reminded of the event (eg. Shaking, sweating, heart pounding, gastro-intestinal discomfort).

☐ The person is still avoiding reminders of the event or is experiencing feelings of dissociation in THREE or more of the following ways:
  - Avoiding thinking or talking about the event.
  - Avoiding activities, places or people that produce reminders of the event.
  - Avoiding contact or relationships with others.
  - Being unable to remember important aspects of the event.
  - Feeling emotionally numb or unable to experience emotions (eg. Happiness or sadness).
  - Feeling detached from others.
  - Being in a daze.
  - Feeling that things around you are not real.

☐ The person is still having symptoms of increased arousal, as indicated by TWO or more of the following ways:
  - Difficulty falling or staying asleep
  - Irritability or anger
  - Difficulty concentrating
  - Feeling constantly on edge or restless
  - Being easily startled or frightened (Jumpy)

☐ The disturbance is causing significant distress or impairment in social, occupational, or other important areas of functioning.
Role play activity 1: Symptoms of Trauma

Vignette 1

John (46) is walking home one evening after finishing work late. A group of men are walking in the opposite direction. When they pass, one of the group members punches John in the stomach and steals his wallet. The group run away. John is initially terrified and runs home as fast as he can. Over the next few days John realises that he is not feeling ‘quite right’ and he finds that he can’t ‘calm down’

John’s symptoms are:

Reexperiencing:

- He goes to the police station the next day and reports the incident. When giving details to the police officer he gets really ‘stressed out’ and begins to worry that it may happen again.
- He is walking home the day after the event and sees a group of young men waiting at the side of the road. Immediately he begins to ‘panic’ his heart races and he starts to shake.

Avoidance:

- When talking to the officer he is unable to remember the street where it occurred.
- After being at the police station for one hour he no longer wants to report the incident and so he leaves the station.
- When he sees the group of boys by the side of the road he walks in the other direction. He then calls a taxi to drive him home.

Arousal:

- He is unusually irritable towards his wife. Very small things start to ‘tick him off’.
- He is easily startled by the movements of others. When others make sharp movements near him he cringes a little.

Note: When talking about these symptoms try not to simply go down the list and read them out. Try to mix them up a little.
Vignette 2

Kathy (48) is walking along the beach early one morning when she finds the body of a young girl lying dead in the sand. Unsure of what to do she stands there staring at the body for about half an hour. She walks slowly up to a nearby surf club to tell them what she has seen. Later on that day she is interviewed by the police; although they are asking her quite simple questions (e.g. “Was there anybody near the body when you found it”?) she is very confused and unable to answer their questions. Over the coming weeks she finds that she keeps having very distressing dreams about dead bodies. Because of this she is having problems with her sleep. She finds that she is unable to watch television shows such as ‘Water rats’ and other police shows as they remind her of the dead girl. When she is reminded of the girls she feels sick in the stomach.

Kathy’s Symptoms:

Reexperience:

• Distressing dreams about dead bodies
• Staring at the body for an extended period of time indicates some degree of emotional numbing and being in a daze. Also she is very confused by simple questions.

Avoidance:

• Stops watching TV shows that remind her of the girl.
• Staring at the body for an extended period of time indicates some degree of emotional numbing and being in a daze.

Arousal:

• Sleep Problems.

Note: When talking about these symptoms try not to simply go down the list and read them out. Try to mix them up a little.
Dear,

RE: Expressions of interest in free of charge training for trauma counselling.

Lifeline South Coast (NSW) is currently involved in a project with the Illawarra Institute for Mental Health, University of Wollongong, to train volunteer counsellors in trauma counselling. The model of intervention is based on the ‘Orienting Approach’ to trauma counselling (Phipps & Byrne, 2003). This is a brief and early model of intervention, specifically designed for use by volunteer counsellors.

The aim of the project is to evaluate how effectively this approach can be taught to volunteer counsellors. We also wish to investigate some of the factors that influence counsellors’ ability to effectively deliver this model. The training will take place over a 1-day workshop. Trainees’ skills in trauma counselling will be assessed both before and after the training is delivered. Trainees will also be asked to fill out some brief questionnaires.

I am coordinating this research under the supervision of Mr Mitch Byrne and Professor Frank Deane. I am currently undertaking a Doctor of Psychology (Clinical) degree at the University of Wollongong. Mitch Byrne and Frank Deane are both lecturers in Psychology at the University of Wollongong. Frank Deane is the director of the Illawarra Institute for Mental Health.

We are currently seeking expressions of interest from Lifeline centres. Training will be undertaken with South Coast volunteers during March 2004. After this we will be conducting training at several other Lifeline centres.

The training will be offered free of charge to lifeline centres. Centres will however need to provide a suitable venue and refreshments for the day. Please refer to the accompanying documents for further information regarding the project. If you wish to discuss the project in more detail please do not hesitate to contact me on the above details. If I have not heard from you in approximately 10 days I will follow-up with a brief phone call.

Yours Sincerely,

Andrew Phipps
Training Volunteers in Trauma Counselling

A joint collaboration between the Illawarra Institute for Mental Health, University of Wollongong and Lifeline South Coast (NSW)

Summary

Early interventions for trauma aim to prevent the onset of a distressing reaction. Because resources in professional mental health services are stretched it is difficult for professional services to respond to offer such preventative measures. In the wake of traumatic events volunteer organizations can offer their skills and services in an effort to prevent chronic psychopathology. Popular models of intervention, however, require expertise and infrastructure that is beyond the capacity of volunteer organizations. The 'Orienting approach' to trauma counselling (Phipps & Byrne, 2003) is designed specifically for use by volunteers shortly after a critical incident. In contrast to other early interventions such as psychological debriefing, the orienting approach does not aim to increase the arousal of the victim. Thus it is a safe intervention that can be used by practitioners of varying expertise over a single session. The model emphasises support, reduction of arousal and the dissemination of information. The model is designed to enable to volunteers to respond to the site of a critical incident and offer, one-on-one, face-to-face counselling. Many of the skills are also equally as practical over the telephone.

What is the aim of the research?

The aim of the research is to evaluate the effectiveness of the training program and investigate factors that may influence counsellors’ competence in this model.

What does the training involve?

The training is a full day workshop from 9.00 am to 5.00 pm including an hour lunch break as well as two 15 minute tea breaks. Participants will be tested before and after the training to assess the effectiveness of the program. Participants will be assessed on measures of skill (assessed via videotaped role play) and knowledge (assessed via multiple choice test). Participants will also be asked to complete some brief questionnaires. The programme will contain lecture style presentation, group discussion as well as participant role-plays.

Who are we wishing to train?

Only accredited Lifeline counsellors can attend these training sessions. The model assumes that trainees already have a basic level of counselling skills and training. Staff members with more advanced counselling training (e.g. Psychologists and Social workers) are also encouraged to attend. Data from these individuals may not be included in the analysis however.

Please note: This training cannot be used as part of counsellors on-going accreditation requirements. Centres cannot make participation in this programme
compulsorily for counsellors. Participants must be free to participate and withdraw from the research.

What we will provide?

Lifeline South Coast (NSW) has already provided funding for this research. This will cover costs such as printing and personnel costs (research assistants). This will enable us to provide the full day training free of charge. We will also provide all participants with resource materials such as trainee manuals free of charge.

Lifeline centre’s wishing to host a training day will also be provided with advertising material and information sheets to be given to interested individuals before training is due to commence.

What do organisations need to provide?

We anticipate that Lifeline centres wishing to host a training day will be able to provide the following things;

1. **A suitable venue for the training:** It is anticipated that this will be the same venue where training ordinarily takes place. We will need access to 2 rooms. The first room will be used for training and the second room will be used for role-play assessments. This second room needs only to be large enough to hold a two-person role-play.

2. **Refreshments for trainees throughout the day:** Centres will need to provide refreshments such as tea and coffee for morning and afternoon tea. We also hope that centres will provide lunch to participants.

3. **An estimation of the number of people attending the training session:** An estimate of the number of people attending will need to be provided to ensure that we bring sufficient resource materials.

4. **Distribution of advertising materials and information to volunteer counsellors:** These materials will be provided to the organisation. Centres will need to be responsible for making the advertising material available to volunteers. It is also hoped that the organisation can include training dates and some information in any newsletters and group communications to volunteers.

5. **Follow-up support for trainees in need:** The training programme emphasises the use of role-play as a training tool. It is possible that counsellors may choose to role-play a traumatic event from their own lives. This may evoke some level of distress in the counsellor. Although we will make ourselves available to participants who wish to discuss these matters further, we will not be able to offer any follow-up assistance. It is expected that centres will adopt the same ‘duty of care’ principles to participants in this training program as they do for counsellors on shift. Support counsellors will need to be available to participants after the training has completed.

Contact details

If you wish to discuss the project further, or would like to negotiate a date for training please contact;
If you wish to discuss any matters concerning the conduct of this research please contact the University of Wollongong Human Research Ethics Committee on (02) 182.

Further Information

If you wish to learn more about the background to this project or the ‘Orienting approach’ to trauma counselling please refer to the enclosed article (Phipps & Byrne, 2003).
Appendix D: Article (begins on the following page)

Please see print copy for image
Please see print copy for image
Optional In-Service Training: The ‘Orienting Approach’ to Trauma Training

Collaboration between Lifeline South Coast (NSW) and The Illawarra Institute for Mental Health, University of Wollongong

Introduction

Traumatic events such as natural disaster and violence can have a significant and lasting impact on those involved. Receiving help can lessen the psychological distress that these individuals experience. Lifeline South Coast (NSW) has been interested in developing its capacity to help individuals in the community who have been exposed to traumatic incidents.

Lifeline South Coast (NSW) has funded research to develop a model of counselling that is likely to help individuals exposed to traumatic incidents. The ‘Orienting Approach’ to trauma counselling (Phipps & Byrne, 2003) is a model of trauma counselling, specifically designed for use by volunteer counsellors. We are seeking interested TCs to participate in a one-day training workshop to assist us with our research.

Note: This is optional training for TCs. Participation in this training is completely voluntary. Participating in this training does not mean that you will be asked to provide this type of counselling. Some of the training involves role-play and assessment activities. This is not to evaluate the participant's counselling skills but rather to assist the researchers in evaluating the training program.

Training sessions

If you would like to attend this training please sign up for one session. Sign-up sheets are on the notice board. There will be a limited number of spaces available per training session (approximately 10-12 people per group). At this stage we have two dates available for training. These dates and venue’s can be found below.

DATES

Please read the attached information sheet for more details about the research and the training.

For further information please contact Andrew Phipps on

Andrew Phipps
27/1/04
Appendix F: Participant Information Sheet

Trauma Training for Volunteer Counsellors: Participant Information Sheet

Background

Trauma is a stress reaction that can be experienced when a person is exposed to a particularly distressing event. This reaction may be short lived or may develop into a more long-term condition (e.g. Post Traumatic Stress Disorder). Early interventions for trauma aim to prevent the long-term duration of this condition. Because resources in professional mental health services are stretched it is difficult for professional services to respond to offer such preventative measures. In the wake of traumatic events volunteer organisations can offer their skills and services in an effort to prevent chronic problems. Popular models of intervention, however, require expertise and infrastructure that is beyond the capacity of volunteer organisations. The ‘Orienting approach’ to trauma counselling (Phipps & Byrne, 2003) is designed specifically for use by volunteers shortly after a critical incident. In contrast to other early interventions it is a safe treatment that can be used by practitioners of varying expertise over a single session. The model emphasises support, reduction of arousal and the dissemination of information. The model aims to train volunteers to be able to respond to the site of a critical incident and offer, one-on-one, face-to-face counselling. Many of the skills are also equally as practical over the telephone.

What are we asking of participants?

We are seeking volunteer lifeline counsellors to take part in a one-day training program that trains participants to deliver this protocol. Trainees will take part in a brief assessment of knowledge and skills before and after the training. The aim of the project is to evaluate whether the training program can train volunteer counsellors can effectively deliver this protocol.

Who is conducting this research?

This project is a joint collaboration between Lifeline South Coast (NSW) and the University of Wollongong. Andrew Phipps, Mitchell Byrne and Frank Deane are running the project. Andrew is currently undertaking a Doctor of Psychology (Clinical) degree. Andrew is conducting this research to meet the requirements of his degree. Mitchell Byrne and Frank Deane are co-supervisors in this project and are lecturers in Psychology at the University of Wollongong.

What does the training involve?

The training is a full day workshop from 9.00 am to 5.00 pm, including a half hour lunch break as well as two 15 minute tea breaks. Lunch and refreshments will be provided. Participants will be tested before and after the training to assess the effectiveness of the program. Participants will be assessed on measures of skill (assessed via videotaped role play) and knowledge (assessed via multiple choice test). We will also ask participants to complete some brief questionnaires. These
questionnaires will ask you about any history of traumatic incidents in your own life as well as your own experience of listening to traumatic incidents while counselling. The programme will contain lecture style presentation, group discussion as well as participant role-plays. Participants will also be provided with treatment manuals and reference materials.

Who can participate in the research?

Only accredited Lifeline counsellors can attend these training sessions. The model assumes that trainees already have a certain level of counselling skills and training.

If you participate in this research you have the right to:
- Withdraw at any time. If you do withdraw any relationship that you have or may develop with Lifeline or the University of Wollongong will not be affected in any way.
- Refuse to participate in any aspect of the project that you do not wish to participate in.
- Ask any further questions about the project at any time during your participation.
- Be informed of the project’s findings when it finishes.
- Provide information on the basis that it will be held in confidence. All records will be kept confidential during the project and after its completion. It will not be possible for you to be identified in any reports that result from the project.

Since the training program involves the use of role-play’s that centre around traumatic experiences it is possible that participation may cause some degree of emotional distress in some people. In this event support counsellors will be available to participants after the training has completed.

Data collected may also be presented at a professional conference or used for the purpose of publication in a scholarly journal. The data will not identify participants in any way.

The Illawarra Area Health Service/University of Wollongong Human Research Ethics Committee has reviewed the study design.

If you have any questions about this project please phone Andrew Phipps on 0431 92 1346, or Mitchell Byrne on (02) 4221 5310 during business hours. If you have any questions regarding the conduct of this project please contact the Ethics Officer of the Illawarra Area Health Service/University of Wollongong Human Research Ethics Committee on (02) 4221 4457.
Appendix G: Participant Consent Form

Trauma Training for Volunteer Counsellors: University Of Wollongong

Consent Form

I have read the information sheet for University of Wollongong's Trauma Training for Volunteer Counsellors project and have had the details of the research explained to me. I understand that this research is being conducted by Andrew Phipps, a Doctor of Psychology (Clinical) student at the University of Wollongong. I understand that Mr Mitchell Byrne and Professor Frank Deane are supervising this project. I understand that Lifeline South Coast (NSW) has funded the University of Wollongong to conduct this research.

I understand that this project involves the evaluation of a training program for trauma counselling. I understand that the researchers will ask me to participate in an assessment of my skills and knowledge before and after the training program. The details of this assessment have been explained to me.

I understand that my participation in this research is voluntary; I am free to refuse to participate in any aspect of the research and am free to withdraw at any time. I understand that I can attend the training session without participating in the data collection. My refusal to participate or withdrawal of consent will not affect my relationship with Lifeline or The University of Wollongong.

I agree to provide information to the researchers on the understanding that this information is confidential.

I understand that if I have any questions regarding the research I can contact Andrew Phipps or Mitch Byrne on (02) 4221 5310. If I have any concerns or complaints regarding the way the research is or has been conducted, I can contact the Complaints Officer, Human Research Ethics Committee, University of Wollongong (02) 4221

By signing below I am indicating my consent to participate in the study under the conditions set out in the information sheet.

Name (please print): ________________________________________________________________

Signature: __________________________ Date: __________________________
Appendix H: Participant Demographic Form

Participant Information and Experience

Participant Code Number: ________________  Lifeline Centre: ________________

1. Age: ____________________________  2. Gender: Male / Female

3. Highest educational attainment (e.g. Yr 10, HSC, University Degree): ____________

4. How many years have you been an accredited Lifeline counsellor? ____________

5. If you were in a counselling role before you started with lifeline, how many years have you been a counsellor? (This is the number of years since your first started working in a counselling role and includes your work with lifeline): ____________

6. Are you a Telephone counsellor, Face-to-face counsellor or Both? (Please Circle).

7. Do you have any other training in counselling or related field? Yes / No
If yes, please give details: ________________________________

8. Have you had any previous training for ‘trauma counselling’? Yes / No
If yes, please provide details: ________________________________

9. Have you personally received any counselling for a traumatic incident in your own life? Yes / No
Appendix I: Multiple Choice Questionnaire (MCQ)

Trauma Training for Volunteers: Multiple Choice Questionnaire

Participant Code Number:______________

Morning / Afternoon (please circle).

Indicate which answer you believe to be correct by circling a, b, c, or d. Only one answer is correct. Please circle only one.

1. Psychological ‘Trauma’ is primarily concerned with:
   a) Issues related to grief and loss
   b) How we cope and adjust to physical injuries
   c) Our reaction to particularly distressing events
   d) Both (a) and (c) are correct.

2. Psychological ‘Trauma’ is best described as:
   a) An adjustment problem/disorder
   b) An anxiety problem/disorder
   c) A mood problem/disorder
   d) A personality problem/disorder

3. Which of the following brief scenario’s best indicates a case of trauma?
   a) Linda walks into her garage and starts to think of the time that she saw a man being assaulted at the beach.
   b) Linda walks into her garage and starts to think about the time that she confronted an intruder in her garage.
   c) Linda walks into her garage and starts to think about her mother that died several months ago in the nursing home.
   d) Linda walks into her garage and starts to think about the spiders that she is likely to see there.

4. Two men have robbed Craig on the street. Which of the following most clearly depicts the symptom of ‘re-experiencing’?
   a) Craig stops going down that street.
   b) Craig walks down the street but is constantly looking around and feels ‘panicky’
   c) Craig is at home and notices that he has become really jumpy.
   d) Craig is at home and he notices that he fell that things around him are not real.

5. Which of the following is not a symptom of ‘dissociation’?
   a) Feeling emotionally numb or unable to experience emotions
   b) Being unable to remember important details of an event
   c) Feeling that an incident was happening again
   d) Feeling like you are in a daze.
6. Which of the following explanations best accounts for why people continue to avoid reminders of a traumatic event when they are traumatised.
   a) Because the reminders of the event are emotionally upsetting.
   b) Because the reminders cause them to experience unpleasant physical reactions (eg. heart pounding, nausea etc.)
   c) Both a and b
   d) Avoidance teaches the person to keep away from the reminder in order to escape upsetting emotions and physical reactions.

7. If a person has been exposed to a traumatic incident and they are repetitively telling you about the incident you should:
   a) Try to divert them away from the topic.
   b) Just let them go over and over the incident until they no longer want to talk about it.
   c) Summarise what they have told you and then try to move the session towards problem solving (i.e. asking “What would you like to do about this?”).
   d) Ask them to describe the event in more detail.

8. Which of the following is true of trauma counselling:
   a) It is un-helpful to allow a traumatised person to recount a story over and over again.
   b) You should encourage the traumatised person to talk about the incident (what happened & and how the person felt) as soon as possible.
   c) If it appears that a person does not want to talk about the incident you shouldn’t ask them to tell you about it.
   d) It is not possible to do more harm than good by getting a person to talk about the traumatising event.

9. Critical Incident Stress Debriefing (CISD) is an intervention designed to be used with people shortly after they have experienced a traumatic event. What has research shown us about CISD?
   a) CISD is useful in reducing the symptoms of trauma.
   b) CISD is a cure for trauma.
   c) The most therapeutic aspect of CISD is the group discussion of the traumatic event.
   d) CISD does not reduce the symptoms of trauma and, in some cases actually increases the likelihood of trauma symptoms developing.

10. Which of the following statements is true
    a) Whether you are the victim of a traumatic event or just hear about it later, the trauma that you experience is likely to be equally as severe.
    b) Being a direct victim of a traumatic event is likely to result in more severe trauma than being told about it later.
    c) Being told about an event later is likely to result in more severe trauma than being directly involved in the event.
    d) Neither being a victim of a traumatic event of being told about it later will result in the person being traumatised.
11. People are more likely to be traumatised by a distressing event if:
   a) They have a history of traumatic events in their lives.
   b) They have little social support.
   c) They have no history of traumatic events in their lives.
   d) Both (a) and (b) are correct.

12. Breathing relaxation is a technique that helps you to relax. Which of the
following is a good technique in breathing relaxation?
   a) Breathe in as deep as you can and let it out slowly.
   b) Make sure your chest moves more than your stomach
   c) Make sure your stomach moves more than your chest.
   d) Breath in, hold it for 5 seconds then let it out quickly.

13. You are counselling someone experiencing trauma. What information should
you give them in regard to seeking further help (i.e. from a counsellor or Doctor).
   a) “Trauma can be a serious condition. No matter how you are feeling you should
      seek out further help from a counsellor or doctor as soon as possible”
   b) “Most people recover from trauma without seeking help. If you are still feeling
      distressed in two months you should consider seeking further help from a
      counsellor or doctor”.
   c) “Most people recover from trauma without seeking help. If you are still feeling
      distressed in two weeks you should consider seeking further help from a
      counsellor or doctor”
   d) “Most people need help from a counsellor or doctor to recover from trauma. If you
      are still feeling distressed in two weeks you should consider seeking further help”

14. What advice should you give someone who is having trouble coping with
trauma?
   a) “Try to maintain contact with other people and use some relaxation strategies”
   b) “Take some time to yourself, it’s not important to be around others during this
      difficult time”
   c) “Make sure you talk about the traumatic experience even if you don’t want to”
   d) You should not give advice to someone who is having trouble coping with trauma.

15. Tony has just been involved in a car accident where he saw the other driver
sustain a bad head injury. He speaks to you 4 hours after the accident and tells
you that he keeps imagining the other drivers face. What should you tell him?
   a) This is a sign that he is not coping with the incident.
   b) This is normal
   c) This is a sign that he needs to go back to the site of the accident.
   d) Try to distract yourself from the image.
Appendix J: Role-Play Assessment, Vignette A – Researchers Instructions

Role-Play Assessment

Vignette A: Researchers Instructions

Client: Claire (28)

Background Information

Claire is a volunteer bush fire fighter who works part time for Australia post in the mail room. She has her HSC but has never been interested in perusing further education. She lives in Helensburgh, NSW. She is married but has no children and lives with her husband in a two-bedroom house.

She is an ordinarily happy person. She has been happily married for the past four years (besides the odd ‘ups and downs’) and enjoys the support and love of her family and close friends.

She is a reasonably fit woman who likes to go bush walking regularly. She also enjoys swimming and occasionally plays squash with friends.

She talks like the ‘average person’ using minimal jargon. She is a ‘down to earth’ person.

Predictor Variables

Mental Health History: She has no history of mental health problems.

Family Mental Health History: To the best of her knowledge her family has no history of mental health problems.

Trauma history: The most traumatic event that she has experienced is the death of her father who died two years ago from a sudden heart attack. She grieved quite badly at the time but recovered quickly, owing to the support of her family and friends. She had some symptoms of anxiety (difficulty falling asleep and concentrating) but no other trauma symptoms. The thought of her father’s death no longer upsets her and she is able to speak fondly about his memory.

She has been involved in one car accident where she was the driver. Another car pulled out in front of her as she was passing though a round about. She was understandably angry at the time but had no other symptoms of traumatisation.

Current life stressors: She does not see her life as particularly stressful. Her husband is an engineer and could easily support them both but she chooses to work to keep her occupied and stay independent.
Social support: She has a good amount of social support; she does not have lost of friends but has two close friends, Suzy and Amanda (‘Mandy’) which she ‘hangs out’ with regularly. Her husband and she also have a small but good social circle.

The incident:

A bushfire had broken out in Helensburgh and Claire was called in to help out. When she arrived at the Fire station she was informed that a team had already left to start fighting the fire. Unfortunately one of the team members (Chris) had lost contact with the rest of the team. The team had been defending several houses when they lost contact with him. The last time the team saw him he was retreating from the fire but was forced to run into the bush as the flames had crept up behind him.

When Claire arrived at the scene the fire was a safe distance from any property. Her job was to help put out any small fires that were burning around the properties. She proceeded to make her way around the houses, lifting lumps of burning wood and putting out small fires. She used a back pack style water sprayer.

She noticed one small fire still burning about 50 metres out from the property line. She walked out towards it. As she approached she noticed what looked like a large irregular shaped log slowly smouldering. As she got within about five metres of the burning object she realised that it was a body lying face up. The body was badly burnt and looked like the skin had melted. The smell from the burning body was very strong. By the shape of the body and the remaining clothes (shoes and belt) Claire could tell that it was her teammate Chris.

Her initial reaction was one of absolute horror. She threw up and began to shake. She felt totally overwhelmed and horrified by the fact that her colleague and friend had been reduced to the repulsive mess that was in front of her.

As she stumbled back to the site where the rest of the team had met she began to cry uncontrollably. She felt like she was unable to talk. After some time she managed to tell the rest of the team what she had seen.

For the rest of the day she stays at the station. She calms down a little but is still very distressed and troubled by the recollection of the event. By the time she gets home that night little has changed. She gets a very little sleep that night. She is troubled by the persisting symptoms and begins to think that there is something really wrong with her. She has never felt this anxious in her life and begins to worry that she is going crazy.

Three days later she calls into lifeline and asks to speak with one of the face-to-face counsellors.

Symptoms:

Reexperiencing:
- Claire can't seem to get the image of Chris's burnt face out of her head. This is very distressing for her. She describes it: "It's just awful every time I close my eyes its there, I keep having to try to think of something else but it doesn't work". The image that she sees is a red face, stretched with all the features of the face burnt off. The eyes are open and so is the mouth.
- She is reminded of the event through several things; these distressing images, the sight of the bush or reports on the news. This morning she was watching the report of the fires on the morning news and she was reminded of the event. She began to feel very ill and almost threw up. She began to shake all over.
- She was woken during the night by a distressing dream where she dreamt that she turning Chris's dead body over to reveal his burnt face.

Avoidance:

- She avoids talking about the event. She does not want to discuss it with her husband when she gets home. Several of her friends call but she says that she does not want to talk to them.
- She turns the television off and does not let her husband turn it back on as she is afraid that another report of the fires will come on.
- She tries to avoid thinking about Chris, the bush-fire service or anything else related to the day.

Arousal:

- She is quite agitated. She has difficulty staying still (this is conveyed in the role play but not overdone or manic).
- She has been really jumpy and has been scared by the most innocuous noises (eg. A can falling on the floor).
- She has been irritable towards her husband. He asked her to come for a walk with him and she replied, "Can't you just go by your bloody self".

Treatment context

The fire service was aware that Lifeline offers a free face-to-face counseling service for people have been involved in a traumatic event. The team leader at the fire service recommended that Claire call this service if she didn't feel any better. Since she has feeling so distressed she called up lifeline and made an appointment to see one of the counselors. When making the appointment she gave some information to the administration staff (see vignette A, participant instructions). She sees the counselor 3 days after the event.

Notes for role-play people

All this information does not need to be relayed. It would be impossible to do so in 7 minutes. These are simply prompts so you don't have to make up your own story. This
will make the role-plays as similar as possible. I have tried to cover most things that people may ask about. Try to develop a ‘character’ and stick with it throughout. Once you feel comfortable with your characters mannerisms and style of relating, try not to deviate too much between role-plays. As you know this is research and we need to give each participant as similar experience as possible.

Please make sure you do the following things:

- The main thing that you want to do is get across what happened (the event) and how it is affecting you (the symptoms). Don’t give the whole story all at once but don’t leave them having to ‘drag’ it out of you.
- At some stage you will need to communicate that you are distressed about the symptoms themselves. You may want to say, “I don’t know what is going on”, or “I think I might be going crazy. This will serve as a prompt for the person to ‘normalise your experience.
- If they instruct you with certain relaxation techniques do these with them. Also, make sure you do them badly the first time (i.e. breath in expanding your chest too much or breath too quickly). This will cue the participant to instruct you correctly.
- Give them exactly 7 minutes. Use a stop watch and stop the session 7 minutes after it began. If they finish before this time this is fine.

Thank you, Thank you, Thank you,

Andrew.
Appendix K: Role-Play Assessment, Vignette B – Researchers Instructions

Role-Play Assessment

Vignette B: Researchers Instructions

Client: Mary (34)

Background Information

Mary lives in a housing commission block in Bellambi. She is not married and has three children. They are 3, 7 and 12. Her husband left her two years ago. She works full time as a receptionist in a busy auto-mechanics.

Predictor variables

Mental Health History: She has a history of depression. Her first depressive episode was 12 years ago after her first child was born. She has been on and off anti depressants for years. She is currently taking Effexor.

Family Mental Health History: She is not aware of any history of mental health problems with any of her other family members.

Trauma history: She has previously been the victim of physical assault and attempted sexual assault. She was attacked 5 years ago while walking home from friends place. This was a significantly traumatising for her at the time. Although she has not been upset by it in years she has found that this recent event has brought back many of those memories.

Current life stressors: With three children and a low income she has trouble paying the bills. While two of her children are doing well at school her eldest (Troy) is often in trouble. She finds this embarrassing and upsetting.

Social support: Besides the fact that she is a single mother she has some good social supports. She has a good circle of friends that visit often. They take turns at minding each others children.

The event

Mary had her house broken into. She has a two story townhouse. She was sleeping upstairs when she heard some noises coming from downstairs.

When she came down the stairs she saw a man disconnecting her stereo system. She found her self unable to react. She felt totally helpless. She did nothing but stood there and looked at the man.

The man approached her but still she was unable to move or say anything. The man struck her by the side of the head and she fell. The man then left.
Several days later she calls Lifeline.

**Symptoms:**

**Re-experience:**

- Mary has been having disturbing dreams about intruders in her house and people trying to kidnap her children.
- She has become preoccupied with the thought of someone intruding into her house. She worries about this constantly.
- She is uncomfortable when in her house. She keeps feeling like someone is going to break in again.
- The event has led to her being reminded of the precious assault.

**Avoidance:**

- She and her children have been spending most of their time at her mother's place as she does not want to be in her house when the intruder returns.
- Walking is her main means of transport and now she is afraid to walk anywhere for fear that she will be attacked.

**Arousal:**

- She is having difficulty staying asleep because of the nightmares and she is woken constantly by small noises in the house.
- She has been easily startled by noises in the house (jumpy). Especially at night.
- She has been feeling very tense, especially in her shoulders.

**Treatment context**

Mary was given a card which informed her that Lifeline offers a free face-to-face counseling service for people who have been involved in a traumatic event. Since she has feeling so distressed she called up Lifeline and made an appointment to see one of the counselors. When making the appointment she gave some information to the administration staff (see vignette B, participant instructions).

**Notes for role-play people**

All this information does not need to be relayed. It would be impossible to do so in 7 minutes. These are simply prompts so you don't have to make up your own story. This will make the role-plays as similar as possible. I have tried to cover most things that people may ask about. Try to develop a 'character' and stick with it throughout. Once you feel comfortable with your characters mannerisms and style of relating, try not to deviate too much between role-plays. As you know this is research and we need to give each participant as similar experience as possible.
Please make sure you do the following things:

- The main thing that you want to do is get across what happened (the event) and how it is affecting you (the symptoms). Don’t give the whole story all at once but don’t leave them having to ‘drag’ it out of you.
- At some stage you will need to communicate that you are distressed about the symptoms themselves. You may want to say, “I don’t know what is going on”, or “I think I might be going crazy. This will serve as a prompt for the person to ‘normalise your experience.
- If they instruct you with certain relaxation techniques do these with them. Also, make sure you do them badly the first time (i.e. breath in expanding your chest too much or breath too quickly). This will cue the participant to instruct you correctly.
- Give them exactly 7 minutes. Use a stop watch and stop the session 7 minutes after it began. If they finish before this time this is fine.

Thank you, Thank you, Thank you,

Andrew.
Appendix L: Role-Play Assessment, Vignette A – Participants Instructions

Role-Play Assessment

Vignette A: Participants Instructions

You are working for a lifeline service that offers free face-to-face counselling for people who have experienced a traumatic event. The client below has booked in an appointment to see one of the counsellors. When making the appointment she gave the following information to the administration staff.

Name: Claire

Age: 28

Address: 17 Bush Street, Helensburgh.

Reason for referral: Claire is a volunteer bush-fire fighter from Helensburgh. 3 days ago she was called to help with a bush-fire that broke out in her area. One of her colleagues was killed in the fire and she was the first to find him. She says that she has been feeling awful since it happened.

The team leader at the fire service recommended that Claire call this service if she didn’t feel any better.

You have seven minutes to role-play a counselling session with Claire.

Please attempt to demonstrate the following skills:

1. Provide support through counselling.
2. Normalise the client’s experience.
3. Give the client some skills to reduce their arousal (anxiety).
4. Provide advice and information as appropriate.
Appendix M: Role-Play Assessment, Vignette B – Participants Instructions

You are working for a lifeline service that offers free face-to-face counselling for people who have experienced a traumatic event. The client below has booked in an appointment to see one of the counsellors. When making the appointment she gave the following information to the administration staff.

Name: Mary

Age: 34

Address: 1/106 Rothery Road, Bellambi

Reason for referral: Mary’s home was broken into three days ago. She found the intruder in her living room. The intruder struck her and left the premises. She says that she has been feeling awful since it happened.

The Police officer that interviewed Mary recommended that she call this service if she didn’t feel any better.

You have seven minutes to role-play a counselling session with Claire.

Please attempt to demonstrate the following skills:

1. Provide support through counselling.
2. Normalise the client’s experience.
3. Give the client some skills to reduce their arousal (anxiety).
4. Provide advice and information as appropriate.
Appendix N: The ‘Orienting Approach’ Rating Scale for Clinicians – Scoring Sheet

Modified from the Medication Alliance & Cognitive Therapy Rating Scale for Psychosis (Byrne & Deane, 2004)

Rater (name): ____________________________

Tape/DVD Number: ________________________

Participant Number: ______________________

Vignette (A or B): ________________________

Scoring Summary: A: _____  B: _____  C: _____  D: _____

Key to Scoring

Circle the appropriate number adjacent to the item according to the following criteria:

0 = Skill was not demonstrated
1 = Skill was demonstrated

A. Support

<table>
<thead>
<tr>
<th>Statement</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The counsellor displayed patience with the client.</td>
<td>0 1</td>
</tr>
<tr>
<td>2. The counsellor refrained from actively eliciting details of the event.</td>
<td>0 1</td>
</tr>
<tr>
<td>3. The counsellor used the client’s own language/concepts.</td>
<td>0 1</td>
</tr>
</tbody>
</table>

Sum of Support (A) scores (0 – 3)
### B. Normalisation

<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The counsellor indicated that the clients experience was “normal” in reaction to the event.</td>
<td>0 1</td>
</tr>
<tr>
<td>2. The counsellor communicated that the symptoms will abate.</td>
<td>0 1</td>
</tr>
<tr>
<td>3. The counsellor gave accurate information about the course of trauma.</td>
<td>0 1</td>
</tr>
</tbody>
</table>

Sum of normalisation scores (0 – 3)

### C. Relaxation

<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The counsellor encouraged relaxation</td>
<td>0 1</td>
</tr>
<tr>
<td>2. The counsellor provided a rationale for relaxation.</td>
<td>0 1</td>
</tr>
<tr>
<td>3. The counsellor provided correct instruction for breathing relaxation.</td>
<td>0 1</td>
</tr>
</tbody>
</table>

Sum of Relaxation (C) scores (0 – 3)

### D. Advice/Information

<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The counsellor encouraged the client to maintain contact with others?</td>
<td>0 1</td>
</tr>
<tr>
<td>2. The counsellor communicated to the client that help is available if they need it.</td>
<td>0 1</td>
</tr>
<tr>
<td>3. The counsellor made a recommendation as to the signs that the client would need to seek further help.</td>
<td>0 1</td>
</tr>
</tbody>
</table>

Sum of Advice/Information (D) scores (0 – 3)
Appendix O: The ‘Orienting Approach’ Rating Scale for Clinicians – Scoring Criteria

A. Support

1. The counsellor displayed patience with the client.
The counsellor scores 0 if they try to ‘move the client on’ or interrupt them if they begin to tell the story for the second time. This may be demonstrated by Summarising and then moving onto options. The counsellor also scores 0 here if they communicate that they ‘need’ to talk about it or ‘it’s a good idea’ to talk about it (ie. They pressure the client to talk).

2. The counsellor refrained from actively eliciting details of the event.
Essentially the counsellor must not actively expose the client to the event. If any questions are posed about the event itself the counsellor scores 0 here. Eg. “Tell me what happened”, “what did you see” etc.

The counsellor must also not expose the client to the symptoms. Questions about the reaction/symptoms also score 0 if they increase the client’s awareness of how distressing these symptoms are. Eg. “What it is like to have those distressing images in your mind”.

3. The counsellor used the client’s own language/concepts.
This skill is designed to ensure that the counsellor does not increase the distress of the client. The counsellor scores 0 here if they introduce words or concepts that are likely to increase the clients’ distress. The counsellor may score 0 here if they introduce new words when reflecting events or feelings. E.g. The client has just said that; “I feel really scared when I go out now. Bad response: “So you’re petrified that you will be hurt worse next time”.

B. Normalisation

1. The counsellor indicated that the clients experience was “normal” in reaction to the event.
To achieve a score of 1 here, the counsellor simply needs to communicate that the experience (symptoms, feelings or behaviour) is a - “normal”, “typical”, “common”, “average” - response to the “event”, “incident”, “trauma” etc.

2. The counsellor communicated that the symptoms will abate.
To score 1 here, the counsellor needs only to indicate that the person will eventually feel better at some time.

3. The counsellor gave accurate information about the course of trauma.
To achieve a score of 1 here, the counsellor must communicate both:
- Most people feel much better within a few days of the event.
- A proportion of people continue to experience symptoms weeks or months later.
NOTE: If a counsellor scores 1 on this criterion, they automatically score 1 on the previous.
C. Relaxation

1. The counsellor encouraged relaxation
To achieve a score of 1 here, the counsellor must either introduce a new relaxation skill or prompted the client to use one that they are already familiar.

2. The counsellor provided a rationale for relaxation.
To achieve a score of 1 here, the counsellor must convey relaxation as useful for either of the following reasons:
1. Relaxation can be used when we are exposed to anxiety provoking situations – allowing us to cope with these situations better.
2. Relaxation helps us cope with stress/anxiety in general.

3. The counsellor provided correct instruction for breathing relaxation.
To achieve a score of 1 here, the counsellor must communicate the following things:
1. Breathe in a 6-second cycle (three seconds in, three seconds out).
2. Breathe from stomach/diaphragm (eg. “breath with stomach, not chest”, or “Stomach expands/contracts” etc.)
3. Do not take unnecessarily deep breaths / take normal breath.

D. Advice/Information

1. The counsellor encouraged the client to maintain contact with others?
To achieve a score of 1 here, the counsellor must communicate that the person should, in some way, maintain contact with others (family, friends etc).

2. The counsellor communicated to the client that help is available if they need it.
To achieve a score of 1 here the counsellor must communicate where to go to get help: This may be any appropriate referral or treatment agency, E.g. GP, Lifeline etc.

3. The counsellor made a recommendation as to the signs that indicated the client would need to seek further help.
To achieve a score of 1 here, the counsellor must communicate to the person that they should seek further help if they continue to experience symptoms or difficulty coping (A time frame must be specified within 2 weeks and a month).
Appendix P: Reliability coefficients of the SLES and ProQOL in the current investigation

Reliability coefficients of the SLES

Describes your Experience scale:
Alpha = .59

Stressfulness Then scale:
Alpha = .62

Stressfulness Now scale:
Alpha = .62

Reliability coefficients of the ProQOL

Compassion Satisfaction scale:
Alpha = .78

Burnout scale:
Alpha = .61

Compassion Fatigue/Secondary Trauma scale
Alpha = .69