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Individual and Interpersonal Risk and Resiliency Factors in Primary and Secondary Trauma

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Individual and Interpersonal Risk and Resiliency Factors in Primary and Secondary Trauma

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Thesis Abstract

This thesis explores individual and interpersonal risk and resiliency factors in primary and secondary trauma across three individual papers.

The first paper is a systematic review examining the role of social cognition in the relationship between attachment style and post-traumatic stress disorder (PTSD). The review synthesises the findings of six studies that met the inclusion criteria. Collectively, the results indicate that social cognition has a mediating role. The review suggests that insecure attachment style is a risk factor and secure attachment is a resiliency factor in PTSD. However, it was not possible to draw firm conclusions due to the small number of heterogeneous studies reviewed. The clear need for future research is discussed. Suggestions are made for the use of attachment and social cognition approaches in the psychosocial treatment of PTSD.

The second paper is an empirical study investigating individual characteristics, secondary trauma, and burnout in police sexual and violent offending teams. The study used a sample of specialist police staff (N=78) who completed an online questionnaire survey. The results indicate that coping self-efficacy, dispositional mindfulness, and psychological flexibility are resiliency factors and insecure attachment style is a risk factor for secondary trauma, burnout, and mental ill-health. Suggestions are made for the use of mindfulness, acceptance and commitment therapy, and attachment approaches in promoting a resilient police work force.

The final chapter expansively discusses the implications of both papers for future research, theory development, and clinical practice. Collectively, the findings suggest that attachment style may serve as an individual and interpersonal risk or resiliency factor in primary and secondary trauma. The socio-interpersonal model of PTSD is referenced as encapsulating the thesis findings in the wider trauma literature.

Chapter 1 - Literature Review

The Role of Social Cognition in the Relationship between Attachment Style and PTSD: A Systematic Review

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Abstract

Purpose: Historically, post-traumatic stress disorder (PTSD) has been conceptualised and treated focusing on individual symptomatology. The person's psychosocial functioning is not usually prioritised, despite the inherently interpersonal and social nature of most traumatic experiences and their aftermath. Socio-cognitive models and attachment theory have increasingly been applied to understand the interpersonal impairments commonly observed in PTSD. However, there remains a lack of consensus regarding the underlying mechanisms of associations. The review aimed to add to the existing literature by systematically exploring the role of social cognition in the relationship between attachment style and PTSD.

Methods: Searches were conducted using the Cochrane Library, PsycINFO, PILOTS and Web of Science databases to identify studies based on inclusion and exclusion criteria.

Results: Six studies were identified. Collectively, social cognition was found to mediate the relationship between attachment style and PTSD. Findings were mixed regarding differences in insecure attachment style (anxious or avoidant) in this association.

Conclusion: The review built on existing literature showing a relationship between attachment style and PTSD by indicating that social cognition has a mediating role. It was inferred that insecure attachment style is a risk factor and secure attachment is a resiliency factor for PTSD. However, due to a paucity of research, this was based on a small number of heterogeneous studies. Therefore, further research is needed, including longitudinal designs.

Practitioner Points: Attachment and socio-cognitive approaches may be advantageous in treating the psychosocial difficulties associated with PTSD. However, further evaluation is required to determine how they can best complement existing intrapersonally-focused treatments.

Introduction

Background

Post-traumatic stress disorder (PTSD) has been defined as the complex somatic, affective, and behavioural effects of psychological trauma (van der Kolk, McFarlane, & Weisaeth, 1996). Notably, not everyone who experiences a traumatic event develops PTSD (Breslau, 2009). A variety of individual and environmental factors have been associated with PTSD risk and resiliency, including prior trauma, family history of psychopathology, perceived life threat during the trauma, and post-trauma social support (Ozer, Best, Lipsey, & Weiss, 2003). However, historically, PTSD has primarily been conceptualised and treated focusing on individual symptomatology. The person's psychosocial functioning is not usually prioritised, despite the inherently interpersonal and social nature of most traumatic experiences and their aftermath. Increasingly, the need for a socio-interpersonal approach to PTSD has been emphasised (Maercker & Hecker, 2016).

Social Factors

Human beings are profoundly social animals. A considerable number of studies and reviews have consistently demonstrated the importance of social bonds in the development and maintenance of PTSD, particularly regarding human-generated traumatic events (Bryant, 2016; Charuvastra & Cloitre, 2008; Nietlisbach & Maercker, 2009). Engagement with social support, especially in close relationships, has been identified as an important risk or resiliency factor across a range of trauma types (Brewin, Andrews, & Valentine, 2000; Ozer et al., 2003). Additionally, the related factors of social acknowledgment and disclosure have been found to be predictive of PTSD, including in the wider social processing of trauma (Nietlisbach & Maercker, 2009; Mueller, Moergeli, & Maercker, 2008).

Interpersonal Difficulties

It is evident that social support and understanding provides the potential for individuals to effectively process and overcome traumatic experiences by engaging with significant others. However, the existing literature clearly demonstrates a high prevalence of interpersonal difficulties following trauma (Charuvastra & Cloitre, 2008; Sharp, Fonagy, & Allen, 2012). PTSD involves a variety of symptoms, including emotional numbing, detachment, and irritability. Such difficulties are likely to impact on the quality of relationships through secondary problems with self-awareness, intimacy, sexuality, and communication (McFarlane & Bookless, 2001). Therefore, negative interpersonal patterns are likely to develop and reduce the potential benefits of social support. However, the direction of associations between interpersonal impairments and PTSD symptomatology remains unclear (Nietlisbach & Maercker, 2009).

Attachment and PTSD

In recent years, there has been increasing interest in the relationship between attachment style and PTSD (Barazzone, Santos, McGowan, & Donaghay-Spire, 2018; Woodhouse, Ayers, & Field, 2015). Attachment Theory (Bowlby, 1969, 1973, 1980) asserts that children are biologically driven to form attachments with others to ensure survival. The quality of the early attachment relationship between a child and their primary caregiver (i.e. the extent to which the parent is attuned to their child's needs and is a secure base from which the child can explore the world) is said to lead to an enduring secure or insecure attachment style. This occurs through the cumulative effect of parent-child interactions and the development of 'self-other representations' in the mind of the child. It is believed these 'internal working models' of relationships and self-awareness form the basis of interpersonal behaviour and emotional self-regulation throughout the lifespan (Mikulincer, Shaver, & Pereg, 2003).

Existing research examining adult attachment style and PTSD is based on applying the assumptions of attachment theory by viewing a person's emotional self-regulation and relational patterns in adult intimate relationships as arising from their internal working models (Woodhouse et al., 2013). This fits with the broader attachment theory literature, which offers a comprehensive account of why some adults feel secure and thrive in their close relationships, while others can struggle to form and maintain healthy relationships (Fraley, 2002). While research has identified 12 different attachment styles, they have been found to fit within two main attachment dimensions: anxiety and avoidance (Brennan, Clark, & Shaver, 1998).

Anxious attachment style is characterised by a fear of abandonment and an excessive need for reassurance. Avoidant attachment style involves excessive self-reliance and a fear of dependency. In contrast, secure attachment style refers to an absence of attachment anxiety or avoidance whereby the individual does not fear rejection and is capable of being depended upon (Bartholomew & Horowitz, 1991). While existing theoretical descriptions provide a plausible account of associations between attachment and PTSD, empirical research examining specific pathways in this relationship is still emerging and findings are mixed (Ortigo, Westen, DeFife, & Bradley, 2013; Woodhouse et al., 2013).

Parallels have been drawn between the insecure attachment style categories of anxiety and avoidance and the three domains of the Posttraumatic Cognitions Inventory (Renaud, 2008). The PTCI (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999) is a well-established measure, which assesses three domains of cognitions found to distinguish those with and without PTSD: negative beliefs about the self (e.g. "I am a weak person"), the world/others (e.g. "People can't be trusted"), and self-blame (e.g. "The event happened because of the way I acted"). These domains emphasise how social, cognitive, and emotional processing of trauma can have an impact upon both individual and interpersonal functioning (Maercker & Horn, 2013).

A recently conducted systematic review (Barazzone et al., 2018) and meta-analysis (Woodhouse et al., 2015) have provided a much-needed synthesis of the existing literature on the relationship between attachment style and PTSD. Woodhouse and colleagues reported a medium association between insecure attachment style and higher PTSD symptoms and secure attachment style and lower PTSD symptoms. Similarly, Barazzone and colleagues reported insecure attachment to be a risk factor, and secure attachment to be a resiliency factor, in PTSD.

The reviews reported that attachment style has both a mediating and moderating influence in the relationship between attachment style and PTSD. Notably, on dimensions of attachment anxiety and avoidance, it was reported that anxious attachment style was more highly associated with PTSD symptoms. The underlying mechanisms accounting for this pattern of results have been hypothesised as being due to attachment-based individual differences in emotion-regulation strategies during and after traumatic events. As trauma is likely to activate the attachment system, it is suggested that anxiously attached individuals may use dysfunctional hyper-activation strategies due to being threat-focused, while avoidantly attached individuals may rely on dysfunctional deactivation strategies, such as suppression and disengagement (Besser & Neria, 2012).

Despite the consistent findings of recent reviews, it has been acknowledged that further research is needed to explore how attachment-based individual differences in emotion-regulation interact with the reported interpersonal and social difficulties observed in PTSD. One suggestion for taking forward this work is to examine attachment alongside socio-cognitive models of PTSD (Woodhouse et al., 2015).

Social Cognition

Social cognition refers to the processing and application of 'self and other' information in the social environment. This allows individuals to function in relationships and as part of social groups (Frith, 2008). Several socio-cognitive models of PTSD have been formulated, which collectively emphasise how a person's social-cognitive functioning - characteristic patterns of thought and interpersonal behaviour - either supports or inhibits socially adaptive responses to traumatic experiences (De Prince, 2005; Maercker, Nietlisbach, & Gaebler, 2008; Nietlisbach & Maercker, 2009). Sharp, Fonagy, and Allen (2012) extended pre-existing socio-cognitive models of PTSD by proposing that impaired social cognition (termed mentalization; Fonagy & Allison, 2012) mediates the relationship between attachment style and PTSD.

While a considerable number of models and studies have hypothesised and demonstrated the significance of attachment and social factors in the development and maintenance of PTSD, there remains a lack of consensus regarding how these variables interact and influence the socio-interpersonal difficulties commonly observed in PTSD. Further exploration of the role of social-cognition in the relationship between attachment and PTSD would improve understanding and potentially provide a rationale for increased focus on social and environmental factors in the treatment of PTSD, which may improve chances of recovery.

Aims

This paper reviews the evidence for the role of social-cognition in the relationship between attachment style and PTSD. The following questions will be addressed:

1. Does social cognition mediate and/or moderate the relationship between attachment style and PTSD?

2. Does this relationship differ according to attachment style?

3. What are the implications of this for clinical practice and future research?

Method

Search Strategy

Electronic searches were conducted on the 19th January 2018 and the following databases were used: The Cochrane Database of Systematic Reviews (all databases, by title, abstract and key words), PsycINFO and Published International Literature on Traumatic Stress (PILOTS) databases (via ProQuest, selected by abstract, limited to peer reviewed papers), and Web of Science (all databases, selected by title). For all searches, the timespan selected was 'all years' and the following search terms were used: *Attachment* AND *soci** *OR cogniti** OR *interpersonal* OR *mental** OR "*object relations*" AND *PTSD* OR *posttraumatic* OR *trauma**

Eligibility Criteria

To be included in the review, studies were required to meet the following criteria based on PRISMA guidelines.

Population: Participants of any age, specified as having experienced a traumatic event (either interpersonal or impersonal).

Intervention: The administration of standardised psychometric and/or mental health diagnostic assessment measures of all three variables of interest: (1) attachment style; (2) social cognition; and (3) PTSD. Due to social cognition being an umbrella term for several cognitive and affective processes involved in socio-interpersonal behaviour, studies were required to have used a measure that could be categorised into one (or more) of four social cognition domains agreed by expert survey (Pinkham et al., 2014) and a previous meta-analysis (Plana, Lavoie, Battaglia, & Achim, 2014). These were: mentalization, emotion processing, social perception/knowledge, and attributional style/bias (See Tables 1 and 2).

Comparison: N/a.

Outcomes: Reported findings of the mediation and/moderation relationship between the variables using the aforementioned measures.

Study Type: A range of study designs were included due to the paucity of research in this area.

Exclusion Criteria: Case studies, editorial commentaries and any other variation of an opinion paper, and non-English language papers (due to time constraints and lack of available resources for translation).

Study Selection

The database search returned a total of 1102 citations. After removing 174 duplicates, 928 remained. Of these, 887 studies were discarded due to being unrelated and/or not meeting the inclusion criteria following screening of the title and abstract. The inclusion/exclusion criteria were applied to the full text of the remaining 41 studies. Subsequently, 35 studies were removed and the reasons for this documented. A total of 6 studies met the inclusion criteria and were used in this systematic review. No unpublished relevant studies were obtained. Figure 1 presents this diagrammatically.

Analysis

As the review aimed to examine an under-researched area, it was decided that a narrative rather than meta-analytical approach would be used to synthesise the findings.

Table 1.

Four Key Social Cognition Domains & Definitions (Pinkham et al., 2013; Plana et al., 2014)

Domain	Definition
Mentalization	The ability to attribute mental states to self and others, including inferences of intentions, desires, and beliefs (typically based on multiple pieces of information regarding the person and the context). Also referred to as Theory of Mind, mental state attribution, or cognitive empathy.
Emotion-Processing	The ability to effectively perceive, identify and use emotions, including emotion recognition (accurately identifying emotions from social stimuli, such as facial expressions), understanding emotions, and managing emotions.
Social Perception/Knowledge	The awareness of social rules, roles and goals and the ability to use this information, including to influence others' behaviour (involves decoding and interpreting social contexts and cues in others).
Attributional Style/Bias	The typical way in which an individual explains the causes (and make sense) of social interactions or events.

Table 2.

Categorisation of Social Cognition Measures Used

Study	Measure	Domain
Arikan et al. (2016)	Posttraumatic Cognitions Inventory (PTCI; Foa et al., 2009). Assesses three domains of trauma-related negative cognitions about the self, world/others, and self-blame. Domains emphasise how social, cognitive, and emotional processing of trauma can have an impact upon both individual and interpersonal functioning (Maercker & Horn, 2013). The study assessed two PTCI domains: negative self-cognitions and negative cognitions about the world/others.	Attributional style/bias
Bistricky et al. (2017)	Interpersonal Competence Questionnaire (Buhrmester et al., 1988). Assesses interpersonal ability in five domains: initiation of interactions and relationships, assertion of personal rights and displeasure with others, self-disclosure of personal information, emotional support of others, and management of interpersonal conflicts.	Social Perception/ Knowledge
Elwood & Williams (2007)	Posttraumatic Cognitions Inventory (see Arikan et al., 2016 description). All three domains assessed.	Attributional style/bias
Ferrajão et al. (2017)	Assessed 'Mental Strategies' using The Axis IV-Structure of the Operationlized Psychodynamic Diagnosis (OPD Task Force, 2008). Considered to be a measure of social cognition in-line with overlapping psychodynamic and object relations theories (Doering et al., 2014).	Mentalization
Ortigo et al. (2013)	The Social Cognition and Object Relations Scale–Global Rating Version (SCORS-G; Hilsenroth et al., 2004). The two scales used were affective quality of representations of others, and views and feelings towards the self. The SCORS-G was considered by the authors to assess the overlapping constructs of object relations and social cognition.	Mentalization
Venta et al. (2017)	The Movie for the Assessment of Social Cognition (MASC; Dziobek et al., 2006). A measure of the social-cognitive abilities required to manoeuvre everyday social situations. Correct responses are calculated to produce an overall mentalizing score.	Mentalization

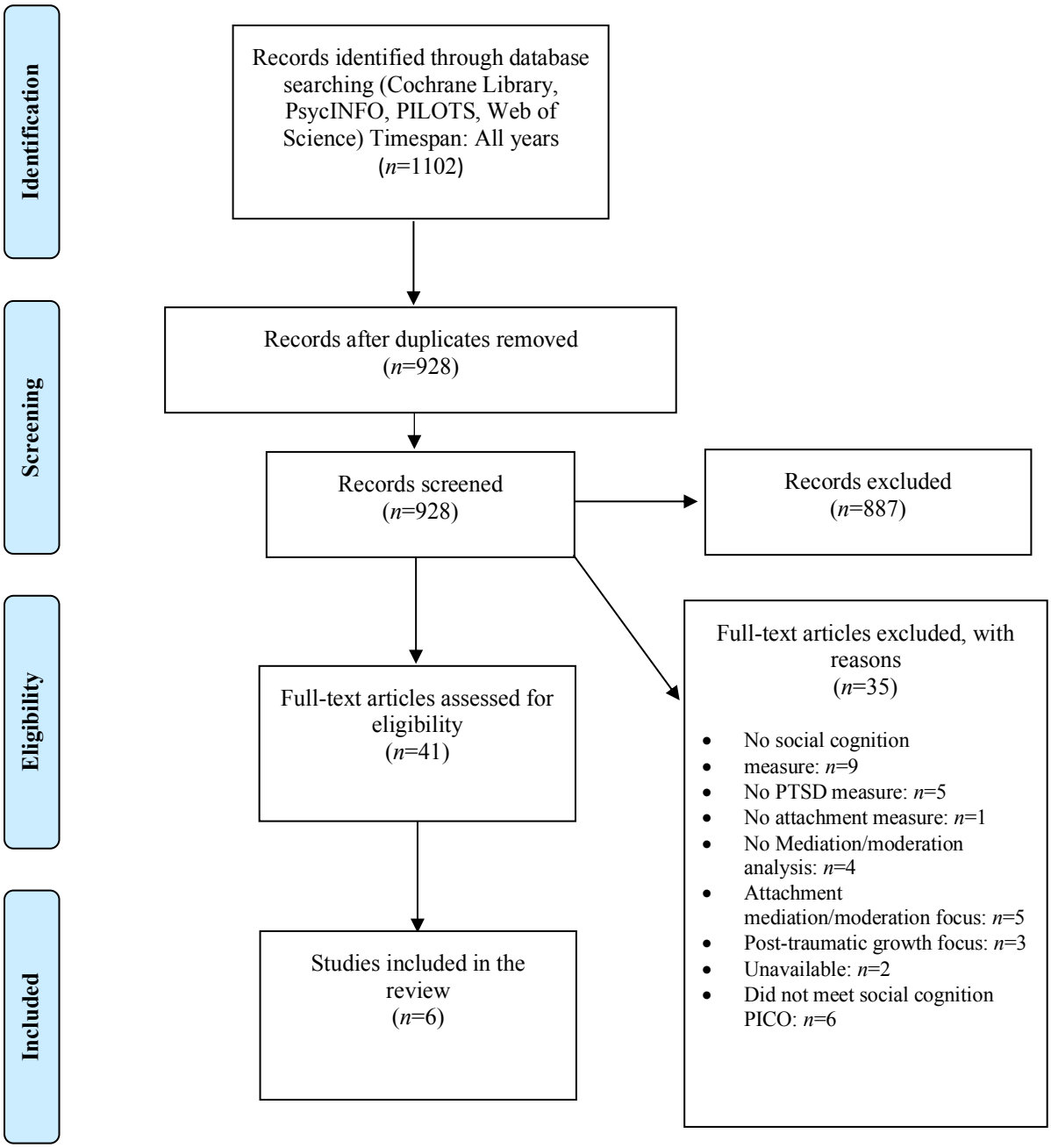

Figure 1. *PRISMA Flow Diagram of Study Selection Process*

Results

The Mediating Role of Social Cognition

Venta, Hatkevich, Mellick, Vanwoerden, and Sharp (2017) sought to provide the first empirical evaluation of Sharp, Fonagy, and Allen's (2012) socio-cognitive model of PTSD. The study included a sample of 142 adolescents from an inpatient psychiatric hospital. PTSD was assessed by parent and self-report using the Youth Self Report (YSR) and Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001) and the PTSD scale from the Trauma Symptom Checklist (TSCC; Briere, 1996). A categorical rating was used to determine the presence of clinically significant PTSD. The type of trauma experienced was not assessed (e.g. interpersonal or impersonal). The Child Attachment Interview (CAI; Target, Fonagy, Shmueli-Goetz, Datta, & Schneider, 2007) was completed by trained staff and used to make a categorical classification of each adolescent's attachment representation of their mother (secure versus insecure).

The Movie for the Assessment of Social Cognition (MASC; Dziobek et al., 2006) was used to assess social cognition. The MASC is a computer-based measure of the social-cognitive abilities required to manoeuvre everyday social situations. The test involves watching a 15-minute video of characters at a party, whereby they experience various emotional states in relation to this (e.g. jealousy). At points throughout the video, the viewer is asked questions regarding their perceptions of characters' mental states (e.g. "What is Cliff feeling?"). Correct responses are calculated to produce an overall mentalizing score, reflecting social-cognitive capacity.

The results of the study showed that the relationship between attachment insecurity and PTSD was fully mediated through impairments in social cognition. The authors stated the findings

provided the first empirical support of the application of the Sharp et al. (2012) model. They further highlighted socio-cognitive skills as intervention targets in the clinical treatment of adolescents with PTSD.

Ortigo, Westen, DeFife, and Bradley (2013) examined the relationship between attachment, social cognition, and posttraumatic stress symptoms, focusing on the potential mediating role of object relations. They used an opportunity sample of adults attending a public hospital (*N*=263). In terms of trauma type experienced, the most common were serious accidents/injuries (48.1%), and being attacked with a weapon (41.3%). The measures of attachment and PTSD used were the Adult Attachment Prototype Questionnaire (Western & Nakash, 2005; Western, Nakash, Thomas, & Badley, 2006) and The PTSD Symptom Scale (PSS; Falsetti, Resnick, Resick, & Kilpatrick, 1993). The Social Cognition and Object Relations Scale-Global Rating Version (SCORS-G; Hilsenroth, Stein, & Pinsker, 2004) was used by researchers to rate participants' quality of object relations. The two scales selected for the study were 'affective quality of representations of others' and 'views and feelings towards the self'. The affective quality scale ranges from 1 (views of self as loathsome) to 7 (tends to have realistically positive feelings about themselves). The self-esteem scale ranges from 1 (tends to have malevolent expectations of relationships) to 7 (has genuinely positive expectations of relationships). Overall, findings confirmed the mediating role of object relations in associations between attachment style and PTSD symptoms. For preoccupied (i.e. anxious) and disorganised attachment styles, partial mediation occurred primarily through self-esteem. For dismissing attachment (i.e. avoidant), an indirect-only relationship was found between attachment style and PTSD via object relations variables.

Arikan, Stopa, Carnelley, and Karl (2016) examined associations between adult attachment style, posttraumatic symptoms, and posttraumatic growth. Their study included an opportunity

sample of university staff and students (*N*=393) who had experienced at least one traumatic event (69% reported accidental or adult trauma and 31% interpersonal or early trauma). The Relationships Structures Questionnaire (RSQ; Fraley, Niedenthal, Marks, Brumbaugh, & Vicary, 2006) was used to measure attachment style and the PTSD Diagnostic Scale (PDS; Foa, Cashman, Jaycox, & Perry, 1997) determined the presence and severity of PTSD according to DSM-IV criteria (American Psychiatric Association, 1994). While the study's use of the Posttraumatic Cognitions Inventory (PTCI; Foa et al., 1999) was not specified as a measure of social cognition, it has been stated that the domains of the PTCI emphasise how social, cognitive, and emotional processing of trauma can have both an individual and interpersonal impact (Maercker & Horn, 2013). Therefore, it met the criteria for inclusion in this review (categorised within the social cognition domain of 'attributional style/bias'). The study analysed participant responses on two sub-scales of the PTCI: negative self-cognitions and negative cognitions about the world. Results showed attachment anxiety was positively related to posttraumatic symptoms and this was fully mediated through negative cognitions about the self. This effect was not found to occur through negative cognitions about the world. Additionally, while avoidant attachment was found to predict negative posttraumatic cognitions about the world, these were not related to posttraumatic stress symptoms.

Bistricky et al. (2017) examined avoidant attachment, interpersonal competence, and posttraumatic symptoms in an opportunity sample of adults and students recruited through trauma and university websites who completed an online survey (*N*=132). The measures of attachment and PTSD used were the Experiences in Close Relationships-Short Form (ECR-S; Wei, Russell, Mallinckrodt, & Vogel, 2007) and the PTSD Checklist-Civilian (PCL-C; Weathers, Litz, Herman, Huska, & Keane, 1993). The 40-item Interpersonal Competence Questionnaire (ICQ; Buhrmester, Furman, Wittenberg, & Reis, 1988) was used to assess interpersonal ability in five domains as noted in Table 2. Results showed that avoidant

attachment did not have a significant direct effect on posttraumatic symptoms but did have a significant indirect effect via interpersonal competence.

Partial Support for a Mediation Effect

Ferrajão, Badoud, and Oliveira (2017) examined mental strategies (i.e. behavioural and intrapsychic strategies used to cope with traumatic events and symptoms) as mediators of the link between attachment and PTSD. They used an opportunity sample of Portuguese military veterans attending a veteran outpatient clinic (*N*=60) reporting combat-related trauma. The Experiences in Close Relationships Scale (ECR; Brennan, Clark, & Shaver, 1998) was used to measure attachment style and the Impact of Event Scale-Revised (IES-R; Weiss & Marmar, 1997) was used to measure subjective response to traumatic events. The Axis IV-Structure of the Operationlized Psychodynamic Diagnosis (OPD-2; OPD Task Force, 2008) was used to assess mental strategies. This interview-based measure includes eight domains, which assess personality functioning in terms of capacities for self and object recognition, regulation, communication, and attachment. Therefore, it is considered to be a measure of social cognition in-line with overlapping psychodynamic and object relations theories (Doering et al., 2014). Results showed a mediation effect of anxious attachment on PTSD through mental strategies organisation only when no other variables (e.g. age, recovery status, combat exposure) were entered as covariates. An indirect effect of avoidant attachment on PTSD through mental strategies organisation was not found to be significant.

No Moderation Effect

Elwood and Williams (2007) examined PTSD-related cognitions and romantic attachment style as moderators of psychological symptoms in victims of interpersonal trauma. They used an opportunity sample of university students (*N*=287), comparing those who had experienced

trauma and those who had not. The measures of attachment and PTSD administered were the Experiences in Close Relationships Scale (ECR; Brennan et al, 1998) and the Purdue PTSD Scale-Revised (PPTSD-R; Lauterbach & Vrana, 1996), respectively. They also used the Posttraumatic Cognitions Inventory (PTCI; Foa et al., 1999) to measure posttraumatic cognitions (about the self, world/others, and self-blame). The results showed that victims reported higher levels of PTSD-related cognitions and anxious attachment, but not avoidant attachment, in comparison to non-victims. Results suggest that the experience of trauma, high levels of insecure attachment, and high levels of PTSD cognitions are associated with higher levels of depressive symptoms (but not PTSD or anxious symptomatology).

Discussion

The aim of the review was to examine the evidence for a mediating and/or moderating role of social cognition in the relationship between attachment style and post-traumatic stress disorder (PTSD) and determine whether associations differed according to attachment style. Additionally, implications for clinical practice and future research are discussed.

Social Cognition as a Mediator in the Relationship between Attachment Style and PTSD

Four of the six studies reviewed reported that social cognition mediated the relationship between attachment style and post-traumatic symptoms (Arikan et al., 2016; Bistricky et al., 2017; Ortigo et al., 2013; Venta et al., 2017). Regarding the other two studies, Ferrajão et al. (2017) only found a significant mediation effect when no covariate was added (i.e. age, recovery status, combat exposure). Elwood and Williams (2007) only examined moderation and did not find a significant effect. Of the four studies that found a significant mediation effect, one also examined moderation and did not report any significant effects (Arikan et al., 2017). Three studies only examined mediation effects (Bistricky et al., 2017; Ortigo et al., 2013; Venta et al., 2017).

Collectively, the findings of the studies provide evidence for the mediating role of social cognition in the relationship between attachment style and PTSD, providing support for Sharp and colleagues' (2012) socio-cognitive model of PTSD model, which states that impaired social cognition - arising from attachment insecurity - mediates the relationship between attachment style and PTSD. However, while the Sharp et al. (2012) model conceptualises social cognition in terms of mentalization, as stated elsewhere in this review, social cognition is an umbrella term for several cognitive and affective processes involved in socio-interpersonal behaviour (e.g. mentalizing, emotion-processing, social perception/knowledge, attributional

style/bias). The studies reviewed reflect this diversity in terms of the heterogeneity of the social cognition measures used. The findings suggest that various aspects of social cognition are likely to interact and influence the interpersonal impairments associated with PTSD, including negative self-cognitions (Arikan et al., 2016), low interpersonal competence (Bistricky et al., 2017), object relations variables (Ortigo et al., 2013), and mentalization (Venta et al., 2017).

Attachment Style

This review also sought to determine whether findings differed by attachment style. Of the four studies reporting a meditating role of social cognition in the relationship between attachment style and PTSD (Arikan et al., 2016; Bistricky et al., 2017; Ortigo et al., 2013; Venta et al., 2017), one found this only for anxious but not avoidant attachment style (Arikan et al., 2016). Additionally, Ferrajão et al. (2017) reported a significant mediation effect of anxious attachment style, but no effect of avoidant attachment style. In contrast, Ortigo et al. (2013) found avoidant attachment style fully mediated the relationship between attachment and PTSD, whilst anxious attachment only partially mediated this relationship. Venta et al. (2017) did not report differences between anxious and avoidant attachment styles, but rather they compared insecure and secure attachment styles. Bistricky et al. (2017), and Elwood and Woods (2007) only examined avoidant attachment style, with the former finding a positive mediation effect and the latter not finding a moderation effect.

Overall, the findings demonstrate a mixed picture regarding differences in insecure attachment style and the impact upon PTSD. Two of the three studies assessing both (anxious and avoidant) attachment styles reported an indirect effect of anxious attachment and PTSD (Arikan et al., 2017; Ferrajão et al., 2017), whilst one study reported the opposite (Ortigo et al., 2013). However, collectively, they indicate that insecure attachment style is a risk factor for PTSD. It may also be inferred that secure attachment is a resiliency factor based on the

underlying assumptions of attachment theory (Cassidy, Jones, & Shaver, 2013). These findings are consistent with those of a recently conducted systematic review (Barazzone et al., 2018) and meta-analysis (Woodhouse et al., 2015) examining the relationship between attachment style and PTSD.

Underlying Mechanisms

Socio-cognitive models of PTSD emphasise how a person's social-cognition either supports or inhibits socially adaptive responses to traumatic experiences (De Prince, 2005; Maercker, Nietlisbach, & Gaebler, 2008; Nietlisbach & Maercker, 2009). The Sharp et al. (2012) model is useful in expanding pre-existing models by integrating a social-information processing approach with attachment-based experiences.

In terms of underlying mechanisms, trauma is hypothesised to activate the attachment system. This includes the triggering of attachment schemas (i.e. internal working models of the self, others, and the world). For insecurely attached individuals, this is said to lead to maladaptive social-cognitive processing, emotion-regulation strategies, and interpersonal interaction. Over time, a vicious cycle develops and prevents the person from engaging with social factors known to provide resiliency from trauma (i.e. social support, acknowledgment, and disclosure), thus increasing the risk of developing PTSD. More specifically, an individual's attachment style is hypothesised to determine their initial processing of traumatic experiences, the types of attachment schemas that become activated, the self/emotion-regulation strategies used to cope, and the interpersonal patterns of behaviour they adopt (Sharp et al., 2012).

Anxiously attached individuals are considered to be hypervigilant to threat, appraising difficult events and experiences more fearfully and catastrophically. Therefore, this places them at increased risk of developing the symptoms of PTSD due to excessive focus on negative

thoughts, emotions, and physical sensations. Anxiously attached individuals are likely to engage in proximity-seeking behaviours with partners and significant others with the intention of reducing distress. Over time, this anxious pattern is likely to have a detrimental effect on relationships, further exacerbating attachment schemas and behaviours, and PTSD symptoms (Besser & Neria, 2012).

In contrast, avoidantly attached individuals are noted to use 'deactivation' strategies, such as inhibition and suppression, in response to threat. Traumatised individuals with an avoidant attachment style - commonly reported amongst military veterans - are likely to try and down-regulate threat-based experiences by using unhelpful self-soothing and safety-seeking behaviours. In certain interpersonal contexts, this may lead to verbal and physical aggression in response to perceived threats. Therefore, while avoidance serves to provide short-term relief from overwhelming emotions and interpersonal encounters, in the longer-term, it can result in the interpersonal impairments associated with PTSD through the person withdrawing from protective sources of social support and close relationships (Renaud, 2008).

Limitations

There are a number of limitations that need to be considered when interpreting the findings of the reviewed studies. All six studies used a cross-sectional design and cannot therefore adequately address the issue of causation. This is a particular issue when studying mediation, as such models make explicit assumptions about the direction of causation. Thus, the underlying mechanisms of causality and directionality in the relationship between attachment style, social cognition, and PTSD remains unclear.

Three of the studies used non-clinical (university) samples (Arikan et al., 2016; Bistricky et al., 2017; Elwood & Williams, 2007) and one study used an opportunity sample of people attending

a public hospital (Ortigo et al., 2013). Therefore, findings may not be generalisable to PTSD treatment-seeking populations. While Ferrajão et al. (2017) did use a clinically diagnosed PTSD sample, participants were veterans who had experienced combat-related trauma and, therefore, findings may not be generalisable to other trauma-experienced populations. All studies used self-report measures and, while some also used clinician rated and/or interview-based measures, the limitations of such methods are well-established (e.g. question misinterpretation and demand characteristics). The preponderance of female and White/Caucasian samples in the studies also limits the generalisability of the findings. Furthermore, most of the studies reviewed (*n*=5) did not specifically report information regarding socio-economic status. Additionally, only one study (Bistricky et al., 2017) reported lesbian, gay, bisexual, and transgender (LGBT) demographic information and it is known this population are more likely to report experiencing trauma (Boroughs, Bedoya, O'Cleirigh, & Safren, 2015). Therefore, it is unclear to what extent these variables influence associations between attachment style, social cognition and PTSD.

In terms of the review itself, specific limitations are acknowledged, which impact the inferences that can be made from the results of the studies reviewed. The first concerns the paucity of literature examining the role of social cognition in the relationship between attachment style and PTSD. Therefore, it was necessary to adopt a wide PICO inclusion criterion, particularly in terms of the measures of social cognition used in studies. Consequently, the studies varied considerably in terms of the aspect of social cognition they assessed, making it difficult to specify which specific aspects of social cognition (e.g. interpersonal competence, mentalization) are the most significant. Additionally, the included studies were heterogeneous in terms of the whether and how they used mediation and/or moderation analysis in examining the role of social cognition and measurement of attachment style (e.g. only comparing insecure versus secure).

Clinical Implications

Currently, in the UK, National Institute for Health and Care Excellence Guidance for PTSD (NICE, 2005) recommends (trauma-focused) cognitive behavioural therapy and eye movement desensitisation and reprocessing (EMDR), approaches which involve unblocking traumatic experiences through exposure and reprocessing techniques (Matheson, 2016). The psychological theories underlying these treatments are well articulated and there is a strong evidence-base for their efficacy (Bisson, 2009; Brewin & Holmes, 2003; Schnyder et al., 2015). Despite this, experts in the field of traumatic stress have highlighted that current intrapersonally-focused evidence-based therapies are not always successful in the 'real world' treatment of PTSD, particularly for complex and comorbid cases (Lab, Santos, & de Zulueta, 2008). Increasingly, the need for a socio-interpersonal approach to PTSD has been emphasised (Maercker & Hecker, 2016).

The findings of this review fit with socio-interpersonal models of PTSD and their focus on broadening perspectives on the development and maintenance of traumatic experiences from an individual to an interpersonal level (Maercker & Hecker, 2016; Maercker & Horn, 2013; Markowitz, Milrod, Bleiberg, & Marshall, 2009). More specifically, findings suggest the potential value of social cognition and attachment-informed assessment, formulation, and treatment of PTSD. Such approaches are intended to complement rather than replace existing intrapersonally-focused evidence-based treatments for PTSD (Karatzias et al., 2018). There is increasing interest in and evidence for the benefits of applying these approaches to improve the interpersonal impairments associated with PTSD (particularly for complex-PTSD). This includes psychodynamically-informed treatments, such as interpersonal therapy (IPT), which emphasise the role of a person's attachments and interpersonal networks (Markowitz et al., 2015; Schottenbauer, Glass, Arnkoff, & Gray, 2008).

The role of the therapist in attachment-based approaches is to act as a 'secure base' from which the person can safely explore traumatic experiences. This involves helping the person gain insight into their attachment style and how this is linked to unhelpful patterns of thoughts, emotions, and interpersonal behaviour in times of stress. It also involves challenging unhelpful beliefs and perceptions about the self, world/others, and modifying unhelpful attachment-based behaviours. Increasing mentalization and emotion-regulation capacity through attachment-based approaches is considered to help the person better manage internal experiences, such as PTSD symptoms, and improve interpersonal interaction. This forms the basis for the person to engage in healthy relationships and benefit from social sources of support (Bateman & Fonagy, 2011).

Future Research

A considerable number of studies in the existing literature have demonstrated the significance of attachment style, social factors, and interpersonal impairments in the development and maintenance of PTSD. However, the role of social cognition remains an under-researched area. This review has indicated a mediating role of social cognition in the relationship between attachment style and PTSD. However, this was based on a small number of heterogeneous studies that used a variety of social cognition measures. Further research is needed to explore the underlying mechanisms of social cognition in PTSD and how this accounts for difficulties in psychosocial functioning. Related to this, three studies were excluded from the review as they used measures of perceived social support (Besser & Neria, 2012; Shallcross, Frazier, & Anders, 2014; Volgin & Bates, 2016). As highlighted by Pinkham et al. (2014) there is a lack of consensus regarding definition and measurement of social cognition. The development of standardised social cognition measures would enable future studies to be more comparable and replicable.

Studies using longitudinal designs would be beneficial in examining fluctuations in attachment style in response to traumatic experiences. It would also be advantageous to explore differences in the type of trauma experienced (e.g. interpersonal versus impersonal) and to compare single episode and complex trauma cases. Within the attachment literature, there is an increasing emphasis on the continuum of attachment styles and it would useful to compare this model to the commonly used categorical approach (Woodhouse et al., 2015). Intervention studies are also needed to evaluate social cognition and attachment-based approaches in the treatment of PTSD and to consider how these best complement existing evidence-based intrapersonally-focused therapies (Karatzias et al., 2018).

Research in this area is challenging due to the nature of attachment style and social cognition as concepts that involve mental representations and social information processing that is not clearly observable. Therefore, the use of SCAN (social cognitive and affective neuroscience) studies would provide insight into the neurobiological impact of trauma on social cognitive processing and the brain regions involved in this (Lanius, Bluhm, Frewen, 2011; Sharp et al., 2012).

Conclusion

This systematic review has added to the findings of recent reviews of the relationship between attachment style and PTSD by indicating that social cognition mediates this relationship. Moreover, the review indicates that insecure attachment style is a risk factor and secure attachment is a resiliency factor for PTSD. However, due to the paucity of literature in this area, further research using longitudinal and SCAN designs are needed. It has been suggested that social cognition attachment-based approaches may be advantageous in attending to the interpersonal impairments reported in PTSD. Further evaluation of how these can best

complement existing intrapersonally-focused treatments is required to more effectively treat PTSD.

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Chapter 2 – Empirical Paper

Individual Characteristics, Secondary Trauma, and Burnout in Police Sexual and Violent Offending Teams

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Abstract

Police specialist sexual and violent offending teams frequently have contact with traumatised individuals, distressing situations, and challenging subject matter. This places them at increased risk of developing work-related stress and psychological health difficulties. The aim of the study was to examine individual risk and resiliency factors for secondary trauma, burnout, and mental ill-health. A convenience sample of specialist police staff (*N*=78) completed measures of work-related stress, mental ill-health, and individual characteristics. Cross-sectional analysis showed higher levels of coping self-efficacy, dispositional mindfulness, and psychological flexibility were associated with lower levels of secondary trauma, burnout, and mental ill-health. Conversely, participants with self-reported insecure attachment styles (both anxious and avoidant) showed higher levels of secondary trauma, burnout, and mental ill-health. The results of study indicate that coping self-efficacy, dispositional mindfulness, and psychological flexibility are resiliency factors and insecure attachment style is a risk factor for secondary trauma, burnout, and mental ill-health. The use of mindfulness, acceptance and commitment therapy, and attachment-based approaches may be beneficial in promoting a resilient police workforce and maintaining operational effectiveness.

Key Words: Secondary-trauma, burnout, resilience, attachment.

Introduction

Police specialist sexual and violent offending teams frequently have contact with traumatised individuals, distressing situations and challenging subject matter (Atkinson-Tovar, 2003; Cross & Ashley, 2004; Karlsson & Christianson, 2003). Along with the rapid growth of the internet, one area of specialist policing that has expanded over the last decade is the investigation of online child sexual abuse (MacEachern, Jindal-Snape, & Jackson, 2015). In 2017, the Independent Inquiry into Child Sexual Abuse in England and Wales was informed that suspected incidents of online child sexual abuse referred to the UK's largest police force had increased by 700% over the previous three years (Bowcott, 2018).

Police staff investigating the production, possession and distribution of indecent images of children using electronic devices are often involved in lengthy investigations, requiring extensive contact with distressing material (Powell, Cassematis, Benson, Smallbone, & Wortley, 2014). As with other specialist police teams, this places staff at risk of experiencing secondary trauma, burnout, and developing psychological difficulties (Powell et al., 2014; Tehrani, 2016; Turgoose, Glover, Barker, & Maddox, 2017).

Research on secondary traumatic stress in the helping professions emerged in the 1980s, focusing upon emergency service workers (Dunning & Silva, 1980; Durham, McCammon, & Allison, 1985; Hartsough & Myers, 1985). Secondary trauma can be defined as the indirect traumatisation of a person through the stress of helping, wanting to help, or knowing about a traumatised individual or event (Figley, 1995). The term is often used interchangeably with compassion fatigue (Figley, 2002; Joinson, 1992) and is also synonymous with vicarious traumatisation (McCann & Pearlman, 1990), despite subtle differences in definition and use existing (Elwood, Mott, Lohr, & Galovski, 2011; Stamm, 1997).

As with post-traumatic stress disorder (PTSD), symptoms of secondary trauma include emotional arousal, avoidance and intrusive thoughts or memories. It is hypothesised to occur quickly and unexpectedly in the context of contact with one or more traumatic events (Elwood et al., 2011; Figley, 1995). The concept of secondary traumatisation developed from research on job burnout (Maslach, 1981, 1982). Unlike secondary trauma, burnout is hypothesised to emerge gradually in relation to long-term work-related stress, resulting in physical, emotional and psychological exhaustion (Maslach, Jackson, & Leiter, 1996). It is not unique to those working with victims of trauma or the helping professions and leads to a sense of reduced professional accomplishment and difficulties in work performance (Maslach, Schaufeli, & Leiter, 2001; Schaufeli, Leiter, & Maslach, 2009).

In contrast to the constructs described above, compassion satisfaction can be understood as existing at the opposite end of the responses to work spectrum. It has been defined as the fulfilment a person receives from being able to do their work effectively and contribute to the wellbeing of others (Stamm, 2005). It is considered to be essential in achieving a balance between professional demand and personal reward. Compassion satisfaction has been found to increase motivation and enable workers to overcome work-based stresses and challenges (Collins & Long, 2003).

The prevalence of secondary trauma and burnout in a variety of helping professions is well recognised (Elliott & Daley, 2012; Tehrani, 2010). However, despite the challenging nature of specialist sexual and violent offending police work, these staff remain an under-researched population (Turgoose et al., 2017). While previous research suggests a high proportion of specialist police staff cope well with the demands of their work (Perez, Jones, Englert, & Sachau, 2010; Powell et al., 2014; Wolak & Mitchell, 2009), it is also recognised that staff can experience a wide variety of trauma-related symptoms, including flashbacks, nightmares,

overprotectiveness of children and a general disruption to personal relationships and social functioning (Burns, Morley, Bradshaw, & Domene, 2008; Krause, 2009; Perez et al., 2010; Powell, Cassematis, Benson, Smallbone, & Wortley, 2015; Wolak & Mitchell, 2009).

The potential ramifications of secondary trauma and burnout are far reaching, both for staff and employers. According to a recent survey of police forces in England and Wales, there has been a 72% increase in staff taking sick leave for psychological reasons since 2010, with mental ill-health now being the main reason for long-term sickness absence in particular areas (Dowling, Chesworth, & Goldberg, 2017; Ingram, 2014; Pugh, 2016). Certain police forces with high levels of sickness absence have estimated the current cost of this to be in excess of £17 million per year (Owen, n.d.).

The existing literature has highlighted that individual characteristics play a role in determining how specialist police staff cope with their work (Burns et al., 2008; Powell et al., 2014). However, research is limited and there remains a lack of clarity regarding which individual characteristics are the most important risk and resiliency factors. Tehrani (2016) examined the role of gender and personality in the development of secondary trauma in internet child abuse investigators and found a higher incidence of introversion and neuroticism in females, but low levels of secondary trauma in the sample overall. Turgoose et al. (2017) found longer-serving specialist police staff had higher levels of compassion fatigue, secondary trauma and burnout. However, while low trait empathy was found to be related to high burnout, empathy otherwise was not found to be related to secondary trauma or compassion fatigue.

The wider literature on psychological wellbeing has provided valuable insights into individual characteristics that enhance resiliency and aid effective coping (Tugade, Fredrickson, & Barrett, 2004). More specifically, studies have consistently shown the beneficial roles of dispositional mindfulness (Baer, 2003), broadly defined as non-judgmental awareness of and

attention to one's experience in the present moment (Kabat-Zinn, 1994); psychological flexibility (Fledderus, Bohlmeijer, Smit, & Westerhof, 2010), which refers to the capacity to mentally adapt and balance situational demands and competing desires (Kashdan & Rottenberg, 2010) and perceived self-efficacy (Schwarzer & Warner, 2013), conceptualised as a person's belief of how well they can cope with adversity and exert influence in their own life (Bandura, 1997). This knowledge has already informed staff support programmes and interventions in a number of occupational settings (Lomas et al., 2017; Moran, 2015).

Additionally, research spanning several decades has highlighted the role of attachment style in influencing psychosocial functioning across the lifespan (Cassidy, Jones, & Shaver, 2013). Attachment theory (Bowlby, 1969) proposes that infants are biologically driven to form attachments with others to survive. The quality of the early attachment relationship between an infant and their primary caregiver is said to lead to the development of an enduring secure or insecure attachment style (Mikulincer, Shaver, & Pereg, 2003). Attachment security is considered to provide an inner resource to deal with life's challenges and adversity, while attachment insecurity is thought to lead to increased difficulties in coping and relating in times of stress (Mikulincer & Florian, 1998).

While an increasing number of studies have shown an association between attachment style and PTSD (Woodhouse, Ayers, & Field, 2015), there is a paucity of research examining this relationship in the context of secondary trauma and burnout. Additionally, questions remain regarding the role of individual characteristics as risk and resiliency factors in how specialist police staff cope with and are impacted by their work. Therefore, a clear gap in the literature exists, which the present study aims to address. It is intended that findings can be used to increase psychological wellbeing and improve support for 'at risk' helping professions.

Aims and Research Questions

The aim of the study was to examine individual characteristics, secondary trauma, and burnout in police specialist sexual and violent offending teams by answering the following research questions.

1. What levels of secondary trauma, burnout and compassion satisfaction are present and do these vary by gender?

2. Are levels of secondary trauma, burnout and compassion satisfaction related to length of service in specialist policing?

3. Which attachment style and individual characteristics are most associated with secondary trauma, burnout, compassion satisfaction and mental ill-health?

Method

Participants

The participants were seventy-eight police staff from several North Wales Police specialist sexual and violent offending teams. The teams included those who have direct and/or indirect contact with both child and adult crime victims or offenders, including online child sexual abuse investigation and domestic violence support teams. To obtain the largest possible sample size, staff were eligible to participate if they worked for any of the North Wales Police specialist sexual and violent offending teams. No other exclusion criteria were applied. The sample was evenly distributed in terms of gender, with 47% male (*n*=37) and 53% female (*n*=41) participants. Regarding age and ethnicity, 67% were in the 35-54 years old category (*n*=52) and 86% were White British (*n*=67).

Procedure

The study was granted ethical approval by the Bangor University School of Psychology Ethics Committee, the Betsi Cadwaladr NHS Research and Development Internal Review Panel and the North Wales Police Ethics Committee (Appendices 1, 2, 3). Online surveys (Jisc, 2017) was used to host the survey. Participants were recruited by a Detective Inspector from North Wales Police identifying relevant specialist police teams and inviting staff to participate by emailing them with the study information sheet. Once participants had consented to take part in the study they were asked to complete the study self-report questionnaire measures. Upon completion of these, they were presented with debriefing information, including contact details for police occupational health support and advised to seek professional advice with any concerns regarding personal wellbeing (Appendices 4, 5). The survey was activated on 23/10/2017 and closed on 12/01/2018.

Measures

The Secondary Traumatic Stress Scale (STSS; Bride, Robinson, Yegidis, & Figley 2004) is a 17-item self-report measure of secondary trauma in workplace settings comprising of three subscales. Respondents rate themselves on a Likert scale from 1 (never) to 5 (very often) regarding how frequently over the last week they experienced symptoms of intrusion (e.g. *I had disturbing dreams about my work with clients*), avoidance (e.g. *I felt discouraged about the future*) and arousal (e.g. *I was easily annoyed*). Bride (2007) suggested the following interpretation of scores: less than 28 (little or no secondary trauma), 28-37 (mild), 38-43 (moderate), 44-48 (high), 49 and above (severe). The STSS has been reported to have high levels of internal consistency and good validity (Bride et al., 2004). Only total STSS scores were used in the data analysis.

The Professional Quality of Life Scale (ProQOL-5; Stamm, 2009) is a 30-item self-report measure of the negative and positive effects of helping others who experience suffering and trauma comprising of three subscales. Respondents rate themselves on a Likert scale from 1 (never) to 5 (very often) regarding how frequently over the last 30 days they experienced compassion satisfaction (e.g. *I get satisfaction from being able to help people*), burnout (e.g. *I feel "bogged down" by the system*) and secondary trauma (e.g. *I jump or am startled by unexpected sounds*). Total scores for each subscale are calculated and equate to severity categories of low (22 or less), average (between 23 and 41) or high (42 or more). The ProQOL has been reported to be reliable with α coefficients ranging from .85 to .94 (Figley & Stamm, 1996; Stamm, 2010). Only the burnout and compassion satisfaction scales of the ProQOL were used in the data analysis (other than for Question 1) due to the use of the STSS in measuring secondary trauma.

The General Health Questionnaire (GHQ-12; Goldberg, 1992) is a 12-item self-report measure designed to screen for general psychiatric morbidity (or 'current mental ill-health'). Respondents rate themselves using a 4-point Likert-scale (which can be scored 0, 1, 2, 3) regarding their health over the past few weeks, with questions focusing upon inability to carry out normal functions (e.g. *Been able to enjoy your normal day-to-day activities*) and appearance of new and distressing phenomena (e.g. *Lost much sleep over worry*). Higher scores equate to higher levels of mental distress. The GHQ-12 has been widely used and extensively validated in general and clinical populations worldwide (Hankins, 2008).

The Experiences in Close Relationships Questionnaire-Revised (ECR-R; Fraley, Waller, & Brennan, 2000) is a 36-item self-report measure of adult attachment style. Respondents rate themselves using a Likert scale ranging from 1 (*not at all characteristic of me*) to 5 (*very characteristic of me*) regarding how they generally feel in emotionally intimate relationships. Questions measure attachment-related anxiety (e.g. *I often worry that my partner will not want to stay with me*) and attachment-related avoidance (e.g. *I prefer not to be too close to romantic partners*). Total scores are calculated for each of the two subscales and mean scores equate to ranges from 1 (low) to 7 (high). The ECR-R has been found to display suitable convergent and discriminant validity as a measure of attachment in the romantic relationships domain (Sibley, Fischer, & Liu, 2005).

The Five Facet Mindfulness Questionnaire (FFMQ; Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006) is 36-item self-report measure of dispositional mindfulness derived from a factor analytic study of five independently developed mindfulness questionnaires. Respondents rate themselves on a 5-point Likert scale ranging from '*Never or very rarely true of me' to 'Very often or always true of me'* in response to questions relating to the five subscales (observing, describing, acting with awareness, non-judging, and non-reactivity). Total and mean scores can

be calculated for each subscale and overall. Higher scores indicate higher use of mindfulness skills. Results have indicated that the FFMQ is a reliable and valid mindfulness measure (Choi, 2015). Only total FFMQ scores were used in the data analysis.

The Acceptance and Action Questionnaire-II (AAQ-II; Bond et al., 2011) is a 10-item self-report measure of psychological flexibility and experiential avoidance. Respondents rate themselves on a Likert scale ranging from 1 (never true) to 7 (always true) regarding how true each statement is for them (e.g. *It's OK if I remember something unpleasant*). Higher scores indicate greater psychological flexibility/lower scores indicate greater experiential avoidance. The authors have reported that the AAQ-II has appropriate discriminate validity and predicts a range of psychosocial outcomes consistent with its underlying theory (Bond et al., 2011).

The Coping Self-Efficacy Scale (CSE; Chesney, Neilands, Chambers, Taylor, & Folkman, 2006) is a 26-item self-report measure of perceived ability to cope with life's challenges. Respondents rate themselves on a Likert scale ranging from 0 (cannot do at all) to 10 (certain can do) regarding confidence to act when things aren't going well (e.g. *Find solutions to your most difficult problems*). Higher scores indicate higher coping self-efficacy (three subscale scores can also be derived). Research has indicated that internal consistency and reliability are strong for all three factors of the questionnaire (Chesney et al., 2006). Only total CSE scores were used in the data analysis.

Statistical Analyses

Power analysis was undertaken using "G Power" software (Faul, Erdfelder, Lang, & Buchner, 2007), which indicated that for a medium effect size of r =.30 to be detected and a desired power of 80%, a sample size of 85 participants would be required, based on correlational analysis (assuming an α of 0.05, two-tailed). This approach was in-line with a recent similar

study (Turgoose et al., 2017). While the final sample size was just below this (N=78) it was not deemed necessary to amend the plan for correlational analysis. Due to non-even distributions for some of the measures, Spearman's Rho correlations were used to assess the strength and significance of associations between the variables. Characteristics of the sample were described using percentage, mean and standard deviation calculations. Independent t-tests (with bootstrapping) were used to compare group differences. All analyses were conducted using IBM SPSS 24.0 for Windows and a 95% (p<.05) significance level was applied.

Results

What levels of secondary trauma, burnout, and compassion satisfaction are present and do these vary by gender?

To address research question one, a frequency analysis was conducted to examine mean scores and severity ratings for the whole sample and by gender on measures of secondary trauma, burnout, and compassion satisfaction. Independent samples t-tests were conducted to examine whether there were significant differences in mean scores by gender.

Table 1.

Mean Secondary Trauma, Burnout, and Compassion Satisfaction Scores and Severity Ratings for the Whole Sample and by Gender

Measure	Whole Sample (*N*=78)	Females (*n*=41)	Males (*n*=37)	*t* statistic and *p* values
Secondary Traumatic Stress (STSS)	Mild 35.29 (13.34)	Mild 32.73 (11.88)	Moderate 38.14 (14.43)	*t*=1.794 *p*=.077
Burnout (ProQOL)	Average 25.77 (6.07)	Average 25.44 (5.31)	Average 26.14 (6.87)	*t*=.497 *p*=.621
Compassion Satisfaction (ProQOL)	Average 36.09 (6.78)	Average 36.49 (5.51)	Average 35.65 (8.00)	*t*=-.534 *p*=.595

Standard deviations in brackets.

Levels of secondary trauma for the whole sample fell within the upper end of the mild range on the STSS (*M*=35.29, *SD*=13.34). Similarly, group scores on the STS subscale of the ProQOL fell within the low range (*M*=20.08, *SD*=6.51). Group levels of burnout (*M*=25.77, *SD*=6.07) and compassion satisfaction were found to be in the average range (*M*=36.09, *SD*=6.78). Scores for all measures fell within the same ranges when considered by gender (except for males having higher/moderate levels of STS, this difference almost being significant, *p*=.077). No significant gender differences were found on any of the measures (all *ps*>.05).

Are levels of secondary trauma, burnout, and compassion satisfaction related to length of service in specialist policing?

To address research question two, a frequency analysis was conducted to determine the average length of service in current and any specialist policing role for the whole sample. Spearman's correlations were used to examine associations between length of service in specialist policing, secondary trauma, burnout, and compassion satisfaction.

Table 2.

Spearman's Correlations between Length of Specialist Policing Service (Current Role and Total), Secondary Trauma, Burnout, and Compassion Satisfaction

Length of Service	Secondary Traumatic Stress	Burnout	Compassion Satisfaction
Current role	.292*	.346**	-.231
Any specialist policing	.076	.231	-.265*

**p<.05, **p<.01 (2 tailed), n=66 due to 12 unclear responses.*

The average length of time employed in current specialist sexual and violent offending police role was 33.80 months (2.82 years, *SD*=36.18). The average length of time employed in any specialist policing role was 97.91 months (8.16 years, *SD*=74.10).

Weak and significant positive correlations were found between number of months in current role and secondary trauma (r=.292, p=.017) and burnout (r=.346, p=.004). This suggests that, as length of service increases, so do levels of secondary trauma and burnout. However, this relationship was not found to be as strong for number of months in any specialist policing role (secondary trauma, r=.076, p=.543 and burnout, r=.231, p=.062). Weak negative correlations were found between length of service and compassion satisfaction. However, this relationship was only found to be significant for length of service in any specialist policing role (r=-.265, p=.031) and not current role (r=-.231, p=.062).

Which attachment style and individual characteristics are most associated with secondary trauma, burnout, compassion satisfaction, and mental ill-health?

To address research question three, Spearman's correlations were used to examine associations between attachment style, individual characteristics, secondary trauma, burnout, compassion satisfaction, and mental ill-health.

Table 3.

Spearman's Correlations between Attachment Style, Individual Characteristics, Secondary Trauma, Burnout, Compassion Satisfaction, and Mental Ill-Health

	Secondary Traumatic Stress	Burnout	Compassion Satisfaction	Current Mental Ill-Health
Avoidant Attachment	.385**	.508***	-.227	.435***
Anxious Attachment	.265*	.331**	-.131	.424***
Coping Self-Efficacy	-.572***	-.661***	.490***	-.662***
Dispositional Mindfulness	-.460***	-.635***	.385***	-.584***
Psychological Flexibility	-.460***	-.485***	.373**	-.530***

p<.05, **p<.01, p<.001* (2 tailed), N=78 for all analyses.*

Regarding attachment style, results showed weak to moderate, significant positive correlations between avoidant attachment style and secondary trauma (r=.385, p=.001), burnout (r=.508, p<.001) and mental ill-health (r=.435, p<.001). Significant weak positive correlations were found between anxious attachment style and secondary trauma (r=.265, p=.019), burnout (r=.331, p=.003), as well as a moderate correlation with mental ill-health (r=.424, p<.001). This suggests that, as levels of attachment insecurity increase, so do levels of secondary trauma, burnout and mental ill-health. This association was found to be strongest for avoidant

attachment style, particularly in relation to burnout. Associations between attachment style and compassion satisfaction were not found to be significant.

Regarding individual characteristics, results showed strong and moderate, highly significant negative correlations between coping self-efficacy (r=-.661, p<.001), dispositional mindfulness (r=-.635, p<.001), psychological flexibility (r =-.485 p<.001) and burnout. Moderate, highly significant negative correlations were also found between coping self-efficacy (r=-.572, p<.001), dispositional mindfulness (r=-.460, p<.001), psychological flexibility (r=-.460, p<.001) and secondary trauma. Strong and moderate, highly significant negative correlations were also found between coping self-efficacy (r=-.662, p<.001), dispositional mindfulness (r=-.584, p<.001), psychological flexibility (r=-.530, p<.001) and mental ill-health.

This suggests that, as levels of coping self-efficacy, dispositional mindfulness, and psychological flexibility increase, levels of secondary trauma, burnout and mental ill-health decrease. This association was found to be strongest for coping self-efficacy, particularly in relation to mental ill-health and burnout. Similarly, coping self-efficacy was found to be most strongly associated with compassion satisfaction (r=.490, p<.001). Dispositional mindfulness (r=.385, p<.001) and psychological flexibility (r =.373, p=.001) were also found to be weakly associated with compassion satisfaction.

Spearman's correlation coefficients were also used to further examine inter-correlations between the psychological risk and resiliency variables.

Table 4.

Intercorrelations Between the Psychological Risk and Resiliency Variables

	1	2	3	4
1. Avoidant Attachment	-	-	-	-
2. Anxious Attachment	.644***	-	-	-
3. Coping Self-Efficacy	-.599***	-.500***	-	-
4. Dispositional Mindfulness	-.486***	-.428***	.710***	-
5. Psychological Flexibility	-.443***	-.539***	592***	.438***

*p<.001*** (2 tailed), N=78 for all analyses.*

Moderate to strong, highly significant negative correlations were found between both avoidant and anxious attachment style and all measures of individual psychological resiliency characteristics (coping self-efficacy, dispositional mindfulness, and psychological flexibility).

Discussion

The aim of the study was to examine individual characteristics, secondary trauma, and burnout in police specialist sexual and violent offending teams. Three research questions were constructed to enable a risk and resiliency analysis of the associations between the variables.

Research question one examined what levels of secondary trauma, burnout, and compassion satisfaction were present. Levels were found to be in the mild, average, and high average ranges respectively. No significant gender differences were found. While the findings appear contrary to the well-recognised existence of secondary trauma and burnout in the helping professions (Elliott & Daley; Tehrani, 2010), they fit with the low prevalence reported in recent studies using specialist police samples (Tehrani, 2016; Turgoose et al., 2017). Therefore, the findings add to a mixed wider literature, showing that a high proportion of specialist police staff cope well with demands of their work (Perez, Jones, Englert, & Sachau, 2010; Powell et al., 2014; Wolak & Mitchell, 2009) alongside reports of a variety of trauma and burnout related difficulties (Burns, Morley, Bradshaw, & Domene, 2008; Krause, 2009; Perez et al., 2010; Powell, Cassematis, Benson, Smallbone, & Wortley, 2015; Wolak & Mitchell, 2009). As the sample had high average levels of compassion satisfaction, it may be the case this provided resiliency from secondary trauma and burnout, which would fit with Stamm's (2002) assertion.

Research question two examined associations between length of service in specialist policing (current role and total) and levels of secondary trauma, burnout, and compassion satisfaction. Length of service in current role was found to be weakly and significantly associated with increased levels of secondary trauma and burnout (stronger for burnout). A weak relationship with decreased levels of compassion satisfaction was not found to be significant. When examined by total length of service, associations were not found to be significant, other than a weak association with decreased levels of compassion satisfaction. Together this suggests that,

as length of service increases, the weak association with increased levels of secondary trauma and burnout does not remain. This does not support a cumulative stress model (Figley, 1995).

However, while it may be the case police staff develop improved ways to cope, it cannot be inferred this is due to the mitigating influence of compassion satisfaction (Stamm, 2002). These findings fit with Turgoose et al. (2017) who found levels of secondary trauma and burnout increased with length of service in current role, but not with overall experience. They suggested this was related to working with rape victims in current role. This study is unable to confirm this suggestion as the total sample used in analyses included staff from a variety of specialist sexual and violent offending teams (to increase statistical power). Further research is needed to examine how and why levels of secondary trauma, burnout and compassion satisfaction change with length of service, including whether this differs by specialist police role. The findings of research question three enabled inferences to be made regarding the role of specific risk and resiliency factors in this relationship.

Research question three examined which attachment style and individual characteristics were most associated with secondary trauma, burnout, compassion satisfaction, and mental ill-health. Regarding attachment style, increased levels of attachment insecurity (anxious and avoidant) were associated with increased levels of secondary trauma, burnout and mental ill-health (most strongly for burnout and mental ill-health). This fits with attachment theory and research, which highlights insecure attachment as a risk factor in poor psychosocial functioning (Mikulincer & Florian, 1998). However, the finding that the association was strongest for avoidant attachment style contrasts with the existing PTSD literature, which suggests a stronger negative impact of anxious attachment style (Woodhouse, Ayers, & Field, 2015). While it was found that increased attachment insecurity was negatively associated with compassion satisfaction, this relationship was not significant. It may be the common difficulties associated

with attachment insecurity (e.g. self-regulation and difficulties in close relationships) do not have a significant impact on a person's capacity for compassion in the workplace. Furthermore, this may have been compounded by the ECR-R measure of attachment used, which focuses on romantic relationships.

Strong and moderate correlations showed increased levels of the hypothesised psychological resiliency variables (coping self-efficacy, dispositional mindfulness, and psychological flexibility) were significantly associated with decreased levels of secondary trauma, burnout, and mental ill-health. This relationship was strongest for coping self-efficacy, particularly with decreased burnout and mental ill-health.

Positive, highly significant correlations were also found between the resiliency variables and compassion satisfaction. Intercorrelations between the psychological risk and resiliency variables showed moderate to strong, highly significant negative correlations between insecure attachment style (both avoidant and anxious) and the hypothesised psychological resiliency variables (most strongly for coping self-efficacy and avoidant attachment across all the correlations).

The findings of research question three fit with the wider literature on psychological wellbeing (Tugade et al., 2004) and provide a potentially valuable basis to enhance resiliency against secondary trauma, burnout and mental ill-health in the helping professions. Further research is needed to estimate the magnitude and significance of hypothesised causal connections between the individual characteristics variables, secondary trauma, burnout and compassion satisfaction.

Methodological limitations must be considered when discussing the findings of the study. The main limitation concerns the analytic strategy employed. As with all correlational studies, causation cannot be inferred from the observed relationships between the variables. The study

data was collected using an online self-report questionnaire survey. While the limitations of such methods are well-established (e.g. question misinterpretation and demand characteristics), they provide the opportunity to gain access to (potentially large) under-researched populations, such as specialist police samples.

Several practice implications for the police arise from the study. While levels of secondary trauma and burnout were found to be in the mild ranges, it remains the case that specialist police staff are vulnerable to the development of these difficulties due to the inherently challenging nature of their work (Powell et al., 2015). The prevalence of stress, anxiety and depression amongst police staff is increasingly recognised as a major issue, with psychological reasons being the main cause of long-term sickness absence in the UK (Dowling, Chesworth, & Goldberg, 2017; Ingram, 2014; Pugh, 2016). Therefore, there is a need for police and crime commissioners to implement policies and practices that attend to the high risk of secondary trauma, burnout and mental ill-health in police forces by ensuring staff are screened, educated and supported in developing resilience (Tehrani, 2016).

The results of the study provide support for the increased use of psychological approaches in recruiting and supporting police staff in the workplace, particularly methods to promote mindfulness and self-efficacy. Mindfulness-based interventions have been used widely in occupational settings (Lomas et al., 2017). In 2015, the mental health charity MIND launched the 'Blue Light' mental health programme for emergency workers, which draws upon cognitive-behavioural therapy and mindfulness approaches. Wild (2016) conducted an RCT evaluation of the group-based six session resilience intervention. Police staff rated mindfulness as being the most helpful topic. However, results showed no significant differences in levels of self-efficacy. It was concluded the intervention may not be cost effective in its current form

and suggested further refinements should focus on targeting the predictors of resilience and mental ill-health.

Regarding refinements, the present study suggests it may be beneficial to use acceptance and commitment therapy (ACT) approaches in promoting resilience against work-related stress and mental ill-health. The general aim of ACT is to increase psychological flexibility (Hayes, Levin, Plumb-Vilardaga, Villate, & Pistorello, 2013). An evaluation of an ACT training programme designed to promote staff wellbeing and resilience (including mindfulness and values-based action) reported there was convincing evidence for the efficacy of the programme with NHS staff (Jennings, Whipday, Egdell, Pestell, & Flaxman, 2016). To a lesser extent, the findings also indicate the potential value of attachment-based approaches in the workplace. Recent research has suggested that models of burnout and work engagement would be more effective if they incorporated employees' perceptions and behaviour associated with attachment style, including how these influence interactions with colleagues and clients (Leiter, Day, & Price, 2015).

The findings of the study provide a novel and potentially valuable basis from which to conduct future research. Regarding the above suggestions, it would be necessary for evaluation to be conducted regarding the efficacy of interventions and support packages. Studies using longitudinal designs would enable understanding of how levels of secondary trauma, burnout and mental ill-health change over time. This being particularly relevant for length of service in specialist policing.

In conclusion, a resilient police work force is crucial in maintaining operational effectiveness in the current UK climate of police cuts. Knowledge of psychological risk and resiliency factors can potentially improve staff wellbeing and promote optimum performance (Hesketh, Cooper, & Ivy, 2015).

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Chapter 3 – Contributions to Theory and Clinical Practice

Abstract

The current thesis has explored individual and interpersonal risk and resiliency factors in primary and secondary trauma. The systematic review examined the role of social cognition in the relationship between attachment style and post-traumatic stress disorder (PTSD). It also considered whether associations differed by attachment style. The empirical study investigated individual characteristics, secondary trauma, and burnout in police sexual and violent offending teams. This paper will discuss the implications of findings for future research, theory development, and clinical practice.

Implications for Future Research and Theory Development

The existing trauma literature clearly highlights an interesting phenomenon - not everybody who experiences a traumatic event develops PTSD (Ozer & Weiss, 2004). Similarly, there is variability in the prevalence and severity of secondary trauma and burnout in the helping professions (Elwood, Mott, Lohr, & Galovski, 2011). This demonstrates that responses to traumatic stress vary greatly. Ascertaining the reasons for this is one of the key objectives in current PTSD research (Ozer & Weiss, 2004).

Collective Findings

The systematic review and empirical study of the current thesis aimed to contribute to the existing evidence-base by exploring individual and interpersonal risk and resiliency factors in primary and secondary trauma. The systematic review found support for the mediating role of social cognition in the relationship between attachment style and PTSD. The empirical study inferred coping self-efficacy, dispositional mindfulness, and psychological flexibility as individual resiliency factors against secondary trauma, burnout, and mental ill-health. Collectively, the findings suggest that attachment style may serve as an individual and interpersonal risk or resiliency factor in both primary and secondary trauma.

Empirical Study

The potential for secondary trauma and burnout in the helping professions is well recognised (Elliott & Daley, 2012; Tehrani, 2010). Additionally, mental ill-health is now the main reason for police staff requiring long-term sickness absence in areas of the UK (Dowling, Chesworth, & Goldberg, 2017; Ingram, 2014; Pugh, 2016). However, despite the challenging nature of specialist sexual and violent offending police work, these staff remain an under-researched population (Turgoose, Glover, Barker, & Maddox, 2017).

The empirical study investigated individual risk and resiliency factors in the context of secondary traumatic stress, including burnout and mental ill-health, using a sample of specialist police staff (*N*=78). The results showed higher levels of coping self-efficacy, dispositional mindfulness, and psychological flexibility were associated with decreased levels of secondary trauma, burnout, and mental ill-health. Conversely, participants with self-reported insecure attachment style (both anxious and avoidant) showed higher levels of secondary trauma, burnout, and mental ill-health. Additionally, anxious and avoidant attachment styles were found to be negatively associated with the individual resiliency factors (i.e. coping self-efficacy, dispositional mindfulness, and psychological flexibility).

Systematic Review

Historically, PTSD has been conceptualised and treated focusing on individual symptomatology (Maerkcer & Hecker, 2016). Broadly, the systematic review was focused upon the interpersonal impairments associated with PTSD (Charuvastra & Cloitre, 2008). It aimed to add to existing literature that has explored psychosocial functioning in PTSD using attachment theory and socio-cognitive models.

The review found evidence that social cognition mediates the relationship between attachment style and PTSD. This provided support for socio-cognitive models of PTSD (Sharp, Fonagy, & Allen, 2012). Furthermore, it was concluded that insecure attachment style appears to be a risk factor in PTSD. It may also be tentatively inferred that secure attachment is a resiliency factor based on the underlying assumptions of attachment theory (Cassidy, Jones, & Shaver, 2013). Due to the heterogeneity of studies reviewed, it was not possible to determine whether associations differed according to anxious or avoidant insecure attachment styles.

The review was novel in systematically examining the under-researched role of social cognition in the relationship between attachment and PTSD. The findings fit with two recent reviews that have synthesised the attachment and PTSD literature (Barazzone, Santos, McGowan, & Donaghay-Spire, 2018; Woodhouse, Ayers, & Field, 2015). However, the findings must be interpreted with caution due to the small number of heterogeneous studies included (*N*=6). It is important for this discussion paper to acknowledge this limitation. Despite this, the systematic review provides clear suggestions for future research and findings can be considered alongside those of the empirical study.

Social Cognition Studies

The systematic review clearly demonstrates there is a paucity of studies examining the mediating and/or moderating role of social cognition in the relationship between attachment style and PTSD. This is likely to be related to a lack of consensus on the definition and measurement of the social cognition construct (Pinkham et al., 2014). Experts in the field have stated that 'social cognition means different things to different people' and 'represents a diversity of interests' (Frith & Blakemore, 2006). While in broad terms the review supported the Sharp et al. (2012) mentalization-based socio-cognitive model, individual findings suggest that various aspects of social cognition are likely to interact and influence the interpersonal impairments associated with PTSD, including negative self-cognitions (Arikan, Stopa, Carnelley, & Karl, 2016), low interpersonal competence (Bistricky et al., 2017), object relations variables (Ortigo, Westen, DeFife, & Bradley, 2013), and mentalization (Venta, Hatkevich, Mellick, Vanwoerden, & Sharp, 2017). Therefore, future studies are needed to better understand how attachment-influenced socio-cognitive processes may help or hinder socially adaptive responses to trauma.

A review by Lanuis, Bluhm, and Frewen (2011) outlined how a SCAN approach (social cognitive and affective neuroscience) can be used to understand the neurobiology of trauma and how this influences socio-cognitive processes. They specified the most common socio-cognitive difficulties involved with complex PTSD: problems in emotional/self-awareness, emotion-regulation, social emotional processing, and self-referential processing. It was stated that a core set of brain regions appear to mediate these processes: the cortical midline structures, amygdala, insula, posterior parietal cortex and temporal poles. Therefore, it was suggested that problems in one area (e.g. emotional awareness) may be linked to difficulties in another (e.g. self-referential processing). It was concluded that future research should not only focus on PTSD symptomatology, but also on underlying socio-cognitive deficits and the effect of treatment on these.

Attachment Style Studies

Collectively, the findings of the systematic review and empirical study suggest that attachment style may serve as an individual and interpersonal risk or resiliency factor in both primary and secondary trauma. This fits with the broader attachment theory and psychological health literature (Mikulincer & Shaver, 2012). However, it should be noted that the findings of the empirical paper showed that insecure attachment style was more associated with burnout and mental ill-health than secondary trauma. Therefore, further investigation of the associations between attachment style, workplace stress, and mental health is warranted.

The systematic review outlined methodological limitations of assessed studies, including that all used cross-sectional designs. It would be beneficial for future studies to use longitudinal designs commencing early in the lifespan to clarify underlying mechanisms of causality and directionality. For example, this would enable a better understanding of the impact of interactions between attachment style and traumatic experiences on psychosocial functioning.

Ongoing debate exists regarding the malleability of adult attachment style. This has important implications for trauma research and clinical practice (Woodhouse et al., 2015). Primarily, attachment theory asserts that adult attachment styles have their origins in early caregiver relationships and are retained throughout the life course. This is referred to as a prototype model (Fraley, 2002). However, more recently, researchers have suggested it is unlikely that early life experiences are the single most important factor in influencing adult attachment style (Fraley & Roisman, 2018). This can be considered a revisionist model (Fraley, 2002). A recent paper by Fraley and Roisman (2018) has outlined four key lessons on the development of attachment styles while acknowledging the need for revision based on new findings. The current thesis suggests it would be beneficial for future attachment-informed trauma research to be guided by these lessons as part of theory development.

Lesson 1: Adult attachment styles do appear to have their origins in early life interpersonal experiences. However, longitudinal data has shown this is influenced by various aspects of early caregiving environments, not just parental relationships (e.g. chronic familial instability). However, so far, findings of these associations have been relatively small in magnitude and lack consistency across early experiences predictors.

Lesson 2: 'Person-driven effects' become more relevant throughout human development. Attachment theory assumes both socialisation (i.e. environment to person effects) and selection (i.e. person to environment effects). These two processes are considered to be differentially active at different points in the life course. For example, socialisation is likely to exert more of an influence in childhood, whereas selection effects increasingly play a more significant role as a person ages. This is described as 'socialisation-selection asymmetries'.

Lesson 3: 'Foundations are not fate'. Research and theory emphasises that the brain is most malleable during early life. While this explains the impact of caregiver relationships on

attachment style, it also suggests that the neuroplasticity of the developing brain can be influenced by multiple, possibly competing, experiences. In statistical terminology, the effect sizes of isolated early caregiver relationships may be small.

Lesson 4: More research is needed. The first lesson suggests that, due to divergent interpersonal experiences, people are able to develop relationship-specific attachment styles (i.e. secure attachments in romantic relationships but insecure in parental relationships). More research is needed to examine how changes in specific relational contexts may or may not translate into others (i.e. relationships with colleagues). The second lesson suggests that a person's adult attachment style may be better understood in terms of more recent interpersonal experiences rather than distal/early life ones. The third lesson is linked to the possible value of using epigenetic studies to better understand the influence of gene-environment processes in attachment relationships and interpersonal functioning.

Implications for Clinical Practice

It is necessary to acknowledge that suggestions for the application of the thesis findings in clinical practice are made tentatively. This is primarily due to the novel line of enquiry followed in the systematic review, resulting in the inclusion of only six studies, all cross-sectional and with other methodological limitations. Additionally, the empirical study employed a cross-sectional design. However, when the findings are considered collectively, it is possible to place them within the wider psychological literature and make suggestions for clinical practice on this basis.

Workplace Wellbeing for the Helping Professions

The results of the empirical study have potentially valuable clinical implications in terms of workplace wellbeing for the helping professions. The findings enable provisional suggestions to be made for the psychological support of an under-researched staff group who are 'at risk' of work-related psychological distress – specialist police staff. Psychologically-informed interventions may promote positive outcomes in three main areas: improved wellbeing and resilience for staff themselves, reduced sickness absence for the organisations they work for, and indirect benefits for users of police services due to improved service.

An increasing evidence-base demonstrates the potential for psychologists to work alongside other organisations to use psychological theories and models to improve staff wellbeing in at-risk helping professions. A recent study by Turgoose et al. (2017) involved delivery of a brief training intervention aimed to educate and reduce compassion fatigue in police staff. Outcome measures showed the training was well received and knowledge improved.

Additionally, in 2015, the mental health charity MIND launched the 'Blue Light' mental health programme for emergency workers. This group-based resilience intervention draws upon

cognitive-behavioural therapy and mindfulness approaches. It also includes a focus on self-efficacy. However, an RCT evaluation concluded it may not be cost-effective in its current form and suggested that further refinements should focus on targeting the predictors of resilience and mental ill-health (Wild, 2016).

Mindfulness, Psychological Flexibility and Coping Self-Efficacy

The findings of the empirical study have the potential to inform refinements to existing helping professions' support and resiliency interventions. The correlational analysis showed an almost identical pattern of associations between the psychological resiliency variables and the specific workplace stress measures - secondary trauma and burnout (more so for burnout), as they did with the general measure of current mental ill-health (The General Health Questionnaire-12; Goldberg, 1992). This suggests it may be useful for interventions to simultaneously focus on both areas, particularly due to the overlap between constructs and the interplay between work-life wellbeing.

Mindfulness-based interventions have already been widely used and well received in a variety of workplace settings (Lomas et al., 2017). While the study findings support the ongoing use of mindfulness approaches, they also suggest it would be useful to focus on enhancing coping self-efficacy and psychological flexibility. Despite crossover between mindfulness and psychological flexibility, the empirical study used an acceptance and commitment therapy (ACT) measure of the latter (The Acceptance and Action Questionnaire-II; Bond et al., 2011). A recent evaluation of an ACT training programme designed to promote staff wellbeing and resilience concluded there was convincing evidence for its effectiveness with NHS staff (Jennings, Whipday, Egdell, Pestell, & Flaxman, 2016). Using an ACT approach with police staff may be conducive due to the emphasis placed on committed action and values. Police staff are known to join the force at an early age and remain for the majority of their working

lives (Kiely & Peek, 2002). This suggests that police staff value and are committed to their role as public servants. Additionally, police are required to adhere to organisational ethical codes, such as The Competency and Values Framework (College of Policing, 2017). It may also be the case that a more proactive ACT approach to wellbeing could potentially increase coping self-efficacy.

Attachment in the Workplace

The empirical study was unique in its combined consideration of attachment style and individual characteristics and their associations with workplace stress and mental health. Despite a substantial evidence-base demonstrating the impact of attachment style on interpersonal dynamics and psychological wellbeing, its application in workplace settings is relatively under-researched (Harms, 2011). Scrima, Di Stefano, Guarnaccia, and Lorito (2015) examined the impact of adult attachment style on organisational commitment and attachment in the workplace. Results showed that securely attached individuals perceived more positive workplace relationships and had less worry about their jobs. In contrast, individuals with preoccupied (i.e. anxious) attachment styles reported a fear of rejection and beliefs their colleagues did not trust them. Individuals with avoidant attachment styles reported feeling uncomfortable with being depended on by colleagues.

Additionally, Leiter, Day, and Price (2015) investigated the impact of attachment style in the workplace using a large sample of Canadian healthcare staff (N=1624). They developed and validated a new measure of anxious and avoidant attachment styles in the workplace (The Short Workplace Attachment Measure). Results showed that anxious attachment style was associated with workplace perceptions of incivility, exhaustion, and cynicism. Avoidant attachment style was negatively associated with perceptions of civility, psychological safety, and trust. It was concluded that models of burnout and work engagement would be more effective if they

incorporated employees' perceptions and behaviour associated with attachment style, including how these influence interactions with colleagues and clients.

Attachment Approaches

Currently, in the UK, National Institute for Health and Care Excellence Guidance for PTSD (NICE, 2005) recommends (trauma-focused) cognitive-behavioural therapy and eye movement desensitisation and reprocessing (EMDR). However, experts in the field of traumatic stress have highlighted that current intrapersonally-focused evidence-based therapies are not always successful in the 'real world' treatment of PTSD, particularly for complex and comorbid cases (Lab, Santos, & de Zulueta, 2008). Suggestions have been made for the increased use of attachment-informed assessment, formulation, and treatment of PTSD; for example, interventions focusing on the development of stable and positive attachment representations. Such approaches are intended to complement rather than replace existing intrapersonally-focused evidence-based treatments (Karatzias et al., 2018).

The current thesis provides a basis from which to consider the possible clinical integration of 'third wave' therapies (e.g. mindfulness and ACT) with attachment and interpersonal methods. A recent paper by Salande and Hawkins (2017) considered associations between the theoretically differing constructs of psychological flexibility, attachment style, and personality organisation. They provided a rationale for integrating relational approaches (attachment-based and psychodynamic) with ACT and mindfulness intrapersonal approaches. Specific suggestions were made, such as the use of interventions focused on increasing psychological flexibility within interpersonal patterns and relational dynamics. They highlighted that relational and third wave approaches share a similarity in terms of the therapeutic focus not being to change what the client thinks or feels, but on how they experience internal events and

their social context. They discuss that an integrative method could assist therapists in understanding clients in their full intrapersonal and interpersonal context.

Socio-Interpersonal Model

The implications for future research, theory development, and clinical practice discussed in this paper can be considered as part of the case made by Maercker and Hecker (2016) for a socio-interpersonal perspective on PTSD. Their socio-interpersonal model proposes an interpersonal view of the processes that occur in the aftermath of traumatic experiences. Based on social psychology, the model emphasises that a person exists within three levels of social contexts. The first level refers to the intrapersonal impact of traumatic experiences, such as individual PTSD symptomatology. The second level focuses on close relationships and the need for social bonds in the interpersonal processing of trauma (i.e. support and disclosure). The third level represents a person's belonging at a 'distal social level' to societal organisations, including religious groups and health systems. The model specifies that how a person interacts interpersonally and on a wider social level is highly relevant to the development and maintenance of PTSD. The authors conclude that chances of successful treatment are improved through the consideration of a person in their social context.

The findings of the current thesis fit within the socio-interpersonal model in terms of the empirical study focusing upon individual characteristics associated with secondary trauma (first intrapersonal level), the systematic review exploring social-cognition in PTSD based upon attachment theory (second interpersonal level), and the focus on workplace trauma and wellbeing (third level).

Conclusion

The current thesis explored individual and interpersonal risk and resiliency factors in primary and secondary trauma. This discussion paper considered the implications of findings for future research, theory development and clinical practice. The key suggestions for future research focused upon the need for further social cognition studies to better understand the relationship between attachment style and PTSD. The possible value of a social cognitive and affective neuroscience approach was outlined as part of this. Throughout the discussion, the findings of both the systematic review and empirical study were contextualised within the theoretical framework of attachment theory. Suggestions were made for the implementation of findings within clinical practice. The potential value of third wave therapy approaches – mindfulness and ACT – were referenced as being beneficial in workplace wellbeing interventions for the helping professions. Additionally, attachment-based approaches were considered as a viable complement to existing intrapersonally-focused evidence-based treatments for PTSD. The possible integrated use of third wave and attachment-based approaches was also presented. The socio-interpersonal perspective on PTSD was referenced as encapsulating the aim and findings of the current thesis.

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Appendices

Appendix 1. Bangor University School of Psychology Ethical Approval Confirmation

ethics@bangor.ac.uk

Tue 04/07/2017, 15:27
Dear Clarabella,

2017-16029 Individual characteristics, secondary traumatic stress, and occupational burnout in North-Wales police specialist sexual and violent offending teams.

Your research proposal number 2017-16029
has been reviewed by the Psychology Ethics and Research Committee
and the committee are now able to confirm ethical and governance approval for the above research on the basis described in the application form, protocol and supporting documentation. This approval lasts for a maximum of three years from this date.

Ethical approval is granted for the study as it was explicitly described in the application

If you wish to make any non-trivial modifications to the research project, please submit an amendment form to the committee, and copies of any of the original documents reviewed which have been altered as a result of the amendment. Please also inform the committee immediately if participants experience any unanticipated harm as a result of taking part in your research, or if any adverse reactions are reported in subsequent literature using the same technique elsewhere.

Appendix 2. Betsi Cadwaladr University Health Board Research and Development Ethical Approval Confirmation

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Panel Arolygu Mewnol Y&D
R&D Internal Review Panel

Betsi Cadwaladr University Health Board
Ysbyty Gwynedd
Clinical Academic Office
Bangor, Gwynedd
LL57 2PW

Chairman/Cadeirydd – Dr Nefyn Williams PhD, FRCGP
Email: rossela.roberts@wales.nhs.uk
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Miss Clarabella Gray (Student)
North Wales Clinical Psychology Programme
Brigantia Building, School of Psychology
Bangor University
LL57 2DG Psp6ba@bangor.ac.uk

24th August 2017

Dear Miss Clarabella Gray

Re: Confirmation that R&D governance checks are complete / R&D approval granted

Study Title	North Wales Police Research - Individual characteristics, secondary traumatic stress, and occupational burnout in North-Wales police specialist sexual and violent offending teams.
IRAS reference	228176

Thank you for submitting your R&D application and supporting documents. The above research project was reviewed at the meeting of the BCUHB R&D Internal Review Panel

The Panel is satisfied with the scientific validity of the project, the risk assessment, the review of the NHS cost and resource implications and all other research management issues pertaining to the revised application. *A full list of documents included in the review is attached as an appendix.*

The R&D Office, on behalf of the Internal Review Panel, is pleased to confirm that all governance checks are now complete and to grant approval to proceed at Betsi Cadwaladr University Health Board sites as described in the application.

All research conducted at the Betsi Cadwaladr University Health Board sites must comply with the Research Governance Framework for Health and Social Care in Wales (2009). An electronic link to this document is provided on the BCUHB R&D WebPages. Alternatively, you may obtain a paper copy of this document via the R&D Office.

Attached you will find a set of approval conditions outlining your responsibilities during the course of this research. Failure to comply with the approval conditions will result in the withdrawal of the approval to conduct this research in the Betsi Cadwaladr University Health Board.

If your study is adopted onto the NISCHR Clinical Research Portfolio (CRP), it will be a condition of this NHS research permission, that the Chief Investigator will be required to regularly upload recruitment data onto the portfolio database. To apply for adoption onto the NISCHR CRP, please go to: http://www.wales.nhs.uk/sites3/page.cfm?orgid=580&pid=31979.

Once adopted, NISCHR CRP studies may be eligible for additional support through the NISCHR Clinical Research Centre. Further information can be found at: http://www.wales.nhs.uk/sites3/page.cfm?orgid=580&pid=28571 and/or from your NHS R&D office colleagues.

To upload recruitment data, please follow this link:
http://www.crncc.nihr.ac.uk/about_us/processes/portfolio/p_recruitment.
Uploading recruitment data will enable NISCHR to monitor research activity within NHS organizations, leading to NHS R&D allocations which are activity driven. Uploading of recruitment data will be

monitored by your colleagues in the R&D office. If you need any support in uploading this data, please contact debra.slater@wales.nhs.uk or sion.lewis@wales.nhs.uk

If you would like further information on any other points covered by this letter please do not hesitate to contact me. On behalf of the Panel, I would like to take this opportunity to wish you every success with your research.

Yours sincerely,

Dr Nefyn Williams PhD, FRCGP
Associate Director of R&D
Chairman Internal Review Panel

Copy to:

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Academic Supervisors:
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Dr Christopher Saville
NWCPP, Bangor School of Psychology
Brigantia Building
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Appendix 3. North Wales Police Ethical Approval Confirmation

From: [redacted]
Sent: 05 October 2017 12:17
To: [redacted]
Cc: [redacted]
Subject: Research Project

Hi [redacted]

Yes, this can be progressed as it has gone through our appropriate board.

[redacted]

Thanks for your patience.

[redacted]

Appendix 4. Participant Information Sheet

Participant Information Sheet

1. Study title
Individual characteristics, secondary traumatic stress, and occupational burnout in North-Wales Police specialist sexual and violent offending teams

2. Invitation to participate
You are being invited to take part in a research study. The work of police staff in specialist sexual and violent offending teams requires extensive exposure to potentially distressing material and subject matter. Naturally, there will be differences in how staff process and respond to the challenges of their work, based on their individual character traits (e.g. personal ways of thinking and behaving). The study aims to explore the relationship between individual characteristics in relation to how you experience your work and its impact on you. Before you decide whether or not to take part in the study, it is important you read through this Participant Information Sheet, as it will provide you with the information you need to make an informed decision.

3. What is the purpose of the study?
The development of secondary trauma (defined as the presence of stress-related symptoms through vicarious experience) is well established. Staff in specialist sexual and violent offending teams are routinely involved in complex and challenging work, often for lengthy periods. Therefore, they may be particularly vulnerable to developing secondary trauma and related occupational stress. However, more recently, research examining the wellbeing of police staff has focused upon the role of protective factors (such as psychological resilience) in mitigating the effects of stress associated with workplace trauma. This exploratory study aims to build on existing research by examining the relationship between individual characteristics, secondary traumatic stress, and occupational burnout in police staff who work in specialist sexual and violent offending teams.

4. Who is conducting the research?
Ms. Clarabella Gray is a Trainee Clinical Psychologist with the North Wales Clinical Psychology Programme (NWCPP) at the University of Bangor, Wales. The anonymised results of the study will form part of a research thesis submitted by Ms. Clarabella Gray in partial fulfilment of her Doctoral studies with the NWCPP. The study is being supervised by Dr. Michelle Rydon-Grange (Senior Clinical Psychologist) and Dr. Julia Wane (Consultant Clinical Psychologist) based at The Tŷ Llywelyn Medium Secure Service, Bryn-y-Neuadd Hospital, Llanfairfechan, Conwy, LL33 OHH.

5. Who is funding and organising the research?
The research is being organised and funded by the North Wales Clinical Psychology Programme at Bangor University.

6. Why have I been chosen?
You have been invited to take part in the study because you work within a North-Wales Police specialist sexual and violent offending team. All police staff working within these specialist teams have been invited to participate.

7. Do I have to take part in the study?
No. It is up to you whether or not you take part. Before you decide whether you will take part, we ask you to read this Participant Information Sheet. If there is anything that is not clear or if you would like more information, please contact a member of the research team (contact details are

provided at the end of this sheet). If you decide not to take part, **you do not need to give a reason**.

8. What will happen if I do take part?
As part of making an informed decision about taking part, please make sure you have read this Participant Information Sheet carefully. If you choose to participate, please use the below link to access the online study:

https://bangor.onlinesurveys.ac.uk/police_psychology

Upon accessing the link, you will be presented with a Consent Form, which you must complete in order to confirm you have made an informed decision to take part. By completing the Consent Form you are giving consent for your anonymised data to be used in the study. **Withdrawal is not possible after this action**. If you do confirm your consent you will then be able to access the study questionnaires. Taking part in the study will take approximately 60 minutes of your time. You are required to answer all of the questions included in the questionnaires. This Participant Information Sheet is for you to keep for your reference.

The questionnaires are available in English only. Unfortunately, it was not possible for them to be translated due to potential issues in losing critical aspects of their meaning.

9. Will my information be kept confidential?

Yes. Any information collected about you during the study will be kept strictly confidential. Your data (consisting of the responses you provide on the electronic questionnaires) will be collected automatically via the computer. You are not required to provide your name. Your organisation will not have access to the online study at any time. While the data you provide will be subject to statistical analyses, individuals will not be identifiable in any study reports.

10. What are the possible disadvantages of taking part?

This study does not involve any direct risks. You will have to spend some time reading this Participant Information Sheet and completing the questionnaires. Some staff may also become distressed as a consequence of thinking about some of the stressors they experience at work. However, it is anticipated that this has a limited likelihood of occurring. If you find yourself in this unlikely position, there are contact details of support services provided by your employer in the Debriefing Information Sheet that will appear on the screen upon completion of the study questionnaires. If for any reason you are concerned about your personal well-being, it is recommended you seek appropriate professional advice.

11. What are the benefits of taking part?
It is hoped that the information gathered in the study will help inform the development of interventions aimed at supporting specialist police staff in their difficult work and reducing occupational burnout. The information you provide will help increase awareness of police staff well-being, as well as having the potential for this to inform the development of specific support packages for police staff in wider teams and contexts.

12. What will happen to the results of the study?
The data will be used for academic research publications in the form of journal articles and/or conference presentations. You will not be identifiable in any research publications. The data collected will be published in the form of group averages, and no reference to individual participant scores will be made. If you decide to participate in the research study, you will receive a brief summary report once the study is completed (approximately November 2018), explaining the main results of the study.

13. Who has reviewed the study?
All research conducted by NHS employees is looked at by an independent group of people, called a Research Ethics Committee. This study has been reviewed and given a favourable opinion by the

Wales Research Ethics Committee. A research panel at the School of Psychology, Bangor University has also reviewed the study and provided a favourable ethical opinion.

14. What if something goes wrong?

If you have a concern about any aspect of this study, you should speak to the researcher, who will do her best to answer your questions. You should contact Ms. Clarabella Gray at psp6ba@bangor.ac.uk. You can also contact:

1) Dr. Michelle Rydon-Grange, Senior Clinical Psychologist on 01248 682 129, or email Michelle.Rydon-Grange@wales.nhs.uk
2) Dr. Julia Wane, Consultant Clinical Psychologist on 01248 682 129 email Julia.Wane@wales.nhs.uk

If you remain unhappy about the research and/or wish to raise a complaint about any aspect of the way that you have been approached or treated during the course of the study, please contact Mr. Hefin Francis, who is the Bangor University contact for complaints regarding research, at the following address:

Mr. Hefin Francis
School Manager
School of Psychology
Bangor University
Gwynedd, LL57 2AS
Email: h.francis@bangor.ac.uk
Telephone: 01248 388 339

15. Contacts for further information

If you have any questions, or would like more information about the study, then please do not hesitate to contact either myself or my supervisor(s), using the details below.

Ms. Clarabella Gray
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We would like to thank you for reading this Participant Information Sheet and for considering taking part in the research study.

1. Teitl yr astudiaeth

Nodweddion unigol, straen trawmatig eilaidd, a chwythu plwc galwedigaethol yn nhimau arbenigol troseddu rhywiol a threisgar Heddlu Gogledd Cymru

2. Gwahoddiad i gymryd rhan

Gwahoddir chi i gymryd rhan mewn astudiaeth ymchwil. Mae gwaith staff yr heddlu mewn timau arbenigol troseddu rhywiol a threisgar yn golygu amlygiad sylweddol i ddeunyddiau a thestunau a allai beri gofid. Wrth reswm, bydd gwahaniaethau yn sut y bydd staff yn prosesu ac yn ymateb i heriau eu gwaith, yn seiliedig ar nodweddion eu cymeriad unigol (e.e. ffyrdd personol o feddwl ac ymddwyn). Bwriad yr astudiaeth yw archwilio i'r berthynas rhwng nodweddion unigol mewn perthynas a'r profiad a gewch o'ch gwaith ac effaith hynny arnoch chi. Cyn i chi benderfynu a ydych am gymryd rhan yn yr ymchwil ai peidio, mae'n bwysig eich bod yn darllen y Daflen Wybodaeth i Gyfranwyr, gan ei bod yn rhoi'r holl wybodaeth y bydd arnoch ei hangen i wneud penderfyniad gwybodus.

3. Beth yw diben yr astudiaeth?

Mae datblygu trawma eilaidd (y diffiniad o hyn yw presenoldeb symptomau'n ymwneud â straen trwy brofiad dirprwyol) yn rhywbeth sydd wedi ei brofi. Mae staff mewn timau arbenigol troseddu rhywiol a threisgar yn ymwneud yn rheolaidd â gwaith cymhleth a heriol, yn aml am gyfnodau hir. Felly, efallai y byddant yn enwedig o agored i ddatblygu trawma eilaidd a straen sy'n gysylltiedig â'u galwedigaeth. Ond, yn fwy diweddar, mae ymchwil yn edrych ar les staff yr heddlu wedi canolbwyntio ar swyddogaeth ffactorau amddiffynnol (megis gwytnwch seicolegol) wrth liniaru effeithiau straen sy'n gysylltiedig â thrawma yn y gweithle. Bwriad yr astudiaeth ymchwiliol hon yw adeiladu ar ymchwil bresennol trwy archwilio'r berthynas rhwng nodweddion unigol, straen trawmatig eilaidd, a chwythu plwc galwedigaethol yn staff yr heddlu sy'n gweithio yn nhimau arbenigol troseddu rhywiol a threisgar.

4. Pwy sy'n cynnal yr ymchwil?

Seicolegydd Clinigol dan Hyfforddiant gyda Rhaglen Seicoleg Glinigol Gogledd Cymru, ym Mhrifysgol Bangor yw Ms Clarabella Gray. Bydd canlyniadau di-enw'r astudiaeth yn ffurfio rhan o thesis ymchwil a fydd yn cael ei gyflwyno gan Ms Clarabella Gray yn rhan o'i hastudiaethau Doethurol gyda Rhaglen Seicoleg Glinigol Gogledd Cymru. Bydd yr astudiaeth yn cael ei goruchwylio gan Dr Michelle Rydon-Grange (Uwch Seicolegydd Clinigol) a Dr Julia Wane (Seicolegydd Clinigol Ymgynghorol) yng Ngwasanaeth Diogelwch Canolig Tŷ Llywelyn, Ysbyty Bryn-y-Neuadd, Llanfairfechan, Conwy, LL33 OHH.

5. Pwy sy'n ariannu a threfnu'r ymchwil?

Trefnir ac ariannir yr astudiaeth hon gan Raglen Seicoleg Glinigol Gogledd Cymru, ym Mhrifysgol Bangor.

6. Pam rydw i wedi cael fy newis?

Rydych wedi cael gwahoddiad i gymryd rhan yn yr astudiaeth am eich bod yn gweithio mewn tîm arbenigol troseddu rhywiol a threisgar gyda Heddlu Gogledd Cymru. Mae pob aelod o staff yr heddlu sy'n gweithio yn y timau arbenigol hyn wedi cael eu gwahodd i gymryd rhan.

7. Oes rhaid i mi gymryd rhan yn yr astudiaeth?
Nac oes. Chi sydd i benderfynu a ydych am gymryd rhan ai peidio. Cyn i chi benderfynu a ydych am gymryd rhan, gofynnwn i chi ddarllen y Daflen Wybodaeth i Gyfranwyr. Os oes rhywbeth yn aneglur neu os hoffech ragor o wybodaeth, cysylltwch ag aelod o'r tîm ymchwil (mae eu manylion cyswllt ar ddiwedd y daflen hon). Os byddwch yn penderfynu peidio â chymryd rhan, nid oes rhaid i chi roi rheswm.

8. Beth fydd yn digwydd os byddaf yn cymryd rhan?
Wrth wneud penderfyniad gwybodus ynglŷn â chymryd rhan, gwnewch y siŵr eich bod wedi darllen y Daflen Wybodaeth i Gyfranwyr yn ofalus. Os penderfynwch gymryd rhan, defnyddiwch y ddolen isod i gael mynediad at yr astudiaeth ar-lein:

https://bangor.onlinesurveys.ac.uk/police_psychology

O glicio ar y ddolen, bydd Ffurflen Gydsynio yn agor, a rhaid i chi ei llenwi i gadarnhau eich bod wedi gwneud penderfyniad gwybodus i gymryd rhan. O lenwi'r Ffurflen Gydsynio rydych yn rhoi caniatâd i'ch data di-enw gael ei ddefnyddio yn yr astudiaeth. **Nid yw'n bosibl tynnu'n ôl ar ôl gwneud hynny**. Os ydych yn cydsynio yna bydd modd i chi gael mynediad at holiaduron yr astudiaeth. Bydd cymryd rhan yn yr astudiaeth yn cymryd tua 60 munud o'ch amser. Mae gofyn i chi ateb pob cwestiwn yn yr holiaduron. Mae'r Daflen Wybodaeth i Gyfranwyr i chi ei chadw er mwyn gallu cyfeirio ati eto.

Yn Saesneg yn unig y mae'r holiaduron i'w cael. Yn anffodus, nid oedd posibl eu cyfieithu oherwydd bod agweddau o'r ystyr mor dyngedfennol.

9. A fydd y wybodaeth amdanaf yn cael ei chadw'n gyfrinachol?

Bydd. Bydd unrhyw wybodaeth a gesglir amdanoch yn ystod yr astudiaeth yn cael ei chadw'n hollol gyfrinachol. Bydd eich data (a fydd yn cynnwys yr atebion y byddwch yn eu rhoi yn yr holiaduron electronig) yn cael ei gasglu yn awtomatig trwy'r cyfrifiadur. Nid oes angen i chi roi eich enw. Ni fydd gan eich sefydliad fynediad at yr astudiaeth ar-lein ar unrhyw adeg. Er y bydd y data a roddir gennych yn cael ei ddadansoddi'n ystadegol; ni fydd modd adnabod unigolion yn unrhyw un o adroddiadau'r astudiaeth.

10. Beth yw'r anfanteision posib o gymryd rhan?

Nid yw'r astudiaeth yn cynnwys unrhyw risgiau uniongyrchol. Bydd rhaid i chi dreulio ychydig o amser yn darllen y Daflen Wybodaeth i Gyfranwyr ac yn llenwi'r holiaduron. Gall meddwl am y pethau sy'n achosi straen iddynt yn y gwaith beri gofid i rai aelodau staff. Fodd bynnag, rhagwelir nad yw hynny'n debygol o ddigwydd. Os gwelwch eich bod yn y sefyllfa annhebygol hon, mae rhifau cyswllt y gwasanaethau cefnogi a ddarperir gan eich cyflogwr i'w cael yn y Daflen Wybodaeth wrth Adrodd yn Ôl a fydd yn ymddangos ar y sgrin wedi i chi orffen llenwi holiaduron yr astudiaeth. Os ydych yn pryderu am eich lles personol am unrhyw reswm, fe'ch anogir i geisio cyngor proffesiynol priodol.

11. Beth yw manteision cymryd rhan?
Gobeithir y bydd y wybodaeth a gesglir yn yr astudiaeth hon yn helpu i lywio'r gwaith o ddatblygu ymyriadau i gefnogi staff arbenigol yr heddlu wrth eu gwaith anodd a lleihau chwythu plwc galwedigaethol. Bydd y wybodaeth ar roddwch o gymorth i gynyddu ymwybyddiaeth o les ymysg staff yr heddlu, yn ogystal â'r posibilrwydd y bydd hyn yn llywio'r gwaith o ddatblygu pecynnau penodol o gefnogaeth i staff yr heddlu mewn timau a chyd-destunau ehangach.

12. Beth fydd yn digwydd i ganlyniadau'r astudiaeth?
Defnyddir y data ar gyfer cyhoeddiadau ymchwil academaidd ar ffurf erthyglau papur newydd a/neu gyflwyniadau cynhadledd. Ni fydd yn bosib eich adnabod o unrhyw gyhoeddiadau

ymchwil. Caiff y data a gesglir eu cyhoeddi ar ffurf cyfartaleddau grwpiau, a ni wneir unrhyw gyfeiriadau tuag at farciau cyfranwyr unigol. Os penderfynwch gymryd rhan yn yr astudiaeth ymchwil, byddwch yn derbyn adroddiad cryno byr unwaith y mae'r ymchwil wedi'i chwblhau (Tua mis Tachwedd 2018), yn egluro prif ganlyniadau'r astudiaeth.

13. Pwy sydd wedi adolygu'r astudiaeth?
Mae'r holl ymchwil a wneir gan weithwyr y GIG yn cael ei hystyried gan grŵp annibynnol o bobl, sef y Pwyllgor Moeseg Ymchwil. Mae'r astudiaeth hon wedi'i hadolygu a'i chymeradwyo gan Bwyllgor Moeseg Ymchwil Cymru. Mae panel ymchwil yn Ysgol Seicoleg, Prifysgol Bangor, hefyd wedi adolygu'r astudiaeth ac wedi rhoi cymeradwyaeth moeseg ar ei chyfer.

14. Beth os aiff rhywbeth o'i le?
Os ydych yn bryderus ynghylch unrhyw agwedd ar yr astudiaeth hon, dylech siarad â'r ymchwilydd a fydd yn gwneud ei gorau i ateb eich cwestiynau. Dylech gysylltu â Ms Clarabella Gray ar psp6ba@bangor.ac.uk. Gallwch gysylltu hefyd â:

1) Dr Michelle Rydon-Grange, Uwch Seicolegydd Clinigol ar 01248 682 129, neu e-bostio Michelle.Rydon-Grange@wales.nhs.uk
2) Dr Julia Wane, Seicolegydd Clinigol Ymgynghorol ar 01248 682 129 neu e-bostio Julia.Wane@wales.nhs.uk

Os ydych yn parhau i fod yn anhapus am yr astudiaeth ac/neu yn dymuno gwneud cwyn am unrhyw agwedd ar y ffordd y cawsoch eich gwahodd neu eich trin yn ystod yr astudiaeth hon, cysylltwch â Mr Hefin Francis, sef cyswllt Prifysgol Bangor ar gyfer cwynion sydd yn ymwneud ag astudiaethau, yn y cyfeiriad canlynol:

Mr Hefin Francis
Rheolwr yr Ysgol
Ysgol Seicoleg
Prifysgol Bangor
Gwynedd, LL57 2AS
E-bost: h.francis@bangor.ac.uk
Ffôn: 01248 388 339

15. Cysylltiadau am fwy o wybodaeth:
Os oes gennych unrhyw gwestiynau, neu os hoffech gael gwybodaeth bellach am yr astudiaeth, mae pob croeso i chi gysylltu â mi neu â'm goruchwyliwr(goruchwylwyr), yn defnyddio'r manylion isod:

Ms Clarabella Gray
Seicolegydd Clinigol dan Hyfforddiant
Rhaglen Seicoleg Glinigol Gogledd Cymru (NWCPP)
Ysgol Seicoleg
Adeilad Brigantia,
Bangor, Gwynedd
LL57 2DG
psp6ba@bangor.ac.uk

Dr Michelle Rydon-Grange
Uwch Seicolegydd Clinigol
Uned Diogelwch Canolig Tŷ Llywelyn
Ysbyty Bryn-y-Neuadd,
Llanfairfechan, Conwy, LL33 OHH
Michelle.Rydon-Grange@wales.nhs.uk

Dr Julia Wane
Seicolegydd Clinigol Ymgynghorol
Uned Diogelwch Canolig Tŷ Llywelyn
Ysbyty Bryn-y-Neuadd,
Llanfairfechan, Conwy, LL33 OHH
Julia.Wane@wales.nhs.uk

Individual characteristics, secondary traumatic stress, and occupational burnout in North-Wales police specialist offending teams.

Page 1: Consent Form/Ffurflen gydsynio

Please click each box if you agree with the statement

Cliciwch bob blwch os ydych yn cytuno â'r datganiad

1. I confirm that I have read and understood the Participant Information Sheet dated 02.07.17 (Version 1.2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

Rwy'n cadarnhau fy mod wedi darllen a deall y Daflen Wybodaeth i Gyfranwyr, dyddiedig 02.07.2017 (fersiwn 1.2), ar gyfer yr astudiaeth uchod. Rwyf wedi cael cyfle i ystyried y wybodaeth, i ofyn cwestiynau ac rwyf wedi cael atebion boddhaol iddynt.

- Yes

2. I understand that my participation in the study is voluntary and if I decide I do not want to take part, I do not have to give a reason and this will not result in any negative consequences for myself. I also understand that **withdrawal is not possible** after I have completed the study questionnaires and been debriefed.

Deallaf fy mod yn cymryd rhan yn yr astudiaeth o'm gwirfodd ac os penderfynaf nad wyf eisiau cymryd rhan, nid oes raid i mi roi rheswm ac ni fydd hyn yn arwain at unrhyw ganlyniadau negyddol i mi. Rwy'n deall hefyd **nad oes modd tynnu'n ôl** ar ôl cwblhau holiaduron yr astudiaeth a chael sesiwn adrodd yn ôl.

- Yes

3. I understand that the data I provide will be anonymous. I give permission for the research team to have access to my anonymised data.

Rwy'n deall y bydd y data y byddaf yn ei ddarparu yn ddi-enw. Rhoddaf ganiatâd i'r tîm ymchwil weld fy nata di-enw.

- Yes

4. I understand that the results of the study may be published and/or presented in journal articles and at conferences. I give permission for my

anonymised data to be disseminated in this way.

Deallaf y gellir cyhoeddi canlyniadau'r astudiaeth ac/neu eu cyflwyno mewn erthyglau mewn cyfnodolion ac mewn cynadleddau. Rwy'n rhoi caniatâd i ledaenu fy nata di-enw yn y modd hwn.

- Yes

5. I understand that a cookie will be installed on my computer to record my progress through the study and that it will not store any of my responses.

Deallaf y bydd cwci yn cael ei osod ar fy nghyfrifiadur i gofnodi fy nghynnydd yn ystod yr astudiaeth ac na fydd yn cadw unrhyw un o fy atebion.

- Yes

6. I hereby freely and fully consent to participate in the study, which has been fully explained to me.

Rwyf gan hynny yn cydsynio'n llwyr ac o'm gwirfodd i gymryd rhan yn yr astudiaeth, a eglurwyd yn llawn i mi.

- Yes

By clicking "Next" you are agreeing to the above statements and giving consent for your anonymised data to be used in the study. **Withdrawal is not possible after this action**. If you do not wish to participate please exit the questionnaire by closing your browser.

Trwy glicio "Nesaf" rydych yn cytuno â'r datganiadau uchod ac yn rhoi eich cydsyniad i ddefnyddio eich data di-enw yn yr astudiaeth. **Nid yw'n bosibl tynnu'n ôl ar ôl gwneud hynny**. Os nad ydych yn dymuno cymryd rhan dylech adael yr holiadur trwy gau eich porwr.

Page 2: Background Information Questionnaire

We would like to gather information about you in relation to the job you do and the team you work within. This will enable us to anonymously compare differences between police staff.

7. Age Group

- 21 and under
- 22-34
- 35-54
- 55 and over

8. Gender

- Male
- Female
- Non-binary/third gender
- Prefer not to say

9. Marital Status

- Single
- Cohabiting
- Married
- Separated
- Divorced
- Widowed

10. Do you have any dependent children living with you?

- Yes
- No

11. Do you have any other dependents living with you?

- Yes
- No

12. Ethnic Group

- White British
- White Irish
- White Other
- Black (African Origin)
- Black (Caribbean Origin)
- Black Other
- Asian (Indian Origin)
- Asian (Pakistani Origin)
- Asian (Bangladeshi Origin)
- Asian (Chinese Origin)
- Asian (Other)
- White and Black Caribbean
- White and Black African
- White and Asian
- Mixed Other
- Other Ethnic Group

13. On average, how many units of alcohol do you drink **per week?** (e.g. 1 unit=half a pint of lager **or** 1 small glass of wine **or** 1 single measure of spirit)

14. On average, how many cigarettes (or cigars) do you smoke **per week?**

15. On average, how many electronic cigarettes do you smoke **per week?**

16. How many cups/cans of caffeinated drinks do you consume **per day?** (e.g. tea, coffee, coke).

17. Do you currently experience any symptoms of mental ill health? (e.g. depression, anxiety)

- Yes
- No

18. Do you currently take prescription medication for mental ill health? (e.g. depression, anxiety).

- Yes
- No

19. Have any major life events happened to you in the last six months? (e.g. bereavement, divorce, marriage, having children, moving house, serious illness).

- Yes
- No

20. Have you ever attended a formal Mindfulness class or course? (Please put No if you have not heard of Mindfulness before).

- Yes
- No

20.a. If Yes, how long ago was this?

- Within the last 6 months
- 6-12 months ago
- Longer than 12 months ago

20.b. If Yes, do you still use what you were taught to manage workplace demands?

- Yes
- No

21. What specialist police team do you work for?

21.a. Your current grade?

22. **Length of time employed in current specialist policing role? (Years/Months)**

23. **Length of time employed in any specialist policing role? (Years/Months)**

24. **How many hours are you contracted to work per week?**

- 15 hours or less
- 16 to 25 hours
- 26 to 35 hours
- 36 to 44 hours
- 45 hours or more

25. **On average, how many hours over your contracted hours do you work per week?**

- None
- 1-2
- 3-5
- 6-9
- 10 hours or more

26. **Do you work shift hours?**

- Yes
- No

27. Have you been absent from work because of sickness in the past six months?

- Yes
- No

27.a. If so, how many days sickness absence have you had in the past six months?

28. How many hours supervision do you receive per month?

29. Do you feel you receive adequate supervision?

- Yes

○ No

30. Please make any additional comments in the space below about your job, organisation and/or the questionnaire or research study.

Page 3: Questionnaire 1

The statements below concern how you feel in emotionally intimate relationships. We are interested in how you generally experience relationships, not just in what is happening in a current relationship. Respond to each statement by selecting a number to indicate how much you agree or disagree with the statement.

31. I don't feel comfortable opening up to romantic partners.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

32. I'm afraid that I will lose my partner's love.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

33. It's easy for me to be affectionate with my partner.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

34. I worry that romantic partners won't care about me as much as I care about them.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

35. When my partner is out of sight, I worry that he or she might become interested in someone else.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

36. When I show my feelings for romantic partners, I'm afraid they will not feel the same about me.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

37. I find it relatively easy to get close to my partner.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

38. I do not often worry about being abandoned.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

39. I find that my partner(s) don't want to get as close as I would like.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

40. I often worry that my partner doesn't really love me.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

41. Sometimes romantic partners change their feelings about me for no apparent reason.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

42. My desire to be very close sometimes scares people away.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

43. I'm afraid that once a romantic partner gets to know me, he or she won't like who I really am.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

44. It makes me mad that I don't get the affection and support I need from my partner.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

45. I worry that I won't measure up to other people.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

46. My partner only seems to notice me when I'm angry.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

47. I prefer not to show a partner how I feel deep down.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

48. I feel comfortable sharing my private thoughts and feelings with my partner.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

49. I usually discuss my problems and concerns with my partner.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

50. I rarely worry about my partner leaving me.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

51. I find it difficult to allow myself to depend on romantic partners.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

52. I am very comfortable being close to romantic parters.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	

Lower	☐	☐	☐	☐	☐	☐	☐	Higher

53. I prefer not to be too close to romantic partners.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

54. I get uncomfortable when a romantic partner wants to be very close.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

55. I tell my partner just about everything.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

56. It's not difficult for me to get close to my partner.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

57. I feel comfortable depending on romantic partners.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

58. It helps to turn to my romantic partner in times of need.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

59. I talk things over with my partner.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

60. I worry a lot about my relationships.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

61. I am nervous when partners get too close to me.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

62. I often wish that my partner's feelings for me were as strong as my feelings for him or her.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

63. I find it easy to depend on romantic partners.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

64. My romantic partner makes me doubt myself.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

65. My partner really understands me and my needs.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

66. I often worry that my partner will not want to stay with me.

	1=Strongly Disagree	2	3	4	5	6	7=Strongly Agree	
Lower	☐	☐	☐	☐	☐	☐	☐	Higher

Page 4: Questionnaire 2

For each question, using the below scale, select a number from 0–10, to show how confident or certain you are that you can do the following when things aren't going well for you, or when you are having problems.

0=cannot do at all.....5=moderately certain can do.....10=certain can do

67. Keep from getting down in the dumps

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

68. Talk positively to yourself.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

69. Sort out what can be changed, and what can not be changed.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

70. Get emotional support from friends and family.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

71. Find solutions to your most difficult problems.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

72. Break an upsetting problem down into smaller parts.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

73. Leave options open when things get stressful.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

74. Make a plan of action and follow it when confronted with a problem.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

75. Develop new hobbies or recreations.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

76. Take your mind off unpleasant thoughts.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

77. Look for something good in a negative situation.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

78. Keep from feeling sad.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

79. See things from the other person's point of view during a heated argument.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

80. Try other solutions to your problems if your first solutions don't work.

	0	1	2	3	4	5	6	7	8	9	10	

Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

81. Stop yourself from being upset by unpleasant thoughts.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

82. Make new friends.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

83. Get friends to help you with the things you need.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

84. Do something positive for yourself when you are feeling discouraged.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

85. Make unpleasant thoughts go away.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

86. Think about one part of the problem at a time.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

87. Visualize a pleasant activity or place.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

88. Keep yourself from feeling lonely.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

89. Pray or meditate.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

90. Get emotional support from community organizations or resources.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

91. Stand your ground and fight for what you want.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

92. Resist the impulse to act hastily when under pressure.

	0	1	2	3	4	5	6	7	8	9	10	
Cannot do at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Certain can do

Page 5: Questionnaire 3

Please rate each of the following statements with the number that best describes your own opinion of what is generally true for you.

93. When I'm walking, I deliberately notice the sensations of my body moving.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

94. I'm good at finding words to describe my feelings.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

95. I criticize myself for having irrational or inappropriate emotions.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

96. I perceive my feelings and emotions without having to react to them.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

97. When I do things, my mind wanders off and I'm easily distracted.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

98. When I take a shower or bath, I stay alert to the sensations of water on my body.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

99. I can easily put my beliefs, opinions, and expectations into words.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

100. I don't pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

101. I watch my feelings without getting lost in them.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

102. I tell myself I shouldn't be feeling the way I'm feeling.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

103. I notice how foods and drinks affect my thoughts, bodily sensations, and emotions.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

104. It's hard for me to find the words to describe what I'm thinking.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

105. I am easily distracted.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

106. I believe some of my thoughts are abnormal or bad and I shouldn't think that way.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

107. I pay attention to sensations, such as the wind in my hair or sun on my face.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

108. I have trouble thinking of the right words to express how I feel about things.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

109. I make judgments about whether my thoughts are good or bad.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

110. I find it difficult to stay focused on what's happening in the present.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

111. When I have distressing thoughts or images, I "step back" and am aware of the thought or image without getting taken over by it.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

112. I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

113. In difficult situations, I can pause without immediately reacting.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	

Lowest	☐	☐	☐	☐	☐	Highest

114. When I have a sensation in my body, it's difficult for me to describe it because I can't find the right words.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

115. It seems I am "running on automatic" without much awareness of what I'm doing.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

116. When I have distressing thoughts or images, I feel calm soon after.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

117. I tell myself that I shouldn't be thinking the way I'm thinking.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

118. I notice the smells and aromas of things.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

119. Even when I'm feeling terribly upset, I can find a way to put it into words.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

120. I rush through activities without being really attentive to them.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

121. When I have distressing thoughts or images I am able just to notice them without reacting.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

122. I think some of my emotions are bad or inappropriate and I shouldn't feel them.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

123. I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadow.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

124. My natural tendency is to put my experiences into words.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

125. When I have distressing thoughts or images, I just notice them and let them go.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

126. I do jobs or tasks automatically without being aware of what I'm doing.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

127. When I have distressing thoughts or images, I judge myself as good or bad, depending what the thought/image is about.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

128. I pay attention to how my emotions affect my thoughts and behavior.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

129. I can usually describe how I feel at the moment in considerable detail.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

130. I find myself doing things without paying attention.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

131. I disapprove of myself when I have irrational ideas.

	1=never or very rarely true	2=rarely true	3=sometimes true	4=often true	5=very often or always true	
Lowest	☐	☐	☐	☐	☐	Highest

Page 6: Questionnaire 4

Below you will find a list of statements. Please rate how true each statement is for you by selecting the corresponding box below it.

132. It's OK if I remember something unpleasant.

	1=never true	2=very seldom true	3=seldom true	4=sometimes true	5=frequently true	6=almost always true	7=always true	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

133. My painful experiences and memories make it difficult for me to live a life that I would value.

	1=never true	2=very seldom true	3=seldom true	4=sometimes true	5=frequently true	6=almost always true	7=always true	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

134. I'm afraid of my feelings.

	1=never true	2=very seldom true	3=seldom true	4=sometimes true	5=frequently true	6=almost always true	7=always true	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

135. I worry about not being able to control my worries and feelings.

	1=never true	2=very seldom true	3=seldom true	4=sometimes true	5=frequently true	6=almost always true	7=always true	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

136. My painful memories prevent me from having a fulfilling life.

	1=never true	2=very seldom true	3=seldom true	4=sometimes true	5=frequently true	6=almost always true	7=always true	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

137. I am in control of my life.

	1=never true	2=very seldom true	3=seldom true	4=sometimes true	5=frequently true	6=almost always true	7=always true	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

138. Emotions cause problems in my life.

	1=never true	2=very seldom true	3=seldom true	4=sometimes true	5=frequently true	6=almost always true	7=always true	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

139. It seems like most people are handling their lives better than I am.

	1=never true	2=very seldom true	3=seldom true	4=sometimes true	5=frequently true	6=almost always true	7=always true	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

140. Worries get in the way of my success.

	1=never true	2=very seldom true	3=seldom true	4=sometimes true	5=frequently true	6=almost always true	7=always true	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

141. My thoughts and feelings do not get in the way of how I want to live my life.

	1=never true	2=very seldom true	3=seldom true	4=sometimes true	5=frequently true	6=almost always true	7=always true	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

Page 7: Questionnaire 5

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the past seven (7) days by selecting the corresponding number below the statement.
NOTE: "Client" is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, etc.

142. I felt emotionally numb.

	1=never	2=rarely	3=occasionally	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

143. My heart started pounding when I thought about my work with clients.

	1=never	2=rarely	3=occasionally	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

144. It seemed as if I was reliving the trauma(s) experienced by my client(s).

	1=never	2=rarely	3=occasionally	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

145. I had trouble sleeping.

	1=never	2=rarely	3=occasionally	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

146. I felt discouraged about the future.

	1=never	2=rarely	3=occasionally	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

147. Reminders of my work with clients upset me.

	1=never	2=rarely	3=occasionally	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

148. I had little interest in being around others.

	1=never	2=rarely	3=occasionally	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

149. I felt jumpy.

	1=never	2=rarely	3=occasionally	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

150. I was less active than usual.

	1=never	2=rarely	3=occasionally	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

151. I thought about my work with clients when I didn't intend to.

	1=never	2=rarely	3=occasionally	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

152. I had trouble concentrating.

	1=never	2=rarely	3=occasionally	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

153. I avoided people, places, or things that reminded me of my work with clients.

	1=never	2=rarely	3=occasionally	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

154. I had disturbing dreams about my work with clients.

	1=never	2=rarely	3=occasionally	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

155. I wanted to avoid working with some clients.

	1=never	2=rarely	3=occasionally	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

156. I was easily annoyed.

	1=never	2=rarely	3=occasionally	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

157. I expected something bad to happen.

	1=never	2=rarely	3=occasionally	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

158. I noticed gaps in my memory about client sessions.

	1=never	2=rarely	3=occasionally	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

Page 8: Questionnaire 6

When you help/investigate people, you have contact with their lives. As you may have found, your compassion for those you help/investigate can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a member of specialist police staff. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

159. I am happy.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

160. I am preoccupied with more than one person I have come into contact with through my work.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

161. I get satisfaction from being able to help people.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

162. I feel connected to others.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

163. I jump or am startled by unexpected sounds.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

164. I feel invigorated after working with those I help through my work.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

165. I find it difficult to separate my personal life from my life as a member of specialist police staff.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

166. I am not as productive at work because I am losing sleep over the traumatic experiences of a person I have helped through my work.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

167. I think that I might have been affected by the traumatic stress of those I have helped through my work.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

168. I feel trapped by my job.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

169. Because of my job, I have felt "on edge" about various things.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

170. I like my work as a member of specialist police staff.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

171. I feel depressed because of the traumatic experiences of the people I have helped through my work.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

172. I feel as though I am experiencing the trauma of someone I have helped through my work.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

173. I have beliefs that sustain me.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

174. I am pleased with how I am able to keep up with specialist police staff techniques and protocols.

	1=never	2=rarely	3=sometimes	4=often	5=very often	

Lowest	☐	☐	☐	☐	☐	Highest

175. I am the person I always wanted to be.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

176. My work makes me feel satisfied.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

177. I feel worn out because of my work.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

178. I have happy thoughts and feelings about those I have helped through my work and how I could help them.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

179. I feel overwhelmed because my workload seems endless.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

180. I believe I can make a difference through my work.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

181. I avoid certain activities or situations because they remind me of frightening experiences of the people involved in my work.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

182. I am proud of what I can do to help through my work.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

183. As a result of my work, I have intrusive, frightening thoughts.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

184. I feel "bogged down" by the system.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

185. I have thoughts that I am a "success" as a member of specialist police staff.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

186. I can't recall important parts of my work with trauma victims.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

187. I am a very caring person.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

188. I am happy that I chose to do this work.

	1=never	2=rarely	3=sometimes	4=often	5=very often	
Lowest	☐	☐	☐	☐	☐	Highest

Page 9: Questionnaire 7

Because people in a wide variety of occupations will answer this survey, it uses the term recipients to refer to the people for whom you provide your service, care, treatment, or instruction. When answering this survey please think of these people as recipients of the service you provide, even though you may use another term in your work.

Instructions: Below are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, select the number "0" (zero) in the space below the statement. If you have had this feeling, indicate how often you feel it by selecting the number (from 1 to 6) that best describes how frequently you feel that way.

189. I feel emotionally drained from my work.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

190. I feel used up at the end of the work day.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

191. I feel fatigued when I get up in the morning and have to face another day on the job.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

192. I can easily understand how my recipients feel about things.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

193. I feel I treat some recipients as if they were impersonal objects.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

194. Working with people all day is really a strain for me.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

195. I deal very effectively with the problems of my recipients.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

196. I feel burned out from my work.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

197. I feel I'm positively influencing other people's lives through my work.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

198. I've become more callous toward people since I took this job.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

199. I worry that this job is hardening me emotionally.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

200. I feel very energetic.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

201. I feel frustrated by my job.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

202. I feel I'm working too hard on my job.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

203. I don't really care what happens to some recipients.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

204. Working with people directly puts too much stress on me.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

205. I can easily create a relaxed atmosphere with my recipients.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

206. I feel exhilarated after working closely with my recipients.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

207. I have accomplished many worthwhile things in this job.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

208. I feel like I'm at the end of my rope.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

209. In my work, I deal with emotional problems very calmly.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

210. I feel recipients blame me for some of their problems.

	0=never	1=a few times a year or less	2=once a month or less	3=a few times a month	4=once a week	5=a few times a week	6=every day	
Lowest	☐	☐	☐	☐	☐	☐	☐	Highest

Page 10: Questionnaire 8

We would like to know if you have had any medical complaints, and how your health has been in general, over the past few weeks. Please answer ALL the questions by selecting the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those you had in the past.

211. Have you recently been able to concentrate on whatever you are doing?

- Better than usual
- Same as usual
- Less than usual
- Much less than usual

212. Have you recently lost much sleep over worry?

- Not at all
- No more than usual
- Rather more than usual
- Much more than usual

213. Have you recently felt that you are playing a useful part in things?

- More so than usual
- Same as usual
- Less useful than usual
- Much less useful

214. Have you recently felt capable of making decisions about things?

- More so than usual
- Same as usual
- Less so than usual
- Much less capable

215. Have you recently felt constantly under strain?

- Not at all
- No more than usual
- Rather more than usual
- Much more than usual

216. Have you recently felt you couldn't overcome your difficulties?

- Not at all
- No more than usual
- Rather more than usual
- Much more than usual

217. Have you recently been able to enjoy your normal day-to-day activities?

- More so than usual
- Same as usual
- Less so than usual
- Much less than usual

218. Have you recently been able to face up to your problems?

- More so than usual
- Same as usual
- Less able than usual
- Much less able

219. Have you recently been feeling unhappy and depressed?

- Not at all
- No more than usual
- Rather more than usual
- Much more than usual

220. Have you recently been losing confidence in yourself?

- Not at all
- No more than usual
- Rather more than usual
- Much more than usual

221. Have you recently been thinking of yourself as a worthless person?

- Not at all
- No more than usual
- Rather more than usual
- Much more than usual

222. Have you recently been feeling reasonably happy, all things considered?

- More so than usual
- About same as usal
- Less so than usual
- Much less than usual

Page 11: Debriefing Information/Taflen Wybodaeth wrth Adrodd yn Ôl

Thank you for taking part in the study. The questionnaires you completed included a variety of measures of your individual characteristics (attachment style, dispositional mindfulness, psychological flexibility and self-efficacy), occupational functioning (burnout, secondary traumatic stress and professional quality of life) and general health. Additionally, you answered background information questions about yourself and your job.

The study will explore the relationship between your individual characteristics in relation to how you experience your work and its impact on you. This is based on the knowledge that staff in specialist sexual and violent offending teams may be particularly vulnerable to developing secondary trauma and related occupational stress due to the complex and challenging nature of their work. The study will also consider the role of protective factors in mitigating the effects of stress associated with workplace trauma.

Your participation in the study is greatly appreciated. If answering any of the questions led you to feel distressed, you can contact the North-Wales Police Occupational Health Department using the below contact details. Alternatively, you can also contact Detective Inspector Jonathan Salisbury-Jones (contact details below). If for any reason you are concerned about your personal well-being, it is recommended you seek appropriate professional advice.

Email: occhealthadministrators@nthwales.pnn.police.uk

Phone: 01492 804 137/01492 804 060

The main findings of the study will be made available to you in approximately November 2018. If you have any further questions or concerns you are able to contact the study researchers using the below details.

Thank you very much for your participation.

Contact Details

1. Ms Clarabella Gray, Trainee Clinical Psychologist, psp6ba@bangor.ac.uk
2. Dr Michelle Rydon-Grange, Senior Clinical Psychologist on 01248 682 129, or email Michelle.Rydon-Grange@wales.nhs.uk
3. Dr Julia Wane, Consultant Clinical Psychologist on 01248 682 129, or email Julia.Wane@wales.nhs.uk
4. Detective Inspector Jonathan Salisbury-Jones, Protecting Vulnerable People Unit, Crime Services Group, on 01352 708 031, or email jonathan.jones3@nthwales.pnn.police.uk

Diolch i chi am gymryd rhan yn yr astudiaeth. Roedd yr holiaduron y gwnaethoch eu llenwi yn cynnwys amrywiaeth o fesurau am eich nodweddion unigol (arddull ymlyniad, ymwybyddiaeth ofalgar, hyblygrwydd seicolegol a hunaneffeithlonrwydd), eich gweithrediad galwedigaethol (chwythu plwc, straen trawmatig eilaidd ac ansawdd bywyd proffesiynol) a'ch iechyd yn gyffredinol. Yn ychwanegol at hynny, fe ateboch chi gwestiynau yn gofyn am wybodaeth gefndirol amdanoch eich hun a'ch swydd.

Bydd yr astudiaeth yn archwilio'r berthynas rhwng eich nodweddion unigol mewn perthynas â'r profiad a gewch o'ch gwaith ac effaith hynny arnoch chi. Mae hyn yn seiliedig ar wybod y gall staff yn nhimau arbenigol troseddu rhywiol a threisgar fod yn agored iawn i ddatblygu trawma eilaidd a straen galwedigaethol oherwydd natur cymhleth a heriol eu gwaith. Bydd yr astudiaeth hefyd yn ystyried swyddogaeth ffactorau amddiffynnol wrth liniaru effeithiau straen sy'n gysylltiedig â thrawma yn y gweithle.

Gwerthfawrogwn eich bod yn cymryd rhan yn yr astudiaeth. Os yw ateb unrhyw rai o'r cwestiynau hyn wedi peri gofid i chi, gallwch gysylltu ag Adran Iechyd Galwedigaethol Heddlu Gogledd Cymru yn defnyddio'r manylion cyswllt isod. Fel arall, gallwch gysylltu hefyd â'r Ditectif Arolygydd Jonathan Salisbury-Jones (manylion cyswllt isod). Os ydych yn pryderu am eich lles personol am unrhyw reswm, fe'ch anogir i geisio cyngor proffesiynol priodol.

E-bost: occhealthadministrators@nthwales.pnn.police.uk

Ffôn: 01492 804 137/01492 804 060

Bydd prif ganfyddiadau'r astudiaeth ar gael i chi tua mis Tachwedd 2018. Os bydd gennych unrhyw gwestiynau pellach neu os oes unrhyw beth yn eich pryderu mae modd i chi gysylltu ag ymchwilwyr yr astudiaeth yn defnyddio'r manylion isod.

Diolch yn fawr i chi am gymryd rhan.

Manylion Cyswllt

1. Ms Clarabella Gray, Seicolegydd Clinigol dan Hyfforddiant, psp6ba@bangor.ac.uk
2. Dr Michelle Rydon-Grange, Uwch Seicolegydd Clinigol ar 01248 682 129, neu e-bostio Michelle.Rydon-Grange@wales.nhs.uk

3. Dr Julia Wane, Seicolegydd Clinigol Ymgynghorol ar 01248 682 129 neu e-bostio Julia.Wane@wales.nhs.uk
4. Ditectif Arolygydd Jonathan Salisbury-Jones, Uned Amddiffyn Pobl sy'n Agored i Niwed, Grŵp Gwasanaethau Trosedd, ar 01352 708 031, neu e-bostio jonathan.jones3@nthwales.pnn.police.uk