Secondary traumatisation and post-traumatic growth: how are employees of charities who provide practical support to asylum seekers affected by their work?

Kara Davey

May 2011

Doctorate in Clinical Psychology

Declaration

I confirm that the literature review, research report and critical appraisal contained within this thesis are my own work and have not been submitted for any other academic award.

Acknowledgments

“Endurance is one of the most difficult disciplines, but it is to the one who endures that the final victory comes”- Guatama Buddha

I would like to thank everyone who participated in or helped to raise awareness of this research. I would also like to thank David and my parents for their love throughout the year and Charly for all of her support. Last but certainly not least, I would like to thank Noelle for all of her help and for her efficiency throughout.

Word Counts

Thesis Abstract	299
Literature Review	6,438
Research Report	11,089
Critical Appraisal	3,825
Total (not including mandatory Appendices)	28,920

Thesis Abstract

Asylum claims in developing countries are increasing as a result of conflict and resource competition. As claims have increased and have included some non-genuine claims that have made headlines, concerns about the number of non-genuine claims have been used to justify increased stringency of legislation and policies relevant to the process of seeking asylum. This thesis explores both the psychological consequences of current asylum legislation on asylum seekers and the psychological consequences of supporting asylum seekers and refugees to meet the requirements of UK law.

The literature review systemically reviewed studies investigating the psychological impact of awaiting an asylum decision and discussed the possible explanatory factors. For those awaiting their decision, the process was associated with increased psychological distress, compared to individuals no longer awaiting a decision. Distress also appeared to increase as a function of duration of wait. Uncertainty was commonly proposed as instrumental to asylum seekers' psychological distress. All studies highlighted that current policies and legislation adversely affect asylum seeker's psychological well-being and it is argued that change is required, reducing time taken for asylum claims.

The empirical study explored positive and negative effects on charity-employed staff supporting asylum seekers and refugees. Secondary traumatic stress (STS) and post-traumatic growth (PTG) were assessed in staff working for charities that provide practical support to asylum seekers/ refugees across the UK. Measures of team support, organisational, social support, empathy, personal characteristics and ways of coping were also assessed. High levels of STS and low levels of PTG were found, potentially highlighting the need for strategies to mitigate distress for individuals providing practical support to asylum seekers and refugees.

Collectively, this thesis suggests that the current asylum process is associated with both direct and indirect psychological consequences, which are prominent and aversive. Suggestions for future research and possible interventions are provided.

Table of contents

Secondary traumatisation and post-traumatic growth: how are employees of charities who provide practical support to asylum seekers affected by their work?

Appendices

Tables

What is the psychological impact of waiting an asylum decision? A critical review

1. Abstract

Background: Awaiting an asylum decision is associated with negative psychological consequences. However, possible explanatory factors of the psychological impact of awaiting an asylum decision have not been rigorously explored.

Aims: This review systemically reviewed studies investigating the psychological impact of the process of awaiting an asylum decision and discussed the possible explanatory factors.

Method: Five electronic databases were searched for relevant studies. A narrative synthesis was conducted on the ten studies that met the inclusion criteria.

Results: For individuals awaiting an asylum decision, the process was associated with increased psychological distress, when compared to individuals no longer awaiting a decision. Distress also increased the longer an individual waited. Uncertainty was commonly proposed as instrumental to asylum seekers' psychological distress.

Conclusions: Specific uncertainty measures need to be developed so that the explanatory role of uncertainty can be further explored. If it is found to be as important as anticipated then interventions aimed at reducing uncertainty should be piloted. Policies and legislation should arguably be reviewed to shorten the wait of asylum claims. Shortcomings are discussed and further research suggested.

Target journal: British Journal of Psychiatry (Appendix E)

2. Introduction

2.1 Seeking political asylum and premigration trauma

According to the Geneva convention (1951, cited in Refugee Council, 2009) a refugee is someone who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of their nationality, and is unable to or, owing to such fear, is unwilling to avail him/herself of the protection of that country". The label 'asylum seeker' describes someone who has applied to become a refugee but who is currently still awaiting the Home Office's decision regarding their claim.

Asylum seekers and refugees are more likely to meet the diagnostic criteria for post-traumatic stress disorder (PTSD) than the general population (NICE, 2006). Recent research has suggested that prevalence rates of PTSD in individuals seeking asylum (in the Netherlands) ranged from 31.5%- 41.7% (Laban, Gernaat, Komproe, Schreuders & De Jong, 2004). In addition to the high levels of PTSD found in the asylum-seeking population, research also consistently reports increased levels of anxiety, depression, psychosis and other mental health problems (Gorst-Unsworth & Goldenburg, 1998; Hauff & Vaglum, 1995; Lie, 2006; Michultka, Balnchard & Kalous, 1998). Consequently, it appears that asylum seekers' experiences in their home country (premigration trauma) make them vulnerable to above average levels of psychological distress in their host country compared to the general population.

2.2 Seeking asylum and postmigration trauma

Asylum claims in developing countries are increasing as a result of conflict and resource competition. Provisional Home Office figures report 25,670 applications for

asylum in the UK in 2008, 10 per cent higher than the 23,430 applications made in 2007 (National statistics online, 2009). As claims have increased and have included some non-genuine claims that have made headlines, concerns about the number of non-genuine claims for asylum have become a prominent focus of political debate. These concerns appear to be used to justify legislation and increased stringency of policies relevant to the process of seeking asylum. The legal requirements and process of seeking asylum vary depending on the host country, but each require applicants to live with extreme restrictions (such as inability to work and problems accessing healthcare) until they receive a decision, which can be years after their claim is filed. In the UK, asylum seekers cannot choose where they live, and can be moved at any time without notice, thus they have no certainty concerning residency and a compromised ability to seek and maintain social support. In Australia, all asylum seekers are detained until they are verified as a refugee when they are given either a temporary or permanent visa. Individuals with a temporary visa are subjected to restrictions in the same way as an asylum seeker in other countries. In the Netherlands, individuals live in specialised residential Asylum Seeker Centres until a decision is given. Consequently, asylum seekers are subject to a range of postmigration stressors and high levels of uncertainty in their host country whilst awaiting the outcome of their asylum decision both as a result of difficult living conditions and other restrictions placed upon them.

Evidence suggests that post-migration stressors are as important, if not more important, than premigration trauma in contributing towards asylum seekers mental health difficulties (Laban et al., 2004). Silove, Sinnerbank, Field, Manicavasagar and Steel (1997) examined the mental health of 40 asylum seekers who attended a community resource centre and found that length of asylum claim was weakly correlated with

anxiety. They also found that PTSD was associated with several post-migratory stressors including delays in processing asylum claims. Silove et al. (1997) concluded that post-migratory factors may interact and/or exaggerate emotional difficulties and trauma symptoms.

Increasingly research is investigating the impact of the asylum process on applicants' psychological wellbeing. However, no review has been carried out to-date which investigates the psychological impact of having to wait for an asylum decision.

2.3 Aim

The aim of this review was therefore to identify and systemically assess studies that have investigated the psychological impact of the process of waiting for an asylum decision, with the specific question: what is the psychological impact of waiting an asylum decision?

3. Method

3.1 Search strategy

The literature search was conducted in December 2010. The search terms 'asylum', 'process', 'procedure', 'uncertainty', 'waiting', 'stress', 'psych*', 'impact', 'well-being', 'psychiatr*' and 'mental health' were used to identify relevant research published in the past 15 years (between 1995 and 2010) in the databases Science Direct, Medline, PsycINFO, PILOTS and ISI Web of Science. The psycINFO database was searched initially. Relevant articles identified in psycINFO were used to refine and identify the most appropriate databases and search terms to be used for a systematic database search. The search terms were also compared to the current literature base to

ensure that they were fully representative. Investigations of the asylum process have only been published for just over a decade so a fifteen year time span was selected to ensure that all relevant papers were identified. See Appendix A for search tables. Of 804 abstracts identified, 712 were excluded. The full-text articles of the 92 remaining abstracts were retrieved. Manual searches of the reference lists of identified papers were also conducted to find further relevant articles. The titles and abstracts were used to assess the potential usefulness of the paper before the rigorous inclusion and exclusion criteria were applied, which elicited ten studies. See Appendix B for a flow diagram of the process.

The following inclusion criteria were utilised:

1. Participants were adults
2. Quantitative measures were employed in the study to assess psychological distress/ mental health.
3. Comparisons of psychological distress were made between two groups (i.e. asylum decision versus still awaiting a decision, OR short wait versus long wait for a decision).

The criteria were selected to ensure that all papers included a quantitative assessment of the *impact* of the asylum process.

Papers were excluded from the review if:

1. No quantitative measures were employed.
2. They were not written in English.
3. They did not investigate the asylum procedure.
4. Participants were psychiatric inpatients

5. The sole comparison was between asylum seekers who had versus those who had not been detained (as being detained is associated with increased psychological distress).

The criteria were selected to ensure that a quantitative assessment of the *impact* of the asylum process was conducted with minimal confounding variables.

These articles were systematically reviewed using a data extraction pro-forma (Appendix C), so that each article was rated on its aims, methodology, sampling methods, participants and sample size, control groups used and reliability and validity of the results. A validity framework was used in collaboration with the data extraction pro-forma to improve the quality of the data (Cook & Campbell, 1979). This information was then synthesised into a summary table (see Table 1).

4. Results

4.1 Characteristics of the studies

The ten studies included in this review all aimed to investigate the psychological impact of waiting for an asylum decision. Despite this consistent overall aim, the samples, study designs and outcome measures varied considerably.

The research papers reported data from samples in Australia, Sweden, the Netherlands and Ireland. All papers included both male and female participants, with a mean age of 37 years. The youngest participant was 18 but the upper age limits were not clear in six of the papers. The percentage of male participants ranged from 44% to 77%. Duration of residence in the host country ranged from less than one month to 4.7 years.

The measures employed in the research varied widely but psychological impact was mostly ascertained using self-reported measures of anxiety, depression and symptoms of post-traumatic stress. Three of the papers (5,7,10) also included measures of physical and mental health related disability. Furthermore, five studies (3,4,8,9,10) included diagnostic interviews. Four papers (1,3,4,7) utilised a prospective longitudinal approach to follow the relationship between psychological distress and status security for a period of up to two years after individuals had arrived in their host country. All the other papers utilised an independent samples, cross sectional design.

Sample sizes ranged from 62 to 294 participants. Initial response rates ranged from 64-92%, with 43- 62% of participants remaining at follow-up in the three longitudinal studies, although the response rate was not provided in study 7. All but two papers (1,7) targeted a specific group of individuals seeking asylum, limiting generalisability. However, no research to date has suggested that the psychological distress caused by the asylum process differs significantly between nationalities when pre-migration trauma levels are controlled for. In addition, single ethnicity samples eliminate the potential for transcultural measurement bias.

4.2 General description

Given the included studies diverse methodology, ease of analysis was aided by identification of two overarching categories: a) studies that compared the psychological distress of individuals awaiting an asylum decision with individuals no longer waiting for a decision and b) studies that compared the psychological distress of individuals who had been waiting varying amounts of time for their asylum decision. The findings from the studies in each category were synthesised. A narrative summary is contained in

section 4.7, following an exploration of the quality of the studies. Summary tables of the findings can also be found in Appendices D and E.

4.3 Sampling

Four of the papers had large sample sizes (241-294 individuals) resulting in 102-151 participants in each comparison group (studies 6,8,9,10). The other two cross-sectional studies (2,5) had smaller samples with some comparison groups having just 30 or 49 participants in respectively. Of the four longitudinal studies, three (1,3,4) had large attrition rates (57- 74%) at 12-24 month follow-up. The final longitudinal study (7) retained 62 of the 73 original participants at follow-up, which was on average nine months later. However, the group whose claims had been 'accepted' consisted of just 16 participants. Consequently, the reliability and generalisability of these studies may be limited due to the relatively small sample sizes. In addition, none of the papers reported statistical power or showed evidence that they had computed power calculations, which may have affected the reliability of findings.

4.4 Measurement

All measures of psychological distress relied on participant self-reports. Consequently, individuals may have reported high levels of psychological distress in an attempt to help their asylum claim. Despite this possibility, all of the studies explained to participants that the research was in no way related to their asylum claims, the levels reported were consistent across the papers and with past findings concerning levels of distress in asylum seekers and individual's reports of past trauma didn't change significantly over time suggesting reliability in participant's self-reports.

All measures included in the papers reviewed here have known reliability and validity, but many were created in Western context and written in English. Consequently, cultural validity may have been inadequate and there may have been transcultural measurement error. However, the papers discussed a process of back translation and checking understanding with participants, where necessary. In addition, studies 3,4,8,9 and 10 included diagnostic interviews, with very similar findings to the self-report measures, suggesting that the measures were valid.

4.5 Design

Six of the papers utilised cross-sectional study designs, so causal relationships could not be commented on and change over time was not explored. In the longitudinal studies, it is possible that the healthier asylum seekers dropped out of the research thus increasing the group's overall psychological distress scores. However, studies 3 and 4 found no significant differences on socio-demographic factors or distress scores when comparing participants who did and didn't drop out.

4.6 Potential explanatory variables and confounders

Many variables (pre-migration trauma, postmigration trauma, living difficulties, separation from family, friends, uncertainty of future domicile and difficulties with the asylum process) are likely to affect levels of psychological distress in asylum seekers. It is acknowledged that it is impossible to investigate the sole explanatory value of any of these factors in the current review.

Table 1: Main characteristics of the studies

Author (s) and Id Code	*Aims of Study*	*Methodology*	*Sampling*	*Country*	*Analysis*	*Results*	*Reliability and validity*	*Evaluative comments*
1. Ryan, Benson & Dooley (2008)	Investigated relationship between status and psychological distress	Longitudinal design- assessed at baseline, and 12-24month follow-up Interviewed and questionnaires administered.	162 participants at baseline (92%response rate). 70 participants (43%) retained at follow-up. 67% still awaiting a decision. Mean age= 32. Recruited via drop in centres and snowballing.	Ireland	Stepwise multiple linear regression analyses and 3x2 mixed ANOVA	Distress reduced only in participants who were accepted as refugees between the study phases.	Measures in English so may have caused measurement error. Measures also created in Western context so were they culturally valid?	Strengths- Study design. - Representative sample - Good response rate at baseline Limitations- Pre-migration trauma not measured - High attrition rate
2. Silove, Steel, McGorry & Mohan (1998)	Investigated relationship between status and psychological distress	Compared asylum seekers, refugees and immigrants. No interviews	196 Tamil participants recruited via community organisations. Mean age= 35.3. 62 asylum seekers (estimated response rate 60%). 30 refugees and 104 immigrants.	Australia	One-way ANOVAs, principal-components analysis and logistic regression analyses	Most postmigration stress (uncertainty) in asylum seekers. Also more anxiety, depression and PTSD in asylum seekers but not significant compared to refugees.	HSCL= culturally robust. Used in other refugee research and validated for population. HTQ- Indochinese version had close agreement with PTSD diagnosis via DSMIII-R structured interview	Strengths- Measures= translated and independently back translated by bilingual workers with mental health experience. Limitations- Response rate of refugees and immigrants unknown
3. Roth & Ekblad (2006a) Part of study 4	Investigated relationship between depression and sense of coherence in mass-evacuated adults.	Prospective design. Questionnaires at baseline, 3& 6 months. Questionnaires and SCID interview at 1.5year follow-up.	Randomly selected from airline passenger lists. 218 at baseline, 131 retained at 3months, 91 at 6months and 56 remained at 1.5year follow-up. (35 still seeking asylum, 21 had returned to Kosovo).	Sweden	Mann–Whitney, t-tests, nonparametric Spearman correlation coefficient, Chi-square and nonparametric Friedman test.	Depression increased and SOC decreased over time. Those who remained in Sweden were significantly more depressed than those who returned.	HTQ- not validated for Kosovars (but matched SCID at follow-up). Validity evaluated with discrimination analysis HTQ and SOC-12- internal consistency checked with Cronbach's alpha	Strengths- Study design Limitations- High attrition rate

Author (s) and Id Code	*Aims of Study*	*Methodology*	*Sampling and Participants*	*Country*	*Analysis*	*Results*	*Reliability and validity*	*Evaluative comments*
4. Roth & Ekblad (2006b)	Investigated trauma levels in mass-evacuated adults from Kosovo	Prospective design. As above but also measured cortisol levels at 1.5year follow-up.	As above	Sweden	As above	PTSD increased over time. Significantly more PTSD symptoms in individuals still in Sweden. Insecurity about future domicile proposed as an explanation for this.	As above	As above
5. Momartin Steel, Coello, Aroche, Silove & Brooks (2006)	Investigated relationship between status and psychological distress	Compared refugees with temporary and permanent status.	116 Persian speaking refugees recruited from Early Invention Programme 49 had temporary status, mean age= 32. 67 had permanent status, mean age= 39.	Australia	Series of stepwise multiple linear regression analyses	Temporary visa holders scored higher on measures of anxiety, depression and PTSD (P<0.001).	Good face validity- tests impact of having temporary status on mental health	Strengths- Translation-back translation employed on measures - Representative sample Limitations- Small sample size of temporary group
6. Steel, Silove, Brooks, Momartin Alzuhari & Suslick (2006)	Investigated effects of detention and temporary status on mental health	Compared refugees with temporary and permanent status. Questionnaires and interviews conducted	241 Mandean refugees recruited via community leaders and snowballing. Mean age= 38. 139 had temporary status and 102 had permanent. 90% response rate of individuals contacted.	Australia	Multilevel model	Temporary status was associated with more depressive and PTSD symptoms.	There may have been transcultural measurement bias Good face validity	Strengths- Good sample size and response rate Limitations- Detention= confounder
7. Silove et al. (2007)	Examine changes in trauma symptoms & identify impact of decision on psychiatric symptoms	Prospective design. Baseline and follow-up 4 months after decision. Questionnaires and interviews	Cluster-probabilistic sampling. Immigration agents identified asylum seekers who met criteria 73 recruited at baseline, 62 remained at follow-up, 16 were accepted, 46 were rejected. Mean age= 39.9.	Australia	T-tests and ANCOVA	Accepted group showed substantial decrease in PTSD, anxiety and depression after decision. Whereas rejected group remained consistent.	Standardised measures with acceptable reliability and validity. Test-retest reliability of pre-trauma scores May have been transcultural bias though	Strengths- controlled for trauma & demographics - Small attrition rate - Design - Representative sample Limitations- small sample size - Response rate not mentioned

Author (s) and Id Code	*Aims of Study*	*Methodology*	*Sampling and Participants*	*Country*	*Analysis*	*Results*	*Reliability and validity*	*Evaluative comments*
8. Laban, Gernaat, Komproe, Schreuders & De Jong (2004)	Investigated the impact of time waiting for an asylum decision on psychiatric symptoms	Compared Iraqi asylum seekers who had been waiting less than six months with those waiting more than 2 years. Questionnaires and CIDI interviews.	Random sampling used to recruit 294 participants from COA lists. Mean age= 36. 143=waiting less than 6 months (response rate 82%). 151=waiting more than 2 years (response rate= 79%).	Netherlands	Univariate and multivariate logistic regression analyses	Anxiety, depression and somatoform disorders were significantly higher in the group waiting more than 2 years. PTSD also higher but not significantly.	No control group Validity- measures what it claims	Strengths- Groups were matched and adjusted for age and gender. - High response rate Limitations- longitudinal design may have been better
9. Laban, Gernaat, Komproe, van der Tweel & De Jong (2005)	In depth analysis of 8, investigated the postmigration period in relation to psychiatric disorders.	As above	As above	Australia	$\chi 2$, Mann-Whitney U, Principal component analysis, multivariate logistic regressions	Clustered postmigration living problems and found lack of work, family issues and asylum procedure stress had the highest odds ratio for psychopathology.	As above	As above
10. Laban, Komproe, Gernaat & de Jong (2008)	Investigated the impact of time waiting for an asylum decision on quality of life (QoL), disability and physical health	As above	As above	Australia	$\chi 2$, t-tests, correlation matrix and multivariate logistic regressions	Respondents with a long asylum procedure reported significantly lower QoL, higher functional disability and more physical complaints. Length of stay was the strongest predictor for a low QoL.	As above	As above

In addition, the studies conducted in Australia are further complicated by individuals being detained on arrival until they are given temporary or permanent status causing potential psychological detriment (Coffrey, Kaplan, Sampson & Tucci, 2010). Consequently, findings in study 6 may have bias given that many of those with temporary status had only recently been released from detention.

A further confounder evident in four of the papers was differing levels of pre-migration trauma in the comparison groups, which is likely to have affected distress scores. Study 1 did not measure pre-migration trauma so it is impossible to ascertain the impact of pre-migration trauma in relation to changes in psychological distress over time in this study. However, it should be highlighted that there were no significant differences in pre-migration stress levels in the studies that measured change over time suggesting that differences in premigration trauma cannot explain the increasing psychological distress scores, or increased distress scores of asylum seekers compared to individuals with an asylum decision.

4.7 Findings

4.8 Comparing psychological distress of individuals awaiting an asylum decision with individuals no longer waiting for a decision

Five papers compared the psychological distress of individuals who were awaiting an asylum decision with individuals who were no longer awaiting a decision (1,2,5,6,7). Two of these (5,6) compared refugees who had been given either temporary or permanent status. One compared asylum seekers, refugees and immigrants (2). One measured change over time in individuals who had an asylum decision at baseline, those

who had received a decision in between baseline and follow-up or those who were still awaiting a decision at follow-up (1). The final paper measured change over time in participants whose claim had been accepted or rejected, between baseline and follow-up (7).

Two papers (3,4) that primarily investigated change in distress over time (see next section), also compared individuals who were still awaiting a decision at 18 month follow-up with those who had returned home. The findings of the latter comparison will also be discussed here. The findings will be discussed in relation to types of distress, following examination of how current living difficulties differed between asylum seekers and individuals no longer awaiting their asylum decision. Each found that waiting was associated with increased psychological distress compared to individuals who were no longer awaiting a decision.

4.9 Post-Migration Living Difficulties (PMLD)

Four of the seven papers (1,2,5,6) compared PMLD in individuals waiting and no longer waiting for an asylum decision. PMLD scores were lower in individuals no longer awaiting a decision. Measures assessing postmigration living difficulties examined ongoing stressors such as worry about the family, worry about housing and financial restraints, as well as a cluster of questions (cluster three on the PMLD) that specifically examined the uncertainty of the asylum procedure. The findings confirmed that as expected asylum seekers experienced greater day-to-day levels of uncertainty, not just in relation to worries about the asylum procedure.

4.10 Anxiety, depression and PTSD

Of the seven papers that investigated the psychological impact of awaiting an asylum decision, five looked specifically at PTSD symptoms (2,4,5,6,7), four looked at depressive symptoms (2,3,5,7) and three measured anxiety symptoms (2,5,7). All found less distress in individuals who were no longer awaiting a decision.

Studies 3 and 4 found significantly less depression and PTSD in the individuals who had voluntarily chosen to return to Kosovo compared to those who were still awaiting an asylum decision in Sweden at one and a half year follow-up. Despite, the very high (74%) attrition rate over the one and a half years, the authors reported no significant differences between participants who had and hadn't dropped out. Study 5 also found significantly less depression, anxiety and PTSD in individuals with a permanent visa than individuals who had a temporary visa. Furthermore, they found temporary status to be the strongest predictor of depression, anxiety and PTSD. Their regression model predicted 73.9% of the variance for PTSD, with temporary status explaining 68% of the variance of this model. These findings suggest that awaiting an asylum decision may have adversely affected mental health. However, the temporary status participants were more likely to have been recently released from detention, which constitutes an obvious confound.

Study 6 found that nine out of 15 items assessing PTSD were significantly higher in temporary compared to permanent visa holders. However, they also noted that due to increasing violence in Iraq at the time there was more pre-migration trauma in the temporary visa holder group, therefore constituting another confound. Study 2 found significant differences between the distress scores of asylum seekers and immigrants,

however although asylum seekers scores were higher than refugees, the differences were not significant. Study 7 compared two sets of baseline and follow-up anxiety, depression and PTSD scores, one for individuals whose asylum claim had been accepted and the other for those whose claim had been rejected. It should be highlighted that they found a significant decrease in all three types of symptoms for those whose claim had been accepted. However, scores remained consistent for those whose claim had been rejected. Asylum decision outcome is therefore likely to have acted as a confound on distress levels as discussed in section 4.12.

Collectively, these five studies suggested a correlation between psychological distress and waiting for an asylum decision, which remained robust even when levels of pre-trauma were controlled for in study 7. In addition, study 5 found that temporary status was the strongest predictor of PTSD, anxiety and depression. However, a variety of confounding variables were present in the studies, alongside large attrition rates and small sample sizes.

4.11 Other measures of psychological distress in relation to waiting for an asylum decision

Four other measures of psychological distress were included in the papers. Studies 5 and 7 looked at the impact of waiting on physical and mental health. Both found higher physical and mental health scores, indicating lower functional impairment in the groups who were no longer awaiting a decision. Differences in mental health, but not physical health scores, were significant in both papers. Studies 3 and 4 found that Kosovars' who remained in Sweden showed significantly lower sense of coherence scores than individuals who had chosen to return to Kosovo by the one and a half year follow-up,

despite no difference in baseline levels of trauma. Finally, studies 1 and 5 compared general levels of distress. Study 1 found that distress scores halved in individuals who had received a positive decision between baseline and follow-up but remained the same for individuals who already had a decision at baseline or were still awaiting a decision at follow-up. This study was well designed and methodologically robust. However, unfortunately psychological distress was only assessed using a general measure. No specific measures of anxiety, depression or PTSD were obtained. Study 5 found significantly higher distress scores in temporary compared to permanent visa holders. Studies 1 and 5 both found therefore that individuals who are no longer waiting for a decision were less distressed than those who were still waiting.

4.12 Limitations of investigating the psychological impact of waiting by comparing individuals who have and those who have not received an asylum decision

A significant difficulty with comparing the distress of individuals with and without an asylum decision is that the outcome of the decision is a confounding variable. A negative decision is likely to have a strong impact on the refused applicant's distress levels because they may be forced to return to their home country inducing fear for their safety. Bearing this in mind it is interesting that study 7 found that distress levels did not increase from baseline in the group whose claim had been rejected, perhaps because that follow-up was conducted on average four months after the asylum decision so that time and an appeal of the decision mitigated distress. However, studies 3 and 4 found that psychological distress was higher in the group who had stayed in Sweden at one and a half year follow-up compared to those who had returned to Kosovo, despite those in Sweden having no reason to fear their personal safety. Consequently, the difference in distress scores between those waiting and those no longer waiting seems unlikely to be

explained fully by differences in terms of the two group's perceived safety. Many other factors are likely to contribute including levels of uncertainty, support, ability to work and ease of accessing healthcare.

In summary, for those awaiting an asylum decision the process appeared to be associated with increased psychological distress compared to individuals who were no longer awaiting a decision. Four papers of the five papers concluded that the high levels of uncertainty that asylum seekers live with whilst awaiting their decision is likely to be an important contributory factor to this distress. More specifically, study 5 found the asylum process to be strongest predictor of distress which they associated with uncertainty; study 1 concluded that legal status insecurity is one of the most stressful demands of seeking asylum. Study 6 suggested that a sense of security, undermined by not having permanent status, seemed essential to allow individuals to recover from trauma symptoms. Finally, study 7 found that fear of repatriation was the only indicator to significantly reduce once individuals received permanent status. This suggests that the safety, security and predictability/certainty of 'permanent' status are significantly associated with reduced psychological distress. Yet despite these studies consistently finding the asylum process to be associated with increased psychological distress (with uncertainty being proposed as an important contributor), no study included specific measures of uncertainty, precluding assessment of the exact contribution of uncertainty. At present, cluster three of the PMLD appears to be the only measure which assesses perceived uncertainty in relation to the process of seeking asylum. However, the PMLD assesses a range of difficulties in the host country. Only a few questions ask specifically about uncertainty and many questions such as "no permission to work" do not indicate how much of the difficulty it is perceived to be problematic for practical reasons and

how much is due to worries associated with the difficulty such as ‘fears that I won’t be able to afford to live’ or ‘worries about finding future employment’. Consequently, a specific measure of the uncertainty asylum seekers experience whilst awaiting their decision needs to be developed to enable the exact contribution of uncertainty to be assessed.

4.13 Length of time waiting for an asylum decision and psychological distress

Five papers compared levels of psychological distress in individuals who had been waiting varying periods for their asylum decision. Studies 8, 9 and 10 compared independent groups of asylum seekers- individuals waiting less than 6 months, with individuals who had been waiting more than two years. Whereas studies 3 and 4 prospectively measured change over time in a group of participants at baseline, three months, six months and at one and a half year follow-up. All found the most psychological distress in the groups who had been awaiting their decision longer.

4.14 Depression, anxiety and somatoform disorders

Studies 3, 8 and 9 looked specifically at the impact of the length of time awaiting an asylum decision on depressive symptoms. Studies 8 and 9 also investigated lifetime prevalence of anxiety and somatoform disorders. Study 3 found that depressive symptoms significantly increased at each follow-up conducted. Study 8 found significantly more depressive, anxiety and somatoform disorders in individuals waiting more than 2 years for their decision, compared to individuals waiting less than 6 months. In addition, they found that length of time in the procedure was the second largest predictor of distress. As the authors acknowledged, it is possible that the healthier participants may have decided to leave the asylum process, resulting in higher

overall distress scores in the group who had been waiting for more than two years. However, there were no differences in the PTSD scores of each group. In addition, leaving the asylum process is more likely to relate to financial and social resources than mental health. Both of these studies suggest a positive correlation between time spent waiting for an asylum decision and psychological distress.

The final paper (9), conducted a more in-depth analysis of the relationship between psychological distress (anxiety, somatoform and depressive symptoms) and PMLD. PMLD scores were three times higher in individuals who had been waiting more than two years for an asylum decision compared to those waiting less than 6 months. Researchers also found a significant difference between the PMLD scores of individuals with and without a depressive disorder. More specifically they found that cluster three: 'issues relating to the asylum procedure' of the PMLD was one of the most important contributors to developing depression, anxiety, somatoform or any other psychiatric disorder. Collectively, these studies suggest that psychological distress (as measured by anxiety, somatoform and depressive symptoms) increase during the course of an asylum claim. Furthermore, cluster three of the PMLD seems to be one of most important contributors. Uncertainty is therefore likely to be an important explanatory factor of psychological distress in individuals awaiting an asylum decision.

4.15 PTSD

Two papers looked specifically at the impact of the length of time awaiting an asylum decision on PTSD symptoms. Study 8 found a higher lifetime prevalence rate of PTSD in individuals waiting more than two years, than in individuals waiting less than six months, although the difference was not significant. Whereas, study 4 found that PTSD

symptoms increased at each of their follow-ups with the most significant difference occurring between the six month and one and a half year follow-ups. Although the HTQ[1] has not been validated to use with the Kosovar population, SCID diagnostic interviews were conducted at one and a half year follow-up suggesting that 73% of participants met the criteria for PTSD, which was similar to the 80% proposed by the HTQ. The authors proposed that the increasing PTSD symptoms may be due to prolonged insecurity about their future, which requires further investigation.

4.16 Other measures of psychological distress

Four other measures of psychological distress were included in the studies investigating the impact of the length of time waiting for an asylum decision. Study 4 compared salivary cortisol levels[2] at one and a half year follow-up of individuals who did and did not met the criteria for PTSD. As expected a negative correlation was found between cortisol levels and PTSD, suggesting that waiting for asylum claims has adverse implications on physical and psychological well-being. However, cortisol levels were not measured at 8am as recommended, which may have affected the study's findings. Study 10 examined impact of time waiting for an asylum decision on health status and disability. The researchers found significantly more physical health disability and significantly lower mental health scores in those whose wait was greater than two years, than those who had been waiting less than six months, also highlighting that prolonged time in the asylum process can negatively affect physical and psychological well-being. Finally study 3 found that sense of coherence scores significantly decreased at each follow-up, despite no severe post-migration traumas, suggesting that postmigration

[1] HTQ= Harvard Trauma Questionnaire (Mollica et al., 1992)

[2] Salivary cortisol was measured because it is a biological marker of stress

stress such as prolonged insecurity/ uncertainty about their future may affect asylum seekers world view.

4.17 Limitations of investigating the psychological impact of waiting by looking at the length of time individuals have been waiting for an asylum decision.

If comparing the distress of individuals who have been waiting different amounts of time for their asylum decision cross-sectionally comparison groups need to be carefully matched. Study 7 was the only cross-sectional study included in this review that controlled for both demographics and pre-migration trauma.

In summary, all five studies suggested that psychological distress increases as a function of duration to decision. Additionally, studies 8 and 10 found that a long asylum procedure was the most important risk factor, after being female, for increased psychological distress (anxiety, depression, PTSD and somatoform disorder) and reduced quality of life. Study 9 further analysed these findings and suggested that worrying about the asylum procedure (uncertainty about residency, fears of being sent away and uncertainty about the future) was one of the most important risk factors for Iraqi asylum seekers, even more important than adverse life events in Iraq. Studies 3 and 4 also proposed that an explanation for the increasing depression and PTSD symptoms was insecurity regarding an individual's future domicile. Consequently, these papers also suggest that uncertainty is important. Despite the findings consistently showing that psychological distress increases the longer asylum seekers are awaiting a decision and uncertainty being proposed as an important contributor to this, as previously mentioned a specific measure of the uncertainty asylum seekers experience

whilst awaiting their decision needs to be developed to enable the exact contribution of uncertainty to be assessed.

5. Discussion

Review findings suggest that awaiting an asylum decision is associated with increased psychological distress when compared to individuals who were no longer awaiting a decision. Psychological distress was also found to increase with time to decision. In addition, eight of the ten studies suggested that uncertainty played a large part in the psychological distress experienced by asylum seekers. Consequently the possible explanatory role of uncertainty needs further exploration.

5.1 Definition of uncertainty

Uncertainty is often defined as a lack of certainty or a state of having limited knowledge, therefore making it impossible to accurately describe either the current state or any future outcome (Wikipedia, 2011).

5.2 Uncertainty and psychological well-being

Social psychologists have for decades argued that humans need to feel certain about their world and how they fit within it (Festinger, 1954; Lopes, 1987; Fiske & Taylor, 1991; Weary & Edwards, 1996 & Hogg 2000). Uncertainty is perceived as threatening with individuals attempting to reduce or eliminate it wherever possible (Wilson, Centerbar, Kermer & Gilbert, 2005). Although uncertainty seems integral to everyday life, research has found it to be a powerful stressor, associated with increased levels of

psychological distress, anxiety and depression, as well as decreased well-being (Cohen 1993; Cowan, 1991; Mishel, 1990; Mishel & Sorenson, 1993; Karasek, 1990).

A large body of research has investigated the psychological impact of uncertainty caused by major life events, including ambiguous loss of a loved one (Landau & Hissett, 2008), going into foster care (Mitchell & Kuczynski, 2010), being diagnosed with (or a loved one being diagnosed with) a life-threatening illness (Wineman, Schwetz, Goodkin & Rudick, 1996; Hoff, Mullins, Gillaspy et al., 2005; Grootenhuis & Last, 1997) and disasters (Boin, van Duin & Heyse, 2001; Goto, Wilson, Kahana & Slane, 2006; Spence, Lachlan & Burke, 2007). These studies all found that major life events affected psychological well-being and suggested that uncertainty was at least one explanatory factor. Consequently, uncertainty engendered by major life events is correlated with increased psychological distress and physical health complaints.

5.3 Psychological definition of uncertainty

A psychological definition of uncertainty that may explain the importance of certainty and why major life events engendering uncertainty can have such a detrimental impact of an individual's physical and psychological well-being was proposed by Michael (1973, cited in Downey & Slocum, 1975). Michael (1973) suggested that uncertainty is a psychological state that arises from an individual losing control of both the situation and their self. He argued that humans learn to seek meaning for themselves from their surroundings. Consequently, maintaining a sense of control over the situation enables humans to find meaning in life and consequently develop the self.

5.4 Seeking asylum and uncertainty

Asylum seekers do not know how long they will have to wait for their decision or its outcome. Such uncertainty is also likely to be exacerbated by fear that they will be deported to their host country of origin and fears for their safety, if deported. In addition to this, restrictions on asylum seekers in the host country make it difficult to create certainty while they wait because they are unable to work, they may experience difficulties accessing healthcare and in the UK they may be moved by the Home Office in some cases frequently and at short notice, fracturing social links.

Study 1 discussed two types of uncertainty felt to explain the association they found between insecure legal status and psychological distress: duration and event uncertainty (Lazarus & Folkman, 1984 cited in Ryan, Benson & Dooley, 2008). Event uncertainty refers to the constant threat of something happening, i.e. being deported. Duration uncertainty refers to the stress of not knowing something important for one's future for a prolonged period of time. Lazarus and Folkman (1984) suggest that event uncertainty can immobilise coping mechanisms, especially for individuals whose lives may be at risk, if the event were to happen. In addition, asylum seekers may lack material resources to build a life for themselves when deported if all existing resources were used to seek and maintain safety in the host country.

Since uncertainty has negative effects on psychological distress, physical health and well-being, finding that eight of the studies proposed uncertainty to explain a large part of the psychological distress experienced by asylum seekers is not surprising. It is also consistent with qualitative investigations of psychological distress in asylum seekers

(Rees, 2003; Eastmond, 2007; Gill, 2009). A qualitative study investigating the effects of prolonged asylum claims on well-being concluded that insecurity of tenure and living with the fear of forced removal "significantly affected and dangerously compromised the well-being of asylum seekers" (Rees, 2003, pS96). Furthermore, Gill suggests that asylum seekers need stillness to create security, which is undermined by relocation, needing to frequently sign on, and living in fear of sudden removal (Gill, 2009). Eastmond (2007) parallels the uncertainty of the asylum process with the uncertainty of having a life-threatening illness and like Michael (1973) discusses how uncertainty undermines the sense of self, compromising one's capacity to develop a sense of belonging and undermining asylum seekers' ability to accurately evaluate their safety. Uncertainty may also exacerbate a sense of isolation. The current review findings and qualitative research both suggest therefore that the uncertainty of seeking asylum adversely affects psychological well-being, especially when this uncertainty is prolonged.

5.5 Alternative explanations

Study ten revealed that worries and uncertainty around the 'asylum procedure' appeared the strongest independent predictor of psychological distress in asylum seekers. In addition, uncertainty was proposed as a potential explanatory factor in eight of the ten papers. However, as discussed throughout there are many other factors involved in awaiting an asylum decision that may also explain the findings including not being able to work, losing significant others, less social support, difficulties accessing healthcare, being frequently moved and ongoing financial constraints.

One explanation for the increasing PTSD scores over time, which was discussed in study 4 was that PTSD may be a progressive disorder. This proposition needs further investigation. However, it is interesting that PTSD symptoms were not significantly higher in individuals who had been waiting more than two years compared to those waiting less than six months in study eight, despite significant differences in other measures of distress.

5.6 Implications

Research is needed which investigates the psychological impact of uncertainty caused by the process of awaiting an asylum decision. To enable the exact contribution of uncertainty to be assessed, a specific measure of the uncertainty asylum seekers experience whilst awaiting their decision needs to be developed. The role of uncertainty in the psychological distress associated with the process of seeking asylum can then be explored. If uncertainty is found to be as important as anticipated, then the findings would provide further evidence for the necessity to reduce the length of asylum claims and could have important clinical implications. For example, a two-session intervention (focussing on what uncertainty is, what causes it and how to manage it), has been found to significantly reduce distress in individuals experiencing illness uncertainty (Hoff et al., 2005). A similar intervention may also be usefully piloted to see if it reduces some of the psychological distress asylum seekers' experience whilst awaiting their decision.

This review suggests that the stringent legislation and policies which subject asylum seekers to extreme restrictions and force them to live with prolonged high levels of uncertainty, adversely affect asylum seeker's psychological well-being, which increases the longer they have to wait for their decision. Although the legislation and policies are

arguably justified at present by concerns about the number of non-genuine claims, the findings of the studies reviewed here highlight that change is required. Consequently, policies and legislation could be reviewed and length of time awaiting a decision shortened to ensure that genuine asylum applicants who have already suffered extensive pre-migration trauma are not unintentionally subjected to prolonged stress in the host country. This is especially important given the finding that awaiting an asylum decision has been found to have a greater negative psychological impact on asylum seeker's psychological well-being, than the initial trauma which led them to seek asylum (Laban et al., 2004). Shortening the wait of asylum claims, identifying causes of distress and where possible reducing distress using brief evidence-based interventions would also be more cost-effective because at present the asylum process inadvertently engenders distress, which results in treatment costs due to subsequent service use.

5.7 Review critique

The aim of this review was to identify and systemically assess studies that have investigated the psychological impact of the process of waiting for an asylum decision. It was hoped that by synthesising the findings of such studies, it would be possible to further discuss the possible explanatory role of uncertainty. However there were large variations in the samples, study designs and outcome measures of the studies. Additionally, given the diversity of countries included in reviewed papers, the legalities, procedures and restrictions that the asylum seeker samples experienced varied largely. Consequently exhaustive synthesis was precluded.

However, the findings of this review highlight that the current legal procedures for seeking political asylum, which require applicants to tolerate prolonged uncertainty, are

correlated with high levels of psychological distress, which increase over time until individuals receive their asylum decision. No quantitative research to date exists which examines the psychological impact of the asylum process in the UK. Future research could be usefully directed to establish how much of a role uncertainty plays in the psychological distress asylum seekers experience. However, a specific measure of the uncertainty asylum seekers experience whilst awaiting their decision needs to be developed first to enable the exact contribution of uncertainty to be assessed. Future studies would be most effective if they utilised an adequately sized and representative sample, a prospective design and employed the measures most commonly used in research with this population which has acceptable reliability and validity such as the PMLD, HSCL-25 and HTQ to assess current difficulties, as well as psychological distress (anxiety, depression and trauma). A measure of uncertainty specific to the asylum seeker population should also be included and diagnostic interviews conducted to reduce the possibility of transcultural measurement bias. In addition, socio-demographic factors and pre-migration trauma should be controlled for. More research utilising this methodology would enhance comparability of future studies and enable the role of uncertainty in asylum seekers psychological distress to be more clearly defined.

6. References

Abbott, P., Wallace, C., & Beck, M. (2006). Chernobyl: living with risk and uncertainty. *Health, Risk & Society, 8,* (2), 105-121.

Boin, A., van Duin, M., & Heyse, L. (2001). Toxic fear: the management of uncertainty in the wake of the Amsterdam air crash. *Journal of Hazardous Materials, 88,* 213-234.

Chida, Y., & Hamer, M. (2008). Chronic Psychosocial Factors and Acute Physiological Responses to Laboratory-Induced Stress in Healthy Populations: A Quantitative Review of 30 Years of Investigations. *Psychological Bulletin, 136,* (6), 829-885.

Coffrey, G. J., Kaplan, I., Sampson, R. C., & Tucci, M. M. (2010). The meaning and mental health consequences of long-term immigration detention for people seeking asylum. *Social Science & Medicine, 70,* 2070-2079.

Cohen, M. H. (1993). The unknown and the unknowable- managing sustained uncertainty. *Western Journal of Nursing Research, 15,* 77-96.

Cook, T. D., & Campbell, D. T. (1979). *Quasi-experimentation: Design and analysis issues for field settings.* Boston: Houghton Mifflin.

Cowan, P. A. (1991). Individual and family life transitions: A proposal for a new definition. In P. A. Cowan & M. Hetherington (Eds.), *Family transitions (pp. 3−30).* Hillsdale, New Jersey: Lawrence Erlbaum Associates, Inc.

Eastmond, M. (2007). Stories as lived experience: narratives in forced migration research. *Journal of Refugee Studies, 20,* 2, 248-264.

Festinger, L. (1954). A theory of social comparison processes. *Human Relations, 7,* 117-140.

Fiske, S. T., & Taylor, S. E. (1991). *Social cognition (2nd ed).* New York: McGraw-Hill.

Gill, N. M. (2009) Longing for stillness: the forced movement of asylum seekers. *Journal of Media and Communication, 12,* 1–'still'.

Gorst-Unsworth, C., & Goldenberg, E. (1998). Psychological sequelae of torture and organised violence suffered by refugees from Iraq. Trauma-related factors compared with social factors in exile. *British Journal of Psychiatry, 172,* 90-94.

Goto, T., Wilson, J. P., Kahana, B., & Slane, S. (2006). The Miyake island volcano disaster in Japan: loss, uncertainty, and relocation as predictors of PTSD and depression. *Journal of Applied Social Psychology, 36,* 8, 2001-2026.

Greco, V., & Roger, D. (2003). Uncertainty, stress, and health. *Personality and Individual Differences, 34,* 1057-1068.

Grootenhuis, M. A. & Last, B., F. (1997). Parents' emotional reactions related to different prospects for the survival of their children with cancer. *Journal of Psychosocial Oncology, 15,* (1), 43-62.

Hauff. E., & Vaglum, R. (1995). Organised violence and the stress of exile. Predictors of mental health in a community cohort of Vietnamese refugees three years after resettlement. *British Journal of Psychiatry, 166,* 360-367.

Hoff, A, L., Mullins, L. L., Gillaspy, S. R., Page, M. C., Van Pelt, J. C., & Chaney, J. M. (2005). An intervention to decrease uncertainty and distress among parents of children newly diagnosed with diabetes: A pilot study. *Families, Systems & Health, 23,* (3), 329-342.

Hogg, M. A. (2000). Subjective uncertainty reduction through self-catergorization: a motivational theory of social identity processes. In W. Stroebe & M. Hewstone (Eds), *European review of social psychology* (pp223-255). Chichester, UK: Wiley.

Jennings, R., Averill, J., Opton, E., & Lazarus, R. S. (1971). Some parameters of heart rate change: perceptual versus motor task requirements, noxiousness, and uncertainty. *Psychophysiology, 7,* 194-212.

Karasek, R. A. (1990). Lower health risk with increased job control among white collar workers. *Journal of Organizational Behaviour, 11,* 171-185.

Laban, C. J., Gernaat, H. B. P. E., Komproe, I. H., Schreuders, B. A., & De Jong, J. T. V. M. (2004). Impact of a long asylum procedure on the prevalence of psychiatric disorders in Iraqi asylum seekers in the Netherlands. *The Journal of Nervous and Mental Disease, 192,* (12), 843-851.*[3]

Laban, C. J., Gernaat, H. B. P. E., Komproe, I. H., van der Tweel, I., & De Jong, J. T. V. M. (2005). Postmigration living problems and common psychiatric disorders in Iraqi asylum seekers in the Netherlands. *The Journal of Nervous and Mental Disease, 193,* (12), 825-832.*

Laban, C. J., Komproe, I. H., Gernaat, H. B. P. E., & De Jong, J. T. V. M. (2008). The impact of a long asylum procedure on quality of life, disability and physical health in Iraqi asylum seekers in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology, 43,* 507-515.*

Landau, J., & Hissett, J. (2008). Mild traumatic brain injury: impact on identity and ambiguous loss in the family. *Families, Systems & Health, 26,* (1), 69-85.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping.* New York: Springer.

Lie, B. (2006). A 3-year follow-up study of psychosocial functioning and general symptoms in settled refugees. *Acta Psychiatrica Scandinavica, 106,* 415-425.

*[3] Asterisks denotes references for studies that were critically reviewed

Lopes, L. L. (1987). Between hope and fear: the psychology of risk. *Advances in Experimental Psychology, 20*, 255-295.

Michael, D. (1973). *Learning to Plan and Planning to Learn.* San Francisco: Josey Bass.

Michultka, D., Blanchard, E. B., & Kalous, T. (1998). Responses to civilian war experiences: Predictors of psychological functioning and coping. *Journal of Traumatic Stress, 11*, (3), 571-577.

Mishel, M. H. (1990). Reconceptualization of the uncertainty in illness theory. *Image: The Journal of Nursing Scholarship, 22,* 256-262.

Mishel, M. H., & Sorenson, D. S. (1991). Uncertainty in gynecological cancer: A test of the mediating functions of mastery and coping. *Nursing Research, 40,* (3), 167-171.

Mishel, M. H., & Sorenson, D. S. (1993). Revision of the Ways of Coping Checklist for a clinical population. *Western Journal of Nursing Research, 15*, 59-76.

Mitchell, M. B., & Kuczynski, L. (2010). Does anyone know what is going on? Examining children's lived experience of the transition into foster care. *Children and Youth Services Review, 32,* 437-444.

Monat, A., Averill, J., & Lazarus, R. (1972). Anticipatory stress and coping reactions under various conditions of uncertainty. *Journal of Personality and Social Psychology, 24*, 237-253.

Momartin, S., Steel, Z., Coello, M., Aroche, J., Silove, D. M., & Brooks, R. (2006). A comparison of the mental health of refugees with temporary versus permanent protection visas. *Medical Journal of Australia, 185,* (7), 357-361.*

National Center for Posttraumatic Stress Disorder. PILOTS researcher database. Available at: www.ncptsd.va.gov

Last accessed: 09/12/2010
Last Updated: 19/06/2007

National statistics online (2009)
Available at: http://www.statistics.gov.uk/cci/nugget.asp?id=261
Last accessed: 08/01/2011
Last updated: 20/05/2009

NICE (2006)
Available at: http://guidance.nice.org.uk/CG26/Guidance/pdf/English
Last accessed: 10/04/2011
Last updated: 22/01/2011

Padilla, G. V., Mishel, M. H., & Grant, M. M. (1992). Uncertainty, appraisal and quality of life. *Quality of Life Research, 1,* 155-165.

Refugee Council (2009)
Available at: http://www.refugeecouncil.org.uk/practice/basics/truth.htm
Last accessed: 10/04/2011
Last updated: 2011

Rees, S. (2003). Refuge or retrauma? The impact of asylum seeker status on the wellbeing of East Timorese women asylum seekers residing in the Australian community. *Australasian Psychiatry, 11,* Supplement, 96-101.

Ryan, D, A., Benson, C. A., & Dooley, B. A. (2008). Psychological distress and the asylum process. A longitudinal study of forced migrants in Ireland. *The Journal of Nervous and Mental Disease, 196,* (1), 37-45.*

Roth, G., & Ekblad, S. (2006i). A longitudinal perspective on depression and sense of coherence in a sample of mass-evacuated adults from Kosovo. *The Journal of Nervous and Mental Disease, 194,* (5), 378-381.*

Roth, G., & Ekblad, S. (2006ii). A longitudinal study of PTSD in a sample of mass-evacuated Kosovars, some of whom returned to their home country. *European Psychiatry, 21,* 152-159.*

Silove, D., Sinnerbank, I., Field, A., Manicavasagar, V., & Steel, Z. (1997). Anxiety, depression and PTSD in asylum-seekers: associations with pre-migration trauma and post-migration stressors. *The British Journal of Psychiatry, 170,* 351-357.

Silove, D., Steel, Z., McGorry, P., & Mohan, P. (1998). Trauma exposure, postmigration stressors, and symptoms of anxiety, depression and post-traumatic stress in Tamil asylum-seekers: comparison with refugees and immigrants. *Acta Psychiatrica Scandinavica, 97,* 175-181.*

Silove, D., Steel, Z., Susljik, I., Frommer, N., Loneragan, C., Chey, T., Brooks, R., le Touze, D., Ceollo, M., Smith, M., Harris, E., & Bryant, R. (2007). The impact of refugee decision on the trajectory of PTSD, anxiety, and depressive symptoms among asylum seekers: a longitudinal study. *American Journal of Disaster Medicine, 2,* (6), 321-329.*

Spence, P. R., Lachlan, K. A., & Burke, J. M. (2007). Adjusting to uncertainty: coping strategies among the displaced after hurricane Katrina. *Sociological Spectrum, 27,* (6), 653-678.

Steel, Z., Silove, D., Brooks, R., Momartin, S., Alzuhari, B., & Suslick, I. (2006). Impact of immigration detention and temporary protection on the mental health of refugees. *British Journal of Psychiatry, 188,* 58-64.*

Weary, G., & Edwards, J. A. (1996). Causal-uncertainty beliefs and related goal structures. In R. M. Sorrentino & E. T. Higgins (Eds), *Handbook of motivation and cognition: the interpersonal context* (pp148-181). New York: Guildford.

Wilson, T. D., Centerbar, D. B., Kermer, D. A., & Gilbert, D. T. (2005). The pleasures of uncertainty: prolonging positive moods in ways people do not anticipate. *Journal of Personality and Social Psychology, 88,* 5-21.

Wineman, M. N., Schwetz, K. M., Goodkin, D, E., & Rudick, R. A. (1996). Relationships among illness uncertainty, stress, coping, and emotional well-being at entry into a clinical drug trial. *Applied Nursing Research, 9,* (2), 53-60.

Secondary traumatisation and post-traumatic growth: how are employees of charities who provide practical support to asylum seekers affected by their work?

1. Abstract

Secondary traumatic stress (STS) may result from indirect exposure to traumatogenic material such as hearing about another person's trauma. STS can affect emotional state, cognitions and physical well-being. A national survey of staff working for charities that provide support and advice to asylum seekers/ refugees across the UK was undertaken to investigate (STS) and post-traumatic growth (PTG) in the population. The Secondary Traumatic Stress Scale (Bride, 2004) and Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996) were completed by 130 participants along with measures of team support, organisational support, social support, empathy and personal characteristics. The revised Ways of Coping Questionnaire (Folkman, Lazarus, Gruen & DeLongis, 1986) was also completed by 123 participants. Findings indicated that 92% of participants experienced at least one symptom of STS as a consequence of their work, with 28% endorsing symptoms that meet the diagnostic criteria for PTSD. Participants did not report high levels of PTG though. 'Planful problem solving' was the most frequently endorsed domain of coping, used by 56% of the sample. 'Escape avoidance' was the least frequently endorsed domain, used by only 25% of the sample. Only three coping domains significantly predicted STS and PTG. 'Escape avoidance' explained the most variance for STS and 'positive reappraisal' explained the most variance for PTG. These findings suggest that STS but not PTG may be an inevitable consequence of listening to other people's trauma. The high levels of STS highlight the need for strategies to mitigate distress for individuals providing practical support to asylum seekers and refugees.

2. Introduction

2.1 Primary and secondary traumatic stress

Many professions' competencies and roles involve providing practical, psychological or emotional support to individuals who have experienced trauma and may be traumatised sufficiently to warrant diagnosis of PTSD. The Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision or DSM-IV-TR (2000) defines Post-Traumatic Stress Disorder (PTSD) as a serious mental condition following "an individual experiencing, witnessing, or being confronted with a traumatic event/s that involved actual death or threatened death or serious injury; or a threat to the physical integrity of himself or herself or others" (American Psychiatric Association, 1994, p427). However traumatogenic events may affect not only those who experience them directly, but also those exposed to them indirectly. Secondary traumatic stress (STS) may result from indirect exposure to traumatogenic material such as hearing about another person's trauma (Zimering, Munroe & Gulliver, 2003). Its symptomatology appears very similar to PTSD (Figley, 1999) and its operationalisation has arisen since the DSM-IV diagnostic criteria for PTSD were revised to recognise that individuals such as close friends or family members may experience post-traumatic stress symptoms through vicarious exposure to another's traumatic experience (American Psychiatric Association, 1994).

STS has been operationalised variously by different researchers. Compassion Fatigue is one such construction, a range of emotional responses and psychological symptoms (such as nightmares) that develop from therapeutic work with trauma victims (Figley, 1995). Another encapsulation of the phenomenology is vicarious traumatisation, a

process whereby an individual's cognitions become altered after hearing about another individual's experiences of trauma, causing significant disruption to the "therapist's feelings, relationships and life" (McCann & Pearlmann, 1990, p136). Secondary traumatisation stress disorder (STSD) is perhaps a broader conceptualisation, referring to both altered emotional responses and psychological symptoms, and altered cognitions that occur as a result of supporting an individual who has suffered a traumatic event (Figley, 1999). Figley argues that frequent contact with trauma survivors may have a cumulative effect, thus increasing the likelihood of developing STSD. There remains much confusion and overlap in the literature concerning the above terms and definitions (Sabin-Farrell & Turpin, 2003). STS in the current study has been defined as STSD because it's symptomology is most consonant with the current DSM-IV PTSD criteria.

Research has identified a variety of protective and risk factors relating to the development of STSD in therapists and mental health professionals. Protective factors include: amount of training and use of available support such as supervision, organisational support and social support (Jenkins & Elliott, 2004; Lerias & Byrne, 2003). Factors conferring risk include: duration working with trauma survivors; detail of the trauma described; perceived stressfulness of current caseload (Lugris, 2000), personal trauma history (Lerias & Byrne, 2003), gender (Lerias & Byrne, 2003), age (Lerias & Byrne, 2003) and empathic engagement (Sexton, 1999). The above risk factors seem likely to also render individuals providing practical support to asylum seekers and refugees vulnerable to STS. However, to date no evidence exists to confirm or refute this

Research over the last two decades has consistently demonstrated that clinicians who provide therapy or more general support to trauma survivors, including survivors of sexual violence (Schauben & Frazier, 1995); physical violence; disasters (Eidelson, D'Alessio & Eidelson, 2003); war zones (Kenny & Hull, 2008) and life threatening illnesses (Sinclair & Hamill, 2007) may develop physical, emotional and cognitive symptoms indicative of STS. Yet STS may also be experienced by individuals working in non-therapeutic contexts, such as police personnel, medical professionals, armed forces and emergency services personnel. Even those performing a routine civic duty such as jury service are reported to suffer symptoms of both short and long term traumatic stress as a result of graphic evidence presented in court, with no subsequent recourse to discussion (Robertson, Davies & Nettleingham, 2009).

More neglected by researchers have been those individuals working in charitable contexts exposed to the trauma histories and narratives of asylum seekers and refugees whom they support. These staff are not necessarily clinically trained but will hear accounts of their clients' pre- and postmigration trauma on a regular basis and thus may be vulnerable to experiencing STS.

2.2 Supporting asylum seekers and refugees

According to the Geneva convention, (1951, cited in Refugee Council, 2009) a refugee is someone who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of their nationality, and is unable to or, owing to such fear, is unwilling to avail him/herself of the protection of that country". An asylum seeker is

someone who has applied to become a refugee but who is currently still awaiting the Home Office's decision regarding their claim. By definition, most asylum seekers will have experienced significant trauma prior to their arrival in the host country, for example, torture, war, domestic violence, rape or imprisonment. As a result asylum seekers and refugees are more likely to meet the diagnostic criteria for PTSD than the general population (NICE, 2006) with recent research reporting prevalence rates of PTSD in individuals seeking asylum in the Netherlands ranging from 31.5%- 41.7% (Laban, Gernaat, Komproe, Schreuders & De Jong, 2004).

Within three days of arriving in the UK, an asylum seeker must declare their reason for wishing to seek asylum in the UK and provide a detailed account of the trauma they have suffered prior to their arrival. In addition, extensive evidential support is required throughout the asylum process both in the form of written documentation and oral accounts in a court of law. As new arrivals in the country, many asylum seekers need practical and legal support to help them to meet these government requirements. Provisional Home Office figures for 2008 indicate that there were 25,670 applications for asylum in the UK last year (National statistics online, 2009). Consequently, a large number of charities now provide nationwide practical support and advice to asylum seekers. The individuals working for these organisations will have both ad hoc meetings with asylum seekers and carry more involved and sustained caseloads with both asylum seekers and refugees. Typically, staff are employed to assist clients with all stages of the asylum process including helping obtain accommodation, accessing legal aid, education and receiving benefits. Much of the role also entails providing client advocacy.

Most supportive roles in the UK involve assisting asylum seekers and refugees, including destitute clients. Employees of charities are thus likely to hear accounts of the trauma their clients have experienced or witnessed in the host country and since arriving in the UK. Examining humanitarian aid workers (HAW) in India who performed a very similar role to those in the current study, Shah, Garland and Katz (2007) investigated the prevalence of STS. The workers were employed to provide practical support due to a lack of trained mental health professionals in India but also informally provided emotional and psychological support to trauma survivors in India with little or no training. The researchers found that all 76 workers reported STS as a consequence of their work with 8% meeting the DSM-IV criteria for PTSD. However, no published research to date has investigated the prevalence of STS in employees of charities who support asylum seekers and refugees, despite their frequent contact with the narratives of trauma survivors, often with little or no formal training.

Although no published studies have focused specifically on the phenomenon of STS in individuals working with refugees or asylum seekers, the emotional responses of therapists at the Medical Center for Refugees in Sweden, a resource who help refugees that have survived political torture have been qualitatively examined (Holmqvist & Anderson, 2003). Seven themes, both positive and negative, emerged from interviews with participants: uncertainty; guilt; exhaustion; psychological symptoms; protective mechanisms; view of life; and construction of their work as meaningful and rewarding. Quantitative changes in the therapist's emotional responses were also examined over time, using psychotherapy unit staff and psychiatric staff from two treatment homes as comparison groups. Therapists working with refugees reported numerically more feelings provoked via work and felt their judgement to be less objective than

comparison therapists. Arguably working with refugees may provoke a more empathetic response in the therapist than working with other trauma survivors. Alternatively, individuals drawn to working with refugees may be more empathic. As empathic engagement is highlighted as a risk factor for experiencing STS this requires further exploration. However, as no measure of therapist's beliefs, trauma history or construction of client's vulnerability were collected it is impossible to rule out the possibility that therapist variables acted as confounder variables

UK-based studies are scarce but are also worthy of note. Woodcock (2010), in an unpublished study explored importance of supervision for psychotherapists working with asylum seekers and refugees, finding high levels of distress, including anger, anxiety, dissociation and intrusive phenomena among therapists. He also found that therapist's existential beliefs were reported to have markedly changed as a result of their work with asylum seekers/ refugees. This is consistent with Gorst-Unsworth and Goldberg's (1998) research investigating PTSD in a sample of Iraqi torture survivors, who found that those with a diagnosis of PTSD were more preoccupied by existential than by medical themes. Woodcock (2010) concluded that supervision was essential to mitigate distress and that further research was required to investigate whether the rewards of helping asylum seekers and refugees serve as a protective factor against the extreme stress of the work.

A further qualitative study, investigated the emotional experiences of twelve members of staff who provided practical support to asylum seekers and refugees (Guhan, 2010). Five themes emerged: aspects of the work; reaping the rewards; personal impact;

managing the impact and training, support and supervision. Like Woodcock (2010), Guhan (2010) found that participants evaluated work as very rewarding and again proposed that the intrinsic rewards of the work may serve as a protective factor against STS. Guhan (2010) also asked staff members to complete a professional quality of life scale, which included a brief measure of secondary traumatic stress. Her sample mean was above the 75th percentile on the secondary trauma subscale and overall five participants (42%) were in the elevated range. Guhan's (2010) findings therefore provide further support for the importance of investigating the prevalence of STS in staff who support asylum seekers and refugees.

2.3 Post-traumatic growth and vicarious post-traumatic growth

Suffering a traumatic event is not always a solely negative experience. Many individuals report positive psychological changes following the struggle of coping with a trauma. Post-traumatic growth (PTG) or adversarial growth refers to the process of finding higher meaning in traumatic experience which results in the individual feeling enhanced or improved as a result of the traumatic experience (Tedeschi & Calhoun, 1995). Examples of growth include finding and acknowledging strengths within oneself, new interests and priorities, better appreciation of life and spiritual development. Calhoun and Tedeschi (1999) estimated that 40- 70% of individuals who experience trauma, later report some benefit from coping with the event(s).

Such positive psychological changes have also been reported in therapists who have not themselves suffered trauma but who have worked with traumatised clients and had

grown vicariously as a result of being exposed to client's experiences of life-threatening events (Linley, Joseph & Loumidis, 2007). The authors proposed the 'organismic valuing theory of growth through adversity' encompassing both the positive and negative changes that may occur after a traumatic experience, with an emphasis on personal growth. The model suggested that good social support was key to an individual growing following adversity consonant with Woodcock (2010) and Guhan's (2010) findings that the rewarding work altered many of the worker's world view. Both concluded that the rewarding elements of the work may result in positive emotional responses which protect workers against secondary stress with social support identified as key to growth and being able to manage the impact of the work (Guhan, 2010). Stamm (2005) also suggested compassion satisfaction may protect against STS. Consequently, PTG and the impact of support also require investigation in staff who support asylum seekers and refugees.

2.4 The current study in context

A growing body of research now highlights the existence of STS, and its consequences for the well-being of therapists and mental health professionals who work with trauma survivors. Research also suggests that individuals who are not overtly engaging in therapeutic work with trauma survivors but who hear narratives of trauma survivor's experiences may suffer from STS. Asylum seekers are often exposed to traumatic events and may report these to staff who subsequently work with them. Consequently, one might expect that the employees of charities who provide support to asylum seekers and refugees will experience high levels of stress and in some cases STS, as a result of their work.

Working both therapeutically and non-therapeutically with asylum seekers and refugees appears to make workers vulnerable to STS. Existing research suggests many risk factors for experiencing STS but for staff working with asylum seekers and refugees this requires further exploration. Lack of support and empathy may be especially relevant risk factors for rendering supporters vulnerable to experiencing STS. Furthermore, recent research is beginning to highlight the positive psychological changes that may occur vicariously through supporting an individual who has witnessed or experienced trauma. However, no published research exists to date which has investigated the relationship between STS and providing practical support and advice to asylum seekers and refugees, investigated PTG in individuals providing practical support and advice to asylum seekers and refugees or explored whether PTG may serve as a protective factor against workers experiencing STS.

2.5 Aims and Objectives

The current study therefore aimed to investigate the presence of STS and PTG in staff who provided practical advice or support to asylum seekers and refugees and factors that might predict such presence.

Specific research questions were:

1. To what extent are employees of charities who provide advice and support to asylum seekers and refugees experiencing STS as a consequence of their work?
2. To what extent do employees of charities who provide advice and support to

asylum seekers and refugees report PTG as a consequence of their work?

3. How do employees of charities who provide advice and support to asylum seekers and refugees cope with the work?

4. What factors best predict STS and PTG in employees of charities who provide advice and support to asylum seekers and refugees?

3. Method

3.1 Design

A cross sectional, quantitative national survey of staff working for charities who provided support and advice to asylum seekers was conducted. Data was gathered using eight questionnaire measures, which are described in the materials section (see Appendix I for full questionnaire pack). Information from these questionnaires constituted the 19 variables examined in the current study (gender, age, months working in the field, supervision, training, empathy, three support variables- social, team and organisational, STSS, PTGI and the eight domains from the ways of coping questionnaire). These variables were chosen based on the protective and risk factors of STSS and PTGI identified in the current literature base.

Prior to the quantitative survey two employees of a local charity that provided practical support to asylum seekers were interviewed and asked to complete the eight questionnaire measures. Upon completion, they were then asked to reflect on their experience of completion of questionnaires and asked whether any additional questions

or measures should be added to the questionnaire pack to capture their experiences more meaningfully.

Mixed methodology was considered and then decided against given an extensive and coherent evidence base describing STS and PTG in mental health professionals. In addition, positive and negative emotional experiences of employees providing practical advice and support to asylum seekers and refugees had been examined, albeit in an unpublished thesis (Guhan, 2010). Consequently, the two interviews and completed questionnaire packs served solely as a pilot to inform the researcher of whether any extra or alternative questions or quantitative measures needed to be included in the national survey (see section 3.31 for details of the pilot study).

3.2 Participants

The sample comprised individuals who were employed to provide practical advice and support to asylum seekers and/or refugees. Most participants were paid employees for charity organisations and offered both one-off consultations and had more in-depth sustained caseloads, although some volunteers also participated. Mental health professionals, or individuals whose job role was to provide therapeutic rather than practical support were excluded as much research already exists regarding the impact of working therapeutically with trauma survivors. The two pilot participants were both recruited from a local charity in the East Midlands. Survey participants were recruited from across the UK (see Table 2 below for participant characteristics).

3.3 Procedure

3.31 Pilot study

Both of the interview participants agreed to take part following the researcher presenting the research study at a local charity. The researcher therefore issued the information sheet (see Appendix F for the pilot participant information sheet), ensured they fully understood the requirements of the study and answered any questions prior to arranging dates for the interviews. Both interviews were conducted in private rooms at the charity base. Prior to the interviews taking place, the patient information sheet was reviewed again and informed consent obtained (see Appendix G). Interviews lasted between 60 and 90 minutes and followed a semi-structured format (see Appendix H for interview schedule). After the interviews, the researcher asked both interview participants for suggestions of any potential improvements to the questionnaire pack. The questionnaire pack was amended accordingly prior to starting the recruitment process for the national survey.

3.32 National Survey

Charities that supported asylum seekers and refugees in the East Midlands were approached initially given established links in the local area. Further participants were then located using online resources such as business search engines (yell.com) and snowballing. Charities were called or sent an email explaining the study. Employees who were potentially interested in taking part or who wanted more information were asked to email the researcher. All participants received an information sheet (see Appendix G for the survey participant information sheet). Confidentiality and anonymity were explained to participants via the patient information sheets.

In addition, to calling and emailing charities, the researcher presented the research to potential participants at a local conference and visited relevant organisations in London and throughout the East Midlands. Links were also made with individuals who publish newsletters and/or network with individuals who support asylum seekers and refugees. Finally, a YouTube video featuring the researcher and a newspaper interview with the researcher, were posted online to allow potential participants who the researcher was unable to meet, to find out more about the research study. The participant pack was available online at www.surveymonkey.com. Alternatively participants could request a paper copy of the questionnaire pack.

All participants who expressed interest in taking part in the survey and who had received a copy of the participant information sheet were directed to the online questionnaire pack or sent a paper copy. The pack included the eight questionnaire measures, an entry form for the £50 prize draw and a support sheet detailing where individuals could seek further support should it be necessary upon completing the study. The questionnaire measures took approximately thirty minutes to complete. Participants who completed the questionnaires online were asked to confirm that it was acceptable to submit their responses to the researcher before being told that their participation is complete. Participants who requested paper copies of the questionnaire pack were asked to return the questionnaires (and the entry form if they wished to be entered into the prize draw) in the pre-paid envelope included in their pack.

3.4 Materials

The questionnaire pack consisted of the following eight self-report measures:

1. A 'personal information' measure, which was compiled by the researcher with feedback from the two pilot participants. The measure gathered demographic information and asked about participant characteristics such as age, gender, length of time working with asylum seekers, whether supervision was received as part of their role, whether they had experienced any significant personal stress in the past six months (such as trauma, bereavement, serious illness), whether they attended personal therapy and details of their trauma work, such as approximately how much trauma they were exposed to each week, what training they had had and asked them to rate their mood on a scale from one to ten.

2. **Secondary Traumatic Stress Scale (STSS; Bride, 2004**) The STSS is a 17-item measure that assesses secondary PTSD symptoms in clinicians over the past seven days, on a five-point likert scale. It comprises five-item subscales for intrusion and arousal and a seven-item subscale for avoidance. It has a maximum score of 85 and a minimum score of 17. Higher scores indicate a greater likelihood of secondary traumatic stress. This scale was selected given it has an appropriate cut off score identified following research with social workers. The cut off score of 38 has a sensitivity of 93. This means that 93% of individuals with PTSD would be correctly identified from a score of ≥38 on the STSS (Bride, 2007). Convergent, factor and discriminate construct validity are reported in Bride (2004) and reliability scores are: full score (.93); intrusion (.80); arousal (.83); avoidance (.87).

3. **Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996).** The PTGI was selected given its use in measuring perceived growth following trauma or adversity, in previous secondary trauma research (Linley & Joseph, 2007). Frazier et al (2009) have suggested that perceived and actual growth appear to reflect different processes. However, no single scale exists which measures actual growth and the PTGI is the most commonly used measure of PTG in the literature. It is a 21-item measure which requires responses to be given on a six-point likert scale, giving an overall score that ranges from zero to 105. Higher scores indicate a greater experience of post traumatic growth. The inventory covers change in five areas of one's life: new possibilities, relating to others, personal strength, spiritual change and appreciation of life. Internal reliability scores vary between .67 (appreciation of life) and .90 (full scale). Acceptable test-retest reliability and construct validity have been reported (Tedeschi & Calhoun, 1996). The full scale scores were used in the current research study.

4. **Reynolds Empathy Scale (RES; Reynolds, 2000).** The choice of RES was informed by Yu and Kirk's (2009) systematic review of empathy measurement tools. This scale was rated as the third highest quality. However, the two higher rated scales were felt inappropriate for this research as one was designed for teachers, the other an 84-item scale developed by nurses. The RES is a 12-item scale, rated on a seven-point likert scale. Higher scores represent greater empathy in respondents. The scale has high levels of concurrent validity, internal consistency, discrimination and test-retest reliability. In addition, it has

good face and content validity as examined by six experts from nursing and clinical psychology (Yu & Kirk, 2009).

5. **The Revised Ways of Coping Questionnaire (WCQ-R; Folkman, Lazarus, Gruen, & DeLongis, 1986).** The WCQ-R identifies the processes and behaviours people use to cope with stressful situations. It is a widely used measure in related studies (Knussen, Sloper, Cunningham & turner, 1992). The questionnaire consists of 50 items (plus 16 fill items) within eight empirically derived scales. It was revised to remove redundant items and to alter the response format from yes/no to a four-point likert scale (zero= does not apply and/or not used; three= used a great deal). Higher scores indicate a wider array of coping strategies utilised. It has good reliability and validity figures and alpha values vary from 0.61- 0.79.

6. **Eight-item Survey of Perceived Organisational Support (SPOS; Eisenberger et al., 1986).** This survey measures the level of organisational support that an individual feels they receive. Higher scores indicate a greater perception of organisational support and was used to investigate whether this is a protective factor for the potentially aversive effects of work. Reliability for the full scale was reported to be .95.

7. **Crisis Support Scale Short Form (CSS; Joseph et al., 1992).** The Crisis Support Scale examines support at the time of trauma (in this study this refers to hearing trauma disclosure), and support following the trauma to date. It is a six item scale, using a seven-point likert scale. The total score will therefore range

from six to 42, where higher scores indicate greater support. Good discriminatory validity has been reported (Elklit et al., 2001) and the reliability score for the full scale version was .82. When tested for construct validity, it was found that the CSS measured multi-factorial aspects of social support rather than just received support (Elklit et al., 2001). This was therefore used as a generalised measure of social support in the current study.

8. A team support measure was also designed by the author. This consisted of four questions asking whether they felt supported, included and valued by the team and whether they felt part of team decisions. Questions were rated on a five-point likert scale, ranging from four to 20. Where one represented- no, two- rarely, three- moderately, four- mostly and five- always. See section five of Appendix I for the questions.

3.5 A Priori Sample Size Power Calculations

The sample size required was calculated by separately considering both of the primary outcome measures (the PTGI and the STSS) and the secondary research questions. The larger sample size number was taken to be the number of participants required to answer the research questions.

A sample size was calculated based on the comparison of PTGI scores between individuals who had grown as a result of their trauma and individuals who had not grown following their trauma. To detect a statistically significant difference, at the 5% significance level, with 80% power whereby the traumatised individuals score 83.16 (SD 19.27) and the non-traumatised individuals score 69.75 (20.47), 35 individuals

were needed per group. Consequently 70 participants were considered necessary in total. The expected values for the PTGI score were taken from 'The Positive Legacy of Trauma' (Tedeschi & Calhoun, 1996).

The calculations explained above were also calculated for the STSS. To detect a statistically significant difference, at the 5% significance level, with 80% power whereby the traumatised individuals score over 38 the non-traumatised individuals score ≤37, 27 individual were needed per group. These expected values were taken from, ' Prevalence of Secondary Traumatic Stress among Social Workers (Bride, 2007).

An a priori sample size calculator for multiple regression (www.danielsoper.com) suggested that to further investigate the impact of up to eighteen predictor variables on the dependent variables STSS and PTGI scores, with an alpha level of 0.05 and with a medium anticipated effect size of 0.15, 118 participants would be required. Consequently, a minimum of 118 participants were sought to answer the research questions.

4. Results

4.1 Feedback from the pilot study.

The pilot participants were asked to comment on the applicability of the questionnaire pack to working with asylum seekers and refugees. Both felt that the measures were applicable. However, some suggestions were made which they felt would improve the usefulness of the research for them. One participant commented that workers'

questionnaire responses were likely be highly affected by mood due to the 'emotional rollercoaster' implicit in this kind of work. It was also commented that adding an open ended question about how support could be improved was likely to be beneficial. Finally, both participants felt that there should be more asked about general stress and emotional responses to the work, how individuals cope and how coping has changed over time, rather than just focussing on STS and PTG. These changes were incorporated into the final questionnaire pack. However, as the research questions were focused on STS and PTG it was decided that responses related to emotions provoked in the work would be written up as a separate research paper.

4.2 Analysis

The Statistical Package for the Social Sciences (SPSS) version 18 was used for statistical analyses. The data met all statistical assumptions. It was normally distributed, with no outliers and no transformations necessary. Due to the snowballing sampling method used in the study it was not possible to calculate a response rate. However, 130 participants started the questionnaire pack, of whom 123 completed all measures. Only four respondents requested paper copies of the questionnaires, prohibiting comparisons with participants who completed responses online.

4.3 Demographics

Participants from all areas of the UK participated in the study (see Table 2 for demographic and background data). The majority of the participants were female (72%)

and British (65%), although participants were of 13 different nationalities. Most participants (69%) reported that their job role involved helping both asylum seekers and refugees. Approximately half of participants felt they had received sufficient training for their role (48%). Similarly, 53% reported receiving regular supervision, although regular was interpreted very differently by participants with some describing it as weekly and others as three-monthly. 52% of the sample reported having taken time off work for stress, with 26% of individuals seeking support to cope either through counselling, self-help books or training for stress.

Table 2: Demographic and background information

	N	%	Mean	SD
Age	**126**		43.48	12.99
Months working in the field	**129**		79.41	57.92
Hours per week	**129**		30.47	10.93
Hours of trauma per week	**124**		4.26	5.00
Mood 1-10	**120**		6.44	1.70
Gender	**130**			
- Female	93	72%		
Nationality	**130**			
- British	85	65%		
- European	11	9%		
- Black African/ Afro Caribbean	9	7%		
- Mixed Race	7	5%		
- Asian/ Indian	6	5%		
- Other	12	9%		
Where work	**130**			
- Not known	36	28%		
- East Midlands	30	23%		
- Yorkshire and the North East	22	17%		
- London and the South East	14	11%		
- North West England	8	6%		
- Wales	7	5%		
- West Midlands	6	5%		
- South West England	4	3%		
- East Anglia	2	1%		
- Scotland	1	1%		
Who support	**127**			
- Asylum seekers and refugees	87	69%		
- Only asylum seekers	27	21%		
- Only refugees	13	10%		
Training received	**126**			
- Regular/ enough	61	48%		
Supervision	**127**			
- Yes regularly	67	53%		
Reported seeking external support i.e. counselling	**127**			
Yes	33	26%		
Taken time off work for stress	**127**			
- Yes	32	52%		

4.4 Research question 1:

To what extent are employees of charities who provide advice and support to asylum seekers and refugees experiencing STS as a consequence of their work?

Table 3: Descriptive statistics for the STSS

	N	Mean	SD	Min	Max	Standardised Mean*	Mean from Paper**	Means sig diff?
STSS- Total	130	34.27	10.73	17	70	40%	29.69	P <0.01
Intrusion	130	10.60	3.31	5	19	42%	8.18	P <0.01
Avoidance	130	13.90	5.14	7	33	40%	12.58	P= 0.01
Arousal	130	9.77	3.39	5	22	39%	8.93	P=0.02
Above cut-off?	36	(28%)						
Endorsed intrusion items	130	1.73	1.35	0	5	35%		
Endorsed avoidance items	130	2.14	1.89	0	7	31%		
Endorsed arousal items	130	1.42	1.39	0	5	28%		
Met full criteria	37	(28%)						

* Mean as a % of total possible score, to allow comparisons between subscales with different numbers of items
** Bride (2007)

36 participants (28%) of the sample were above the suggested cut off score of 38 on the STSS (Bride, 2007). Bride (2007) suggested that secondary trauma levels can also be established by looking at whether the items marked were in line with the DSM-IV criteria for PTSD, which states that individuals should endorse at least 3 avoidance symptoms, 2 arousal symptoms and 1 intrusion symptom. If a symptom was reported to be experienced "occasionally," "often," or "very often" in the preceding seven days, then the item was endorsed. 10 participants (8%) did not endorse any symptoms. However, 37 participants (28%) endorsed symptoms in line with the DSM-IV criteria for PTSD. Consequently, the two methods both suggested that 28% of the sample were experiencing STS. In addition, the mean score on the STSS was 34.27, which was only

slightly below the cut-off score of 38. The mean score and each of the subscale scores fell between the 51st to the 75th percentile of the normed data, which indicates mild secondary traumatic stress (Bride, 2007).

Consequently, individuals who provide advice and support to asylum seekers and refugees do appear to be experiencing STS as a consequence of their work, with 28% of the sample endorsing symptoms that meet the diagnostic criteria for PTSD. (See Appendix K for a graphical representation of the total STSS scores). By converting the mean subscale scores into percentages of the maximum score available (see standardised means in Table 3) it was found that symptoms of intrusion were the most highly reported by the sample (for example, 66% of the sample endorsed the item "I thought about my work with clients when I didn't intend to" as between 3 and 5 therefore "occasionally", "often" or "very often"). In line with this, the intrusion subscale score was found to be only 0.40 from the 75th percentile of the normed data, with the 75th percentile indicating moderate secondary traumatic stress. Comparisons of the sample mean with the normed data from Bride (2007)'s sample of 282 social workers revealed that the current sample reported significantly more STSS (total and all three subscale scores- see Table 3) than Bride found in his sample of social workers.

4.5 Research question 2:

To what extent do employees of charities who provide advice and support to asylum seekers and refugees report PTG as a consequence of their work?

Table 4: Descriptive statistics for the PTGI

	N	Mean	SD	Min	Max	Standardised Mean*	Non-trauma paper mean**
PTGI- Total	130	49.41	21.92	0	92	47%	73.49
New possibilities	130	11.71	5.98	0	25	47%	18.26
Relating to others	130	16.39	8.05	0	35	47%	23.94
Personal strength	130	9.68	5.12	0	20	48%	14.65
Spiritual change	130	3.05	3.16	0	10	31%	6.48
Appreciation of life	130	8.58	3.42	0	15	57%	10.16

* Mean as a % of total possible score, to allow comparisons between subscales with different numbers of items
** Tedeschi & Calhoun (1996)

The mean score of 49.41 on the PTGI (see Table 4), suggested that participants had not grown to the levels reported for traumatised samples (Tedeschi & Calhoun, 1996). However some participants did fall into traumatised levels (see Appendix L for a graphical representation of the total PTGI scores). By converting the mean subscale scores into percentages of the maximum score available it was found that 'appreciation of life' was the factor where participants most reported change as a result of their work. The least change was reported in the 'spiritual change' domain. The mean PTGI score was 2.4, where 2 represents "a small degree" and 3 represents "a moderate degree" of change. Similarly, to other papers that have utilised the PTGI (Widows, Jacobsen, Booth-Jones & Fields, 2005; Cordova, Giese-Davis, Golant, Kronwetter, Chang & Spiegel, 2007) frequency of PTG was calculated by including items where at least a moderate degree of change was endorsed (3-5 on the scale). The mean frequency of items endorsed was 11.1 but the full range from 0 to 21 was observed. Three items were endorsed by more than 70% of the sample: "I have a greater appreciation for the value of my own life" (79%), "I have more compassion for others" (74%) and "I learned a great deal about how wonderful people are" (74%). Three items were endorsed by less than 40% of the sample: "I better accept needing others" (39%), "I have a better

understanding of spiritual matters" (37%) and "I have a stronger religious faith" (25%).

4.6 Research question 3:

How do employees of charities who provide advice and support to asylum seekers and refugees cope with the work?

Table 5: Descriptive statistics for the ways of coping questionnaire

Measure	N	Mean	SD	Min	Max	Standardised Mean*
Ways of coping total	123	73.37	21.54	30	159	34%
Confrontative coping	123	5.20	2.45	0	13	40%
Distancing	123	5.26	3.23	0	15	35%
Self-controlling	123	9.11	3.24	2	18	51%
Seeking social support	123	8.76	2.98	2	17	52%
Accepting responsibility	123	3.57	2.50	0	12	30%
Escape avoidance	123	5.41	4.07	0	22	25%
Planful problem solving	123	10.00	3.63	1	18	56%
Positive reappraisal	123	6.86	3.95	0	20	34%

* Mean as a % of total possible score, to allow comparisons between domains, despite having a different numbers of items

The 'planful problem solving' domain was most frequently used by the sample, the sample mean being 10 out of a possible 18 (56%). The 'escape avoidance' domain was least frequently used (see Table 5), with a sample mean of 5.4 out of a possible 22 (25%) Item 8: "Talked to someone to find out more about the situation" was the most used item, with 81% of the sample reporting that they used it "quite a bit" or "a great deal". The seven items that were used least by the sample, with just 7% reporting that they used it "quite a bit" or "a great deal" were: "I did something which I didn't think would work, but at least I was doing something"; "I expressed anger to the person(s) who caused the problem"; "I got professional help"; "I realized I brought the problem

on myself"; "I found new faith"; "I avoided being with people in general" and "I refused to believe that it had happened".

4.7 Research question 4:

What factors best predict STS and PTG in employees of charities who provide advice and support to asylum seekers and refugees?

Table 6: Descriptive statistics for the empathy and support measures

Measure	N	Mean	SD	Min	Max	Standardised Mean*
Team support	129	15.88	3.60	4	20	80%
Organisational support	128	35.58	12.20	0	48	73%
Social support	129	28.94	9.88	6	42	69%
Reynolds Empathy Scale	130	51.32	5.93	31	66	71%

* Mean as a % of total possible score, to allow comparisons between domains, despite having a different numbers of items

Multiple regression analysis

Demographic factors, participant variables and participants' scores on the study's questionnaire measures were entered into two multiple regression analyses. One multiple regression analysis explored the relationship between the eighteen predictor variables and STSS scores, the other explored their relationship with PTGI scores. Collinearity diagnostics were examined and no multicollinearity found.

Some of the variables were interrelated; see correlations in Table 7. However, no correlations were high enough (.70) to affect the regression analyses. STS was

significantly negatively correlated with five of the variables: gender, age, the three support variables (team, organisational and social) and positively correlated with a further four of the variables: regular supervision, and three domains of the ways of coping questionnaire (self- controlling, accepting responsibility and escape avoidance). PTG was significantly negatively correlated with two of the variables: gender, regular supervision and positively correlated with a further six of the variables: two of the support variables (team and organisational) and four domains of the ways of coping questionnaires (confrontative coping, seeking social support, planful problem solving and positive reappraisal).

The regression results are presented in Table 8. The multiple regression model for STS was significant, $F= 3.80$, $p<.001$, power= 0.99. The 18 predictor variables accounted for 30% of the variance in STSS scores. Two of the variables were found to be significant predictors: the distancing and escape avoidance domains from the ways of coping questionnaire. Distancing was negatively associated with STS, whereas as escape avoidance was positively associated. Escape avoidance explained the most variance. The multiple regression model for PTGI was also significant, $F= 3.43$, $p< .00$, power= 0.99. The 18 predictor variables accounted for 27% of the variance in PTGI scores. However, only positive reappraisal was found to be a significant predictor.

Table 7: Intercorrelations between the study variables *p<.05, **p<.01, ***p=.00

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1.STSS total																		
2.Gender	-.178*																	
3.Age	-.287**	.258**																
4.Months in field	-.056	-.081	.252**															
5 Supervision	.165*	-.032	.082	-.013														
6.Training	-.005	-.084	.148	-.025	.370***													
7.Confron coping	.105	-.073	-.231**	.088	-.137	-.108												
8.Distancing	.067	.206*	-.139	-.023	-.111	-.175*	.164*											
9.SelfControlling	.224**	.093	-.061	-.101	-.005	-.091	.118	.568***										
10.Seeking Social	-.039	-.209*	-.050	.014	-.062	-.097	.322***	.007	.170*									
11.Accept Respo	.303***	-.029	-.115	-.046	.021	.000	.185*	.344***	.529***	.246**								
12.EscapeAvoid	.506***	-.205*	-.344***	-.099	.017	-.017	.302***	.491***	.502***	.123	.629***							
13.Planful prob	-.024	-.038	-.021	-.002	-.048	.000	.366***	.131	.329***	.443***	.098	.016						
14.Positive Re-ap	-.098	-.014	.053	-.003	-.091	.017	.158*	.350***	.389***	.361***	.380***	.257**	.348***					
15.Empathy	-.089	.172*	.072	-.072	-.027	-.186*	-.073	-.098	.110	.085	-.015	-.138	.118	-.010				
16.Team support	-.394***	.040	.213*	.128	-.328***	-.077	.006	-.010	-.105	.185*	-.108	-.315***	.167*	.186*	-.071			
17.Org support	-.390***	.010	.223**	.120	-.307***	-.008	-.033	-.049	-.140	.263**	-.170*	-.306***	.203*	.167*	-.203*	.731***		
18.Social support	-.335***	.153*	.117	.116	-.323***	-.210*	.032	-.012	-.159*	.292**	-.094	-.337***	.074	.128	-.047	.575***	.595***	
19.PTGI Total	-.087	-.154*	-.079	.144	-.211*	-.071	.164*	.090	.032	.231**	.102	.071	.208*	.494***	-.124	.253**	.205*	.087

Table 8: Results of the multiple regression analyses for the STSS and PTGI total score variables

Independent Variables	Beta	P Value	Independent Variables	Beta	P Value
Gender	-.009	.924	**Gender**	-.039	.688
Age	-.092	.337	**Age**	-.144	.140
Months in the field	.046	.592	**Months in the field**	.145	.094
Regular Supervision	.076	.415	**Regular Supervision**	-.130	.172
Enough training	-.071	.436	**Enough training**	-.074	.427
Ways of coping-			**Ways of coping-**		
Confrontative coping	-.065	.499	Confrontative coping	.011	.911
Distancing	**-.228**	**.046**	Distancing	-.045	.702
Self-controlling	.101	.399	Self-controlling	-.145	.232
Seeking social support	-.053	.613	Seeking social support	.052	.631
Accepting responsibility	.050	.659	Accepting responsibility	-.012	.918
Escape avoidance	**.494**	**.001**	Escape avoidance	-.044	.772
Planful problem solving	.122	.245	Planful problem solving	.038	.722
Positive reappraisal	-.168	.133	Positive reappraisal	**.537**	**.000**
Empathy	-.105	.248	**Empathy**	-.109	.239
Team support	-.084	.501	**Team support**	.183	.147
Organisational support	-.154	.251	**Organisational support**	-.007	.958
Social support	.030	.796	**Social support**	-.196	.096
PTGI total	.004	.971	**STSS total**	.004	.971
Dependent Variable: STSS total			Dependent Variable: PTGI total		

5. Discussion

A national survey of staff working for charities who provide support and advice to asylum seekers and refugees across the UK was conducted to investigate presentation of STS and PTG in this population. Findings indicated that 92% of participants experienced at least one symptom of STS as a consequence of their work, with 28% endorsing symptoms that meet the diagnostic criteria for PTSD. Participants did not report PTG to the extent expected in traumatised nor non-traumatised samples though (Tedeschi & Calhoun, 1996). In terms of coping, 'planful problem solving' was the most frequently endorsed domain, used at least 'quite a bit' by 56% of the sample, whereas as 'escape avoidance' was the less frequently endorsed domain, used at least 'quite a bit' by only 25% of the sample. Despite STS being significantly correlated to

nine of the variables and PTG being significantly correlated to eight, only three domains from the ways of coping questionnaire significantly predicted STS and PTG. 'Escape avoidance' explained the most variance for STS and 'positive reappraisal' explained the most variance for PTG. The findings of each research question will now be interpreted and related to theory and practice.

5.1 Research question 1:

To what extent are employees of charities who provide advice and support to asylum seekers and refugees experiencing STS as a consequence of their work?

Guhan (2010) investigated the emotional experiences of twelve members of staff who provided practical support to asylum seekers and refugees, including a brief measure of STS. The sample mean was above the 75th percentile on the secondary trauma subscale and five participants (42%) were in the elevated range. She suggested that STS may be prevalent in staff who support asylum seekers and refugees and therefore required further investigation. The current study's findings confirm Guhan's (2010) suggestion because the total score and the three subscale scores were indicative of STS. In addition, the current sample reported significantly more STS than Bride (2007) found in his sample of social workers. However, the mean (34.27) was lower than the 41.44 found in Shah, Garland and Katz's (2007) sample of Indian HAW's. Interestingly, this latter study found that only 9% of their sample met the criteria for PTSD, whereas 28% of the current sample endorsed symptoms that meet the diagnostic criteria for PTSD. Although these findings may appear contradictory, one possible explanation may be due to homogeneity of samples. Shah, Garland and Katz (2007) reported that 100% of their

sample reported at least one symptom of STS. However, in the current study, ten participants did not report any symptoms, which may have reduced the overall mean score. Although the participants in neither sample were employed to provide emotional or psychological support, Shah, Garland and Katz (2007) reported that due to a lack of mental health professionals in India, workers did provide some emotional and/or psychological support. It is interesting therefore that in the current study the percentage of participants who the met the criteria for PTSD was so much higher than in Shah, Garland and Katz's research. These differences may confirm that duration working with trauma survivors is an important risk factor (Lerias & Byrne, 2003) because the current sample had on average been working in the field for seven years. Additionally, respondents in this sample were still actively working in this field, whereas Shah and colleagues asked respondents to complete the STSS five months after mass violence had subsided in India, which may have resulted in a period of recovery in STS symptoms, which resulted in lower levels of diagnosable PTSD.

The current findings appear to fit theoretically with Figley's description of STS as "the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced or suffered by a person" (Figley, 1995, p7). STS at a level indicative of diagnosable PTSD was a natural consequence of supporting asylum seekers and refugees for 28% of this sample. In some respects, this figure is unsurprising given that individuals seeking asylum have higher levels of PTSD than the general population (Nice, 2006). However, considering the sample did not therapeutically support clients through trauma, finding that over a quarter of them met the criteria for PTSD is a cause for concern. Such levels are not only troubling for individuals themselves but are likely to engender sub-optimal practice and support in

organisations if staff distress has attained such levels. Figley (1995) reported that individuals with STS are more likely to feel tired and less likely to be effective team members. For example, they may be more unavailable to or overly judgemental of clients or colleagues who want to discuss cases, as well as unwilling to carry out activities that contribute to the growth of their organisation such as professional networking. Figley (1995) also highlighted that cynicism is often a result of STS, which can lead to a spread of disrespect for clients and workers throughout the organisation.

Although it is important to report the prevalence of STS symptoms and percentage of participants who reported diagnosable levels of PTSD, it is equally as important to consider the findings in a wider, more psychological context. Consequently, it should be highlighted that reporting one symptom of STS is not unusual and should not be considered to be pathological or of concern. For example, many people in a range of different roles are likely to indicate at least one of the following symptoms at any one time: “I had trouble sleeping”; “I was less active than usual”; “I thought about my work with clients when I didn't intend to”; “I had trouble concentrating” or “I was easily annoyed”.

Personality factors also play a salient role in how well individuals manage stress. For example, self-efficacy, self-esteem and self-acceptance can buffer against stress (Davidson, 1999). In addition, research suggests that the ability to successfully manage stressful situations may depend on how ‘hardy’ an individual is (Kobasa, 1979). Hardiness is a personality variable consisting of three related beliefs, known as the three ‘C’s. The three ‘C’s are control, commitment and challenge (Kobasa, 1979). Whereby a

high hardy (high control, commitment and challenge) individual is likely to be better able to manage stress and therefore take less stress-related sick leave than a low hardy individual. However, some debate concerning the validity of this finding exists in the literature. Funk and Houston (1987) highlighted that a low hardy individual may just be more likely to complain of sickness or stress when it isn't present than a high hardy individual. As experiences of distress can be affected by a large number of variables and the effects of distress on people also vary so widely it is important to acknowledge that high levels of self-reported distress will not inevitably affect an individuals' ability to function well both at work and outside of the work setting.

5.2 Research question 2:

To what extent do employees of charities who provide advice and support to asylum seekers and refugees report PTG as a consequence of their work?

The mean score for each item of the PTGI was 2.4, representing a small to moderate degree of change. In addition, three items were endorsed by more than 70% of the sample. Consequently, participants appear to report some PTG as a result of their work. However, when the PTGI was developed, it was validated on American psychology undergraduates, with the authors reporting mean values for males (73.61) and females (90.26) who had experienced trauma and for males (66.13) and females (73.49) who hadn't experienced trauma (Tedeschi & Calhoun, 1996). The current sample mean (49.41) is significantly below these mean values, despite the high levels of vicarious trauma exposure and STS observed in the current sample.

Over the past decade, PTG has been increasingly researched in relation to survivors of life threatening illnesses. Mean PTG scores in survivors of breast cancer have consistently been found to fall between 55 and 65 (Cordova, 1999; Sears, Stanton & Danoff-Burg, 2003; Weiss, 2002; Widows, Jacobsen, Booth-Jones & Fields, 2005). Manne, Ostroff and Winkel (2004) measured change in breast cancer survivor's longitudinally and found baseline PTGI scores to be 49 which rose to 52.8 at nine month follow up and 55.7 at 18month follow-up. In addition, Linley and Joseph (2007) recently investigated vicarious PTG in 156 therapists found a mean PTGI score of 64.42. The mean PTGI score in the current study (49.41) is consonant with the baseline score in Manne, Ostroff and Winkel's (2004) research and significantly lower than levels of PTG in therapists (Linley & Joseph, 2007).

Despite participants in previous studies rating their work with asylum seekers as very rewarding and the researchers therefore proposing that the intrinsic rewards of the work may serve as a protective factor against STS (Woodcock, 2010; Guhan, 2010), no significant correlation was observed between STS and PTG, and PTG did not possess significant explanatory power as a predictor variable of STS. Consequently, PTG did not appear to mediate the relationship between exposure to other people's trauma and STS. This is supportive of research by Widows et al. (2005) and Cordova et al. (2007) who also found no significant correlations between the STS or PTSD symptoms and PTG. However, the low levels of PTG observed in the current sample may or may not have influenced the lack of apparent association between STS and PTG in this population.

There are a number of factors that may have contributed to the low levels of PTG found in employees of charities who support asylum seekers and refugees. For example, differences in sample constitution is one explanatory factor. Peterson (2001) conducted a second order meta-analysis on the use of college student subjects in social science research. He found that student samples exhibit somewhat greater homogeneity and larger effect sizes than is the case with nonstudent samples. In almost one-fifth of studies, all conducted in America, even the directionality of effects among student samples differed from nonstudent samples. This highlights the potential lack of validity of student sample findings, which may in part explain the significant differences between the PTGI mean scores in Tedeschi and Calhoun's (1996) research and the current study. However, this would not explain why the mean was consonant with the baseline score in Manne, Ostroff and Winkel's (2004) research and significantly lower than levels of PTG in therapists (Linley & Joseph, 2007). In addition, despite the means provided in Tedeschi and Calhoun's (1996) research being derived from student samples, the PTGI is still the most frequently used measure of PTG in the literature and has good utility.

It is important to consider that PTG is proposed to result from the experience of struggling with a difficult life event (Tedeschi & Calhoun, 2004). However the current sample provided practical support rather than engaging therapeutically with client's traumatic life events. Consequently, the majority of the sample may not have grown to the expected levels because providing practical support does not entail struggling with their own trauma or helping clients with the struggle of dealing of their trauma, thus trauma material is likely to remain unresolved. In addition, the majority of the sample were not receiving supervision that facilitated them to process their own emotional

responses to client's traumatic material. Consequently, this finding may confirm that growth is not an inevitable result of trauma and that it is a person's struggle with their new reality following trauma, which leads to PTG (Tedeschi & Calhoun, 2004).

A further factor that needs to be considered as a possible contributor to the lower levels of PTG than expected in the current study is the heterogeneity of the sample. There were large variations in PTGI scores, 49 participants had very low scores on the PTGI (between zero and 40), whereas 44 participants scored very highly (between 60 and 92). Relationships between months working in the field, training, support, supervision and PTG were explored, although some limitations in the measurement of the training and supervision variables are discussed in the limitations section. However, participants' job roles varied between helping with accommodation, accessing legal aid, education, benefits and client advocacy. In addition, individuals working with destitute and on-going cases rather than holding one-off consultations may hear more traumatic material than other participants. Unfortunately, detailed differences in job roles were not controlled for in the current study. All individuals who provided practical support were included in the current study to enable the first quantitative study of its kind examining the effects of supporting asylum seekers and refugees and to ensure that findings were generalisable across the population. Further exploration of the prevalence of PTGI in specific job roles or organisational contexts in this population is therefore still necessary.

Finally, as previously mentioned, comparisons of PTGI ratings with scales measuring current behaviours in each of the PTGI domains concluded that perceived and actual

growth appeared to reflect different processes (Frazier, Tennen, Gavian, Park, Tomich & Tashiro, 2009). Consequently, the current sample may not have reported levels of perceived PTG found in previous research but participants may have displayed actual growth, which was not highlighted on the PTGI due to difficulties with the validity of the concept. Future research should therefore consider comparing perceived and actual growth within this population, as well as controlling more rigorously for job role and quality of supervision, including how regularly employees are provided with opportunities to work through their own emotional responses to traumatic material when necessary.

5.3 Research question 3:

How do employees of charities who provide advice and support to asylum seekers and refugees cope with the work?

'Planful problem solving' was the most frequently endorsed domain on the ways of coping questionnaire and 'escape avoidance' was the least frequently endorsed domain. These findings are not surprising considering the participants' job roles were to provide practical support to their clients. Consequently, one would expect participants to endorse items such as "Just concentrated on what I had to do next – the next step" and "I made a plan of action and followed it" (items one and 26, planful problem solving domain of the ways of coping questionnaire), rather than "refused to believe that it had happened" (item 50, escape avoidance domain of the ways of coping questionnaire).

5.4 Research question 4:

What factors best predict STS and PTG in employees of charities who provide advice

and support to asylum seekers and refugees?

Although 'escape avoidance' was the least endorsed domain on the ways of coping questionnaire it was the predictor that explained the most variance for STS. This finding requires further investigation longitudinally, and with path analysis, to find out whether individuals who use escape avoidant methods of coping are more at risk of developing STS or whether participants became more escape avoidant as a result of STS. In addition, modest negative correlations between the escape avoidance domain and team support, r= -.315, n= 123, p=0.00, organisational support, r= -.306, n= 123, p=0.00 and social support r= -.337, n= 123, p=0.00, also require further investigation. Longitudinal investigation of the association between escape avoidance and support would provide a better understanding of whether individuals are more likely to use escape avoidant methods of coping because they do not have adequate support or whether escape avoidant methods of coping disrupt personal relationships, resulting in less support.

The finding that the 'positive reappraisal' domain of ways of the coping questionnaire explained the most variance for PTGI score is consistent with past research. Sears, Stanton and Danoff-Burg (2003) also found that positive reappraisal coping predicted posttraumatic growth twelve months after receiving a diagnosis of breast cancer, even after controlling for time since diagnosis and perceived cancer stress. Due to the cross-sectional design of the study, it is again impossible to know whether positive appraising situations was a coping strategy that participants used preceding growth or whether it developed as a result of an increase in PTG.

Existing research suggests that amount of training and use of available support such as

supervision, organisational support and social support (Jenkins & Elliott, 2004; Lerias & Byrne, 2003) are protective factors against developing STS. Whilst duration working with trauma survivors, gender (Lerias & Byrne, 2003), age (Lerias & Byrne, 2003) and empathic engagement (Sexton, 1999) are potential risk factors. The finding that gender, age, months working in the field, perceptions of sufficient supervision and training, empathy and the three support variables were not significant predictors of STS nor PTG contradicts current literature. STS was significantly correlated with gender, age, regular supervision and the three support variables (team, organisational and social). However, regression analyses revealed that the distancing, escape avoidance and positive reappraisal coping domains were the only significant predictors of STS and PTG. This finding suggests that how an individual copes is the most important predictor of whether they are adversely or positively changed as a result of being exposed to traumatic material. Chang et al. (2003) also found that distancing, escape-avoidance and positive reappraisal were significant predictors of posttraumatic morbidity in rescue workers who helped following an earthquake. In Boudreaux, Mandry and Brantley's (1997) research investigating STS in emergency medical technicians, they also found that escape avoidance was highly correlated with negative outcomes including high levels of perceived stress, psychological exhaustion and physiological stimulation, and were more likely to have poorer attitudes towards patients. Consequently, the current findings are line with previous research. However, further research could usefully evaluate the reliability and consistency of the finding that coping is more important than other predictors of STS and PTG.

5.5 Limitations of research methodology and design

The measurement of training and supervision variables could have been improved. Although individuals reported whether or not they received 'regular' supervision and this variable was included in the regression analyses for STS and PTG, descriptions of participant's supervision revealed their definitions of 'regular' varied from weekly to three monthly and was on average four-six weekly. Consequently, it would have been better to ask how regular supervision was using pre-defined categories. In addition, many participants reported that supervision was provided from in-house managers and focussed mainly on practicalities such as annual leave and case load numbers, rather than in-depth case discussions or explorations about emotional aspects of the work. Some participants also stated that their supervision was on a group rather than a 1:1 basis. Consequently, the findings in relation to the supervision need to be interpreted with caution as many of the 61 participants who reported receiving 'regular' supervision did not appear satisfied with their supervision. In addition, only two participants reported receiving external supervision, despite recommendations that supervision should not be provided by management (Woodcock, 2010), which was echoed by participant's comments that they felt unable to speak openly about cases or how they felt in supervision due to a fear that management may perceive them to be incompetent or unable to handle the job. Bearing this in mind it is interesting to consider a proposition by Cohn (1994) that emotional distress may be responded to by finding "something practical to do", instead of reflecting on the experience. Use of planful problem-solving as the predominant coping strategy in this sample may also therefore reflect the lack of adequate supervision described by the majority of the sample.

Similarly, the amount of training individuals received varied largely. Some participants reported it to be very good and stated that they continue to receive regular training, whilst other participants talked about receiving no training and learning on the job or reported that they have self-funded training or instead rely on experience or training from past jobs. Again the qualitative descriptions of the training variable revealed that some participants who described having sufficient training reported that it had focused mainly on practical issues such as writing reports or legal issues. Again the training variable may have been more useful therefore if pre-defined categories were used and as it was not operationalised clearly enough here, the finding that training did not correlate with or predict STS nor PTG, should also be interpreted with caution.

The majority of participants did not meet the researcher and completed the survey online potentially increasing risk of self-selection bias. Consequently, individuals who were being most adversely affected by the work or individuals who had adjusted well to the work (healthy worker effect) may have been more likely to participate. However, as recruitment was geographically widespread, the sample size was quite large and many organisations were supportive of the research (encouraging participants to take part and allowing them to do so in work time) it is less likely that participants volunteered only if they felt excessively or not at all distressed by their work. The supportive nature of many of the organisations was greatly appreciated although it is also acknowledged that this may have affected participants self-reports of how supportive their team and organisation were, with participants over-reporting support. However, participants' anonymity and the independence of this research study from their employment were clearly explained in the participant information sheets.

The cross sectional study design precludes assessment of causality in significant associations found. A longitudinal approach would enable a better understanding of whether support and coping styles are predictive or a consequence of STS and PTG. The current sample had been working in the field for an average of seven years and such high levels of STS were already present so it may be difficult to recruit an adequate sample of participants who were new to the work and/or did not have established patterns of coping and utilising support to answer the research questions with sufficient statistical power. The length of time available to conduct this research would also have made a longitudinal design difficult. In addition, it was important to establish prevalence rates of STS and PTG initially to provide evidence for the need of future prospective studies. Future research utilising a prospective design could now usefully investigate STS, PTG, support and coping in participants new to supporting asylum seekers and refugees, or measure changes in current staff via routine monitoring over time.

5.6 Contribution to the area

The high levels of STS and low levels of PTG in this population should not be ignored. 92% of participants reported at least one symptom of STS and 28% met the diagnostic criteria for PTSD. STS can negatively affect the psychological well-being of individuals and engender sub-optimal practice and support in organisations, affecting both clients and the organisation (Figley, 1995). Consequently, practice guidelines need to be developed to address the needs of the individuals who support asylum seekers and refugees as well as the organisations (Tehrani, 2010). The low levels of PTG also

confirm that PTG is not an evitable consequence of listening to other people's trauma and may only come from therapeutically engaging with trauma material, or from being well supported, supervised and/or trained. The need for supervision and a space to reflect and make sense of their own difficult emotions may be greater in the current sample than in individuals who make sense of a client's world following a traumatic event with them because neither the client's or the helper's emotional reactions to the event(s) have been understood. Bearing this in mind, it is especially concerning to learn that only 53% of individuals reported receiving supervision and of those, many stated it was irregular or ad hoc and that they felt unable to speak openly about cases or their emotional responses to the work due to be supervised by management.

5.7 Implications

The current study highlights high levels of distress in individuals who provide practical support to asylum seekers and refugees, which need to be addressed. There appears to be no single way to mitigate the effects of STS on the individual or organisation. The most appropriate intervention for individuals or organisations is often decided upon in collaboration with a trauma specialist (Salston & Figley, 2003). However, Cerney (1995) highlights that regular supervision and consultancy can be vital to preventing STS. Supervision provides emotional support, assists in developing relevant skills and provides the opportunity to discuss other relevant issues (Nicklin 1995). Cerney (1995) also highlights that supervision can provide an essential opportunity to process both client's painful material and the individual's emotions and cognitions, which may otherwise be overwhelming. Edwards et al. (2001) found that effective clinical supervision was associated with lower levels of emotional exhaustion and staff burn out.

Consequently, clinical supervision may result in lower levels of STS and reduced emotional distress for individuals providing practical support to asylum seekers and refugees.

Another form of support accruing evidence of effectiveness and may be useful for this population is group-delivered staff support, aiming to help. 'the members of a staff team talk together about the emotional impact of their work and supporting each other in coping with stressful situations' (Hartley & Kennard, 2009) They reviewed 12 studies, which suggested that staff support groups that are well set-up and well run are experienced as beneficial by those taking apart, especially if facilitated externally. The usefulness of groups was found to be affected by style of facilitator, personal expectations, role status and the atmosphere and culture of the workplace.

Increasing awareness of the concept of STS and how to mitigate its potential impact is a professional responsibility (Salston & Figley, 2003). It is also cost effective to mitigate the effects of STS because it reduces the psychological impact on the individual and as well as increasing capacity, efficiency, and ability to make good decisions and reducing sickness rates which are beneficial to organisations (Ehrenreich, 2004). Employers of individuals who support asylum seekers and refugees should therefore ensure that as well as adequate support, employees are given specific training regarding STS and how staff can protect themselves against it. For example, they may educate employees about adequate self-care, encourage a healthy balance between work and personal activities and raise employees' awareness so that they are mindful of any changes to trauma related schemas, such as trust, intimacy, control, self-esteem and safety (Munroe, 1999;

Pearlman & Saakvitne, 1995; Salston & Figley, 2003).

5.8 Responsibility for improving supervision, staff support and training

Organisations that require employees to be in direct contact with human suffering have a duty to safeguard their workforce, which includes undertaking a risk assessment of employees whose work may put them at risk of developing secondary trauma, burnout or mental health difficulties (Tehrani, 2010). As previously discussed it is the employer's responsibility to provide information, supervision, training, support and adequate leave, as well as limiting caseloads and providing opportunities for individuals to receive mental health support if required, to allow individuals to carry out their role with minimal risk (Rudolph & Stamm, 1999; Salston & Figley, 2003). Tehrani (2010) also highlights that individuals have a responsibility to protect their own well-being by engaging in appropriate self-care and ensuring that their well-being does not harm others. Self-care can include physical aspects such as maintaining a healthy lifestyle including good sleep hygiene, a healthy diet, ensuring regular exercise and engaging in relaxation exercises and emotional aspects such as seeking appropriate support and journaling thoughts and dreams (Salston & Figley, 2003).

5.9 Future work

As this is the first quantitative study to investigate STS and PTG in individuals who provide practical advice and support to asylum seekers and refugees, the current findings pose as many additional questions as it has answered. Consequently, future research is required which further investigates: whether STS reduces when an individual is no longer supporting trauma survivors; the processes that enable PTG to occur, for

example does an individual need to engage therapeutically with trauma survivors trauma to experience growth or could PTG be experienced by utilising support mechanisms to make sense of their own emotional responses such as supervision, staff support groups, colleagues, family or friends. The effect of an individual's role in supporting asylum seekers and refugees on the likelihood of experiencing PTG also requires further exploration. Finally, the current study highlighted that coping style was most predictive of whether an individual develops STS or PTG, which future research could usefully explore to establish its reliability and validity. The most effective study design to further explore the relationship between support, coping styles, STS and PTG would be longitudinal as it would enable the researcher to establish whether support and coping are predictors or consequences of STS and PTG. Useful samples may include participants new to supporting asylum seekers and/or refugees, or current staff measured over time via routine monitoring. In addition, the current study did not use pre-defined categories to investigate the amount of supervision and relevant training individuals received. However, research commonly shows that these can be effective in preventing STS. Consequently, the current findings showing supervision and training not to be significant predictors need to be interpreted with caution. Future longitudinal research assessing levels of STS pre and post the delivery of training pertaining to STS and regular supervision would enable speculations that this may reduce STS levels to be investigated.

6. References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders (4th ed.)* Washington, DC: American Psychiatric Association.

Boudreaux, E., Mandry, C., & Brantley, P. (1997). Stress, job satisfaction, coping and psychological distress among emergency medical technicians. *Prehospital and Disaster Medicine, 12,* 242-249.

Bride, B. E. (2004). Development and Validation of the Secondary Traumatic Stress Scale. *Research on Social Work Practice, 14,* (1), 27-35.

Bride, B. E. (2007). Prevalence of Secondary Traumatic Stress among Social Workers. *Social Work, 52,* (1), 63-70.

Calhoun, L. G., & Tedeschi, R. G. (1999). *Facilitating posttraumatic growth.* Mahwah, NI: Lawrence Erlbaum Associates, Publishers.

Chang, C, M., Lee, L. C., Connor, K. M., Davidson, J. R., Jeffries, K., & Lai, T. J. (2003). Posttraumatic distress and coping strategies among rescue workers after an earthquake. *Journal of Nervous & Mental Disease, 191,* (6), 391-398.

Cohn, N. (1994). Attending to emotional issues on a special care baby unit. In A. Obholzer & V. Zagier Roberts (Ed.) *The unconscious at work: individual and organisational stress in the human services.* London: Routledge.

Cerney, M. (1995). Treating the "heroic treaters". In C. R. Figley (Ed.), *Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized* (pp131-149). New York: Brunner/Mazel.

Cordova, M. J. (1999). *Cognitive processing and the positive and negative psychosocial sequelae of breast cancer as trauma.* Unpublished doctoral dissertation. University of Kentucky, Lexington.

Cordova, M. J., Giese-Davis, J., Golant, M., Kronwetter, C., Chang, V., & Spiegel, D. (2007). Breast cancer as trauma: posttraumatic stress and posttraumatic growth. *Journal of Clinical Psychology in Medical Settings, 14,* 308–319.

Downey, H. K., Slocum, W. J. (1975). Uncertainty: Measures, Research and Sources of Variation. *Academy of Management Journal, 18,* (3), 562-578.

Edwards, D., Burnard, P., Hannigan, B., Cooper, L., Adams, J., Juggessur, T., Fothergil, A., & Coyle, D. (2001). Clinical supervision and burnout: The influence of clinical supervision for community mental health nurses. *Journal of Clinical Nursing, 15,* (8), 1007-1015.

Eisenberger, R., Hungtington, R., Hutchinson, S., & Sowa, D. (1986). Perceived organizational support. *Journal of Applied Psychology, 71,* 500-507.

Ehrenreich, J. (2004). Managing stress in humanitarian aid workers: the role of the organization.
Available at: http://www.docstoc.com/docs/42146671/Managing-Stress-in-Humanitarian-Aid-Workers-The-Role---Managing
Last accessed: 23/04/2011

Eidelson, R. J., D'Alessio, G. R., & Eidelson, J. I. (2003). The Impact of September 11 on Psychologists. *Professional Psychology: Research and Practice, 34,* (2), 144–150.

Elklit, A., Schmidt Pederson, S., & Jind, L. (2001). The crisis support scale: psychometric properties and further validation. *Personality and Individual Differences, 31,* 1291-1302.

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1-20). New York: Brunner-Routledge.

Figley, C. R. (1999). Compassion fatigue: Toward a new understanding of the costs of

caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, & educators (2nd ed*., pp. 3-28). Lutherville, MD: Sidran Press.

Folkman, S., Lazarus, R. S., Gruen, R. J., & DeLongis, A. (1986). Appraisal, coping, health status and psychological symptoms. *Journal of Personality and Social Psychology, 50,* (3), 571-579.

Frazier, P., Tennen, H., Gavian, M., Park, C., Tomich, P., & Tashiro, T. (2009). Does self-reported post-traumatic growth reflect genuine positive change? *Psychological Science, 20,* 912-919.

Gorst-Unsworth, C., & Goldenberg, E. (1998). Psychological sequelae of torture and organised violence suffered by refugees from Iraq trauma-related factors compared with social factors in exile. *The British Journal of Psychiatry, 172,* (1), 90-94.

Guhan, R. (2010). *The experience of staff working with refugees and asylum seekers in the United Kingdom: A grounded theory exploration*. Unpublished doctoral thesis. University of Coventry.

Hartley, P. & Kennard, D. (2009). *Staff Support Groups in the Helping Professions: Principles, Practice and Pitfalls.* East Sussex: Routledge.

Holmqvist, R., & Andersen, K. (2003). Therapists' reactions to treatment of survivors of political torture. *Professional Psychology: Research and Practice, 34,* (3), 294-300.

Jenkins, R., & Elliott, P. (2004). Stressors, burnout and social support: nurses in acute mental health settings. *Journal of Advanced Nursing, 48,* (6), 622–631.

Joseph, S., Andrews, B., Williams, R., & Yule, W. (1992). Crisis support and psychiatric symptomology in adult survivors of the Jupiter cruise ship disaster. *British Journal of Clinical Psychology, 31,* 63-73.

Kenny, D. J., & Hull, M. S. (2008). Critical Care Nurses' Experiences Caring for the Casualties of War Evacuated from the Front Line: Lessons Learned and Needs Identified. *Critical Care Nursing Clinics of North America*, *20*, (1), 41-49.

Laban, CJ., Gernaat, HBPE., Komproe, IH., Schreuders, GA., De Jong, JTVM. (2004). Impact of a long asylum procedure on the prevalence of psychiatric disorders in Iraqi asylum seekers in the Netherlands. *Journal of Nervous and Mental Disease, 192*, (12) 843–852.

Lerias, D., & Byrne, M.K. (2003). Vicarious traumatization: symptoms and predictors. *Stress and Health 19,* (3), 129–138.

Linley, P. A., & Joseph, S. (2007). Therapy work and therapists' positive and negative well-being. *Journal of Social and Clinical Psychology*, *26*, (3), 385-403.

Linley, P. A., Joseph, S. A., & Loumidis, K. (2005). Trauma work, sense of coherence, and positive and negative changes in therapists. *Psychotherapy and Psychosomatics*, *74*, (3), 183-188.

Lugris, V. (2000). Vicarious traumatisation in therapists: Contributing factors, PTSD symptomatology, and cognitive distortions. *Dissertation Abstracts International: Section B: the Sciences & Engineering, 61, 5572.* US: University Microfilms International.
Available at: http://lifecyclejourneys.com/Masterfiles/vicariousTraumatization.htm
Last Accessed: 13th November 2009.

Manne, S., Ostroff, J., Winkel, G., Goldstein, L., Fox, K., & Grana, G. (2004). Posttraumatic growth after breast cancer: Patient, partner, and couple perspectives. *Psychosomatic Medicine*, *66*, (3), 442-454.

Munroe, J. F. (1999). Ethical issues associated with secondary trauma in therapists. In B. H. Stamm (Ed.), *Secondary traumatic stress (pp. 211−229)., Second edition.* Letherville, Maryland: Sidran Press.

National Statistics Online (2009).
Available at: http://www.statistics.gov.uk/cci/nugget.asp?id=261
Last accessed: 23rd May 2009.

NICE (2006). CG26 Post-traumatic stress disorder (PTSD): full guideline, including Appendices 1-13.
Available at: http://guidance.nice.org.uk/CG26/Guidance/pdf/English
Last Accessed: 13th November 2009.

Nicklin, P. (1995). Super supervision. *Nursing Management, 2,* (5), 24–25.

Pearlman, L. A., & Saakvitne, K. W. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized (pp. 150−177).* New York, NY: Brunner/Mazel.

Peterson, R. A. 2001. On the use of college students in social science research: Insight from second-order meta-analysis. *Journal of Consumer Research 28,* (3), 450–461.

Refugee Council. (2009). Definition of a refugee.
Accessed at: http://www.refugeecouncil.org.uk/glossary/
Last accessed: 4th January 2010.

Reynolds, W. J. (2000). *The measurement and development of empathy in nursing*. Ashgate, Aldershot.

Robertson, N., Davies, G. M. & Nettleingham, A. (2009). Vicarious traumatisation as a consequence of jury service. *Howard Journal of Criminal Justice, 48,* 1-12

Rudolph, J. M., & Stamm, B. H. (1999). Maximizing human capital: Moderating secondary traumatic stress through administrative and policy action. In B. H. Stamm (Ed.), *Secondary traumatic stress (pp. 277−290). Second edition.* Letherville, Maryland: Sidran Press.

Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: Implications for the mental health of workers? *Clinical Psychology Review, 23,* 32−36.

Salston, M., & Figley, C. R. (2003). Secondary traumatic stress effects of working with survivors of criminal victimization. *Journal of Traumatic Stress, 16*, 167−174.

Schauben, L.J., & Frazier, P.A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly, 19,* (1), 49-64.

Sears, S. R., Stanton, A. L., & Danoff-Burg, S. (2003). The Yellow Brick Road and the Emerald
City: Benefit finding, positive reappraisal coping, and posttraumatic growth in women with early-stage breast cancer. *Health Psychology, 22*, 487-497.

Sexton, L. (1999). Vicarious traumatisation of counsellors and the effects on their workplaces. *British Journal of Guidance and Counselling, 27,* 393–403.

Sinclair, H. A., & Hamill, C. (2007). Does vicarious traumatisation affect oncology nurses? A literature review. *European Journal of Oncology Nursing, 11,* (4), 348-356.

Shah, S.A., Garland, E. & Katz, C. (2007). Secondary Traumatic Stress: Prevalence for Humanitarian Aid Workers in India. *Traumatology, 13,* 59-70.

Stamm, B. H. (2005). *The ProQOL Manual: The professional quality of life scale: Compassion satisfaction, burnout, and compassion fatigue/secondary trauma scales.* Lutherville, MD: Sidran Press.

Tedeschi, R. G., & Calhoun, L. G. (1995). *Trauma and transformation: Growing in the aftermath of suffering.* California: Sage Publications.

Tedeschi, R. G., & Calhoun, L. G. (1996). The posttraumatic growth inventory: measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9,* (3), 455-471.

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: conceptual foundations and empirical evidence. *Psychological Inquiry, 15,* 1-18.

Tehrani, N. (2010). *Managing trauma in the workplace: supporting workers and organisations.* New York: Routledge/ Taylor & Francis Group.

Weiss, T. (2002). Posttraumatic growth in women with breast cancer and their husbands: an intersubjective validation study. *Journal of Psychosocial Oncology, 20,* 65–80.

Widows, M. R., Jacobsen, P. B., Booth-Jones, M., & Fields, K. K. (2005). Predictors of posttraumatic growth following bone marrow transplantation for cancer. *Health Psychology, 24,* 266–273.

Wikipedia (2011). Uncertainty.

Available at: http://en.wikipedia.org/wiki/Uncertainty
Last accessed: 20/08/2011

Woodcock, J. (2010). *Trauma and supervision. The effects of trauma work on psychotherapists and their needs for supervision.* Unpublished doctoral dissertation. University of London.

Yu, J., & Kirk, M. (2009). Evaluation of empathy measurement tools in nursing: a systematic review. *Journal of Advanced Nursing, 65,* (9), 1790-1806.

Zimering, R., Munroe, J., & Gulliver, S. B. (2003). Secondary traumatization in mental health care providers. *Psychiatric Times, 20,* (4), 43-47.

1. Critical appraisal

1.1 Origins of the literature review and research topic

I have a longstanding interest in learning about other cultures, which has led me to travel much of Asia. In addition, both my undergraduate and MSc research projects investigated trauma and resilience, with a particular focus on recovery after a major stressor. These interests coalesced in one of my first year clinical psychology training placements, which involved working in a GP surgery specifically for asylum seekers. Conducting some brief counselling and psychoeducational work in this placement, my role was predominantly to signpost asylum seekers to other services or to provide practical support. I noticed that despite my role being primarily practical, many clients disclosed to me the trauma they had suffered in their home country and ongoing trauma they were experiencing in the UK. These narratives provoked powerful emotional responses in me that were understood in supervision as transference.

I presented my experiences of "working psychologically with asylum seekers" with another trainee who had conducted the same training placement at a conference in Leicester in 2009. The other trainee was in the process of conducting a qualitative thesis, which involved her interviewing men from Zimbabwe who were seeking asylum in the UK about the psychological impact of their experiences. As we talked, I knew that I also wanted to investigate the psychological impact of seeking asylum or evaluate the usefulness of an intervention with asylum seekers. I believe my passion for helping asylum seekers was largely due to a combination of empathy for their situation and anger that UK law means that many asylum seekers struggle to access healthcare let alone help for mental health issues, as well as being subjected to many other restrictions

and postmigration stressors, including living with prolonged feelings of powerlessness and uncertainty. As a result, I observed very high levels of distress with very little psychological support, especially whilst in the asylum process. As a British Citizen I felt ashamed of the UK asylum legislation, especially given that postmigration factors have been found to exacerbate and in some cases be a stronger predictor of mental health issues than the initial trauma suffered in their home country (Silove et al., 1997). I also felt ashamed of the negative stigma that still exists both in the public domain and in politicians surrounding individuals who seek asylum. Consequently, I initially planned to evaluate the usefulness of a seven week CBT-based group aiming at reducing PTSD symptoms in asylum seekers. However, this was not feasible given the available sample size and likely attrition before the thesis hand-in deadline.

As my research supervisor had an interest in STS, I began thinking about the numbers of staff that provide practical support, who may also frequently hear about their client's traumatic experiences and be coping with the powerful emotions that can be provoked without a psychological understanding or regular space in supervision to comprehend it. This was the basis of my first research question. However, I knew that if I wasn't going to conduct an intervention to help asylum seekers I wanted to at least report the positive aspects of working with asylum seekers and refugees. I quickly discussed fears with my research supervisor that my research would end up feeding into the vast negative social stigma that already exists should STS levels be high in individuals who support asylum seekers and refugees. This resulted in me choosing to investigate PTG too. In addition, to ensure the research was useful to individuals working in the field I decided to explore protective and risk factors in the population, as well as how individuals cope with the work.

As I had initially wanted to investigate the psychological impact of seeking asylum, rather than looking at the psychological impact of supporting individuals who were seeking asylum I decided to conduct my literature review in my initial area of interest, which I felt would add context in the form of a rigorous review.

1.2 Ethics process

My research did not utilise NHS staff or patients, so I needed to submit my proposal through the university ethics process. The University of Leicester ethics process is quite straightforward but it is less commonly utilised by clinical psychology doctoral students and consequently a misunderstanding in how to submit the form resulted in a delay of almost two months, which I found very frustrating as I was keen to begin. This taught me the importance of planning when carrying out research in a time-limited and efficient manner. I also chose to voluntarily go through the NHS ethics process to improve the robustness of my research and to help when submitting the research for publication in a peer-reviewed journal. The NHS ethic's board feedback helped me to: refine the methodology of this study, make information clearer for participants and make questionnaires more user-friendly and appropriate for the population. I found the panel friendly and so I learnt that the NHS ethical process is not as terrifying as I'd heard from colleagues! However, due to the research utilising non-NHS participants, I did encounter some unusual complications which necessitated me needing to locate a sponsor at the university and get hold of a copy of the university's insurance certificate for non-NHS based research studies. There were also some discrepancies in terms of the amendments suggested from each panel, which caused confusion. I resolved this by

clarifying which ethics panel's amendments I was legally bound to adhere to. The process of seeking acceptance of my research study as ethically sound taught me that I can envisage tasks to be much larger and more daunting than they are in reality. In addition, I now feel confident about completing the NHS ethics process for any future research I chose to conduct.

1.3 Recruitment process and data collection

I started the recruitment process by contacting local charities. One local organisation agreed to let me present to their employees at a team meeting and I recruited the pilot participants from this charity. I found talking to them about their experiences of supporting asylum seekers and refugees very interesting as I was able to empathise from my work supporting asylum seekers the previous year. However, I also noticed that I found it hard to remain in the researcher role (rather than as a trainee clinical psychologist) at times when the pilot participants told me about the impact of the work on them because as a psychologist I wanted to explore some of the difficult emotions and coping strategies they described further, which was not appropriate in a one hour research interview.

I realised that it was important to raise awareness of the research before beginning recruitment for the national survey and that it made sense to start doing this in the local area where I already had some connections. Consequently, I presented my research to a number of charities in the East Midlands, at multi-agency forums and health task groups across the East Midlands, which were meetings attended by lots of employees from

various local charities and organisations. I also presented at a local conference for individuals who supported asylum seekers and refugees and included participant information sheets in the conference packs. I quickly noticed that engaging local staff who work with asylum seekers and refugees was invaluable, as many were then very willing to raise further awareness and speak to colleagues about completing the survey on my behalf.

Once I had local support, I focused on raising awareness nationally, by contacting members of other multi-agency forums across the UK, advertising the study in relevant newsletters and publications and asking individuals to forward participant information sheets to other branches and to their personal contacts on my behalf. I realised that if I made strong connections with managers of organisations or co-ordinators of forums and asked them to forward my research request then response rates were much better than when I sent the requests myself. I asked some individuals why this was and was repeatedly told three things. One, that potential participants were very busy, received lots of requests to help with research and consequently did not necessarily have time to help someone they didn't know. However, if told about the study by a colleague then the research was assumed to be worthwhile and the researcher trustworthy. Two, related to me not working for an organisation that provided support to asylum seekers or refugees, which resulted in concerns about an 'outsider' conducting the research. Dywer and Buckle (2009) highlight that participants can consider outsiders to be unable to understand their experience. A number of the charities that I presented at seemed to support this suggestion as they said they would never had agreed to me visiting the team if I had not told them on the phone that I used to work in the field and as a result also feel passionately about helping individuals seeking asylum and staff who support them.

Finally, many organisations were interested in how the research would help them. It seemed important for them to ensure that the research was valuable before they agreed to be involved, perhaps due to the same fears that I had expressed- that it could add to social stigma if levels of STS were found to be high and the findings were not reported sensitively. As a result of learning these things, I realised that to recruit individuals from across the UK with the limited time and resources I needed to continue to appeal to managers and co-ordinators of services to raise awareness of my research, convey my passion to help individuals who supporting asylum seekers and refugees following experience working in the area and think creativity about making my requests more personal. So I added a photograph of myself to the participant information sheets, I spoke more about my personal experience in the field and how the research would help when talking to organisations, I made a YouTube video so that individuals could feel like they knew who they were helping and I conducted an interview with the world press which was published online to enable potential participants to read more about my personal views on asylum and find out more about the research. I believe these realisations were crucial to my success in the recruitment process.

However, I also acknowledge that the snowballing technique may have contributed to sampling bias, with managers asking employees who perceived themselves to be most or least affected by the work to participate or individuals who were most keen to impress management taking part. Some managers copied me into emails that were sent to the employees of organisations though and the requests simply asked employees if they would be willing to help. In addition, I emphasised on recruitment emails that responses were in no way linked to employment and findings were not fed back to organisations.

1.4 Online data collection

I found placing questionnaires on SurveyMonkey simple. It was convenient, saving lots of time administering and inputting the data. It was also relatively cheap, especially as it permitted access to national data collection without travelling across the UK. It has also been found that individuals are more likely to disclose socially sensitive issues online (Gerbert et al., 1999). Consequently, individuals may have been more likely to report that they did not feel stressed by the work if asked in person.

However, some difficulties of online data collection are also acknowledged. For example, it is possible that participants could have participated more than once. IP addresses were checked and no duplicates found, as suggested by Jones (2010). In addition, no two sets of demographics were identical. However, there is still a small possibility that individuals could have completed surveys more than once, from different computers, with different details if they felt passionately about the research showing a particular effect. Jones (2010) also suggested that participants may find it more tedious to complete large numbers of questions online than on traditional pen and paper methods. Seven participants failed to complete the last questionnaire measure, which may have been due to boredom with the process of answering questions online. This taught me that if I conduct another online survey, it will be useful to inform participants of how much of the survey remains and request that they complete the pack, rather than just thanking people for their participation at the end.

Another element of online data collection that was difficult was when participants reported feeling distressed by their work. Due to anonymity I was unable to check whether they were accessing the support suggested on the participant information sheet, if necessary. I discussed one response in particular with my research supervisor who felt that there was no cause for concern. Subsequently, I engaged in appropriate self-care by making sense of the feelings of powerlessness it had evoked in me in personal psychotherapy. This was an important reminder to me about the importance of being reflective as a researcher, as well as a clinician.

1.5 Research questions and measurement considerations

Due to a large number of measures available to assess STS and PTG, careful consideration needed to be taken when choosing the measures. Initially, I was going to use the Compassion Fatigue- Short Scale (Adams et al., 2006), however upon emailing one of the authors of this scale I learnt that it didn't have published means for traumatised versus non-traumatised groups. Conversely, I chose to utilise the STSS to measure STS because there were published means for traumatised versus non-traumatised groups, as well a cut-off score to suggest that an individual may be suffering from STS. In addition, the endorsement scoring method meant that responses could be linked to the diagnostic criteria for PTSD. The scale was also the most used measure amongst similar research in the area and allowed me to most effectively answer my research question. I also found it easy to obtain permission to use this scale from the author as he quickly responded to my request with a copy of the scale and associated publications. Similarly, I chose the other measures because they appeared to be the most relevant, reliable and robust measures available to answer my research questions. The process of finding the most appropriate measures was time consuming from a position

of relative inexperience in the area but I was very grateful for the time I spent reading around the measures and planning when it came to interpreting and writing up my findings.

1.6 Data analysis

I completed an MSc in Research Methods in Psychology prior to beginning my clinical training, which enabled me to navigate my way around SPSS and interpret the outputs relatively easy. Consequently, I did not find data entry or data analysis too challenging. In fact, I found this the most exciting part of the research process due to a genuine interest in the findings. However, I did notice that at times my passion for the area combined with my quite perfectionist nature led me to conduct analyses and over-interpret findings to a level that was unnecessary. I noticed that this was connected to a personal desire to find lots of significant effects that replicated past findings. When I was able to acknowledge the unhelpfulness of this desire and the potential for it to lead me to report bias findings, I re-read my research questions and reminded myself that I needed to stick to reporting the findings in relation to these questions. This reinforced to me the importance of being critical of studies that have conducted lots of extra analyses in their research.

1.7 Writing up the thesis

The writing up process took much longer than I had anticipated, especially that for the literature review. I found that process of conducting and writing the literature review very challenging and quickly learnt that I had made things even more difficult for

myself by choosing complementary but different areas for the thesis and literature review. As a result, I needed to conduct two literature reviews to gain a thorough understanding of the background literature pertaining to my thesis research questions, as well as the question answered by my literature review. I found it harder to immerse myself in other people's research studies because I did not feel as passionately about the reviewed studies as I had felt about my own research. This was partly because I had not conducted the research and none of the reviewed articles were conducted in the UK (asylum laws are different abroad) but also because the findings were already published so I did not feel as strongly about the importance of disseminating the findings. In addition, I was identifying weaknesses of the papers throughout which made be question the rigor of some of the studies. This taught me that it is important for me to feel passionately about my topic area, which includes being able to personally relate to the study and believing that disseminating that the findings will be useful. Conducting the literature review also improved by critical thinking skills.

Despite the positive aspects of my passion, it also needed to be reflected upon regularly to ensure that it did not interfere with my need to remain an objective researcher. I am aware that I asked more research questions than most other published studies, who may have solely investigated the prevalence of STS in a specific population. In addition, when writing up the discussion of my thesis, I felt frustrated that although I had asked and answered numerous questions, the findings had then generated lots more questions, which I could not immediately set about answering! This taught me that I need to be aware that my passion can cause me to have very high expectations of the research I

conduct. As part of this, I noticed a desire to fully answer research questions by finding an absolute truth to feel that that the research was an important contribution to the literature base. Upon reflection, I am aware that absolutism is problematic, especially in the current study due to the heterogeneity of the sample and the nature of the research.

1.8 Limitations

As highlighted in the thesis discussion, the measurement of the supervision and the training variables could have been improved. Upon reviewing descriptions of these variables, it was evident that reports of 'regular supervision' or 'enough training' have different meanings to each of the participants. I felt disappointed that I had not pre-empted the difficulty of not utilising pre-defined categories. This has taught me to be more critical and forward thinking concerning the questions that I design and of the research design and measurement in general.

Whilst writing my discussion I also became increasingly aware that a longitudinal research design would have better answered by final research question as the cross-sectional study design meant it is impossible to establish the cause and effect of the significant associations found. However, given the time restraints this would not have been possible for a doctoral thesis. In addition, the current study did contribute well to a currently scarce literature base concerning STS and PTG in individuals providing practical support to asylum seekers and refugees. My desire to explore cause and effect relationships further may be another example of me having too high expectations about what can be achieved in a single study.

1.9 Dissemination

Many participants, managers and organisations have requested a copy of the study's findings. Consequently, a summary will be produced and circulated to those who requested it. In addition, the findings will be presented at the 'multi-agency forum' meeting in Leicester and a couple of the charities who ask me to return once the research was complete. The thesis will be submitted for publication in a peer-reviewed journal. The research will also be disseminated to members of PsyRAS (Psychologists Working with Refugees and Asylum Seekers) and at relevant national conferences.

My initial fears that the high levels of STS found in individuals working with asylum seekers and refugees could feed into social stigma remain, especially considering that low levels of PTG were found. However, I am excited about disseminating the findings of this research because raising awareness of STS is the first step to helping to reduce it and I feel a strong ethical responsibility to the individuals who participated. I am especially looking forward to presenting at conferences where I will be able to explain and discuss the findings in context.

I am aware that following the recent change in government the funding of many charities and voluntary organisations has been reduced or cut completely. As a result, it may be harder for organisations to apply for funding that enables them to improve support and training or buy in external supervision for individuals who support asylum seekers and refugees. However, as evidence of need is always essential to increasing

resources I feel it is very important to publish the findings of my research. In addition, I intend to write up the coping strategies that individuals reported as most helpful in the current study, as well as drawing together the findings in relation to coping in an unpublished qualitative thesis in the same area (Guhan, 2010). I hope this will enable individuals who may be feeling distressed due to STS to learn more about the cause of their distress and try out new coping strategies. Furthermore, I intend to conduct a qualitative analysis on the open ended questions I asked surrounding the positive and negative aspects of helping asylum seekers and refugees to ensure that the research does not misrepresent the views of individuals who provide the support who clearly talked about doing such difficult work for so long because of how rewarding it is to help asylum seekers and refugees, despite huge frustrations with the systems around political asylum.

1.10 Summary

I found the process of conducting research both enjoyable and rewarding. I have always valued research but this has confirmed that it is important to me to find a job that enables me to combine the clinical and research elements of the Clinical Psychologist role. The research process was very time-consuming though. Good planning skills and effective supervision to aid me in thinking critically about each stage, seemed essential to enjoying the research process. The process re-enforced the importance for me of reflexivity, supervision and self-care when I felt overwhelmed by the volume of work, the research process or the emotions that responses evoked in me. It has also improved my critical thinking skills and my confidence in my abilities to seek ethical approval, conduct and write up a research study. Finally, I learnt the importance of being open

and personable during recruitment to ensure that I wasn't viewed as an 'outsider' researcher or potential threat, much like the importance of a good therapeutic relationship to an effective intervention. I also learnt that the snowballing technique is effective and online data collection is quick, easy and relatively cheap so I would now feel happy to use these again, if relevant to my research question.

1.11 References

Adams, R. E., Boscarino, J. A., & Figley, C.R. (2006). Compassion fatigue and psychological distress among social workers: A validation study. *American Journal of Orthopsychiatry, 76,* 103–108.

Dwyer, S. C., & Buckle, J. L. (2009). The space between: on being an insider-outsider in qualitative research. *International Journal of Qualitative Methods, 8,* (1), 54-63.

Gerbert, B., Bronstone, A., Pantilat, S., McPhee, S., Allerton, M., & Moe, J. (1999). When asked, patients tell: disclosure of sensitive health-risk behaviors. *Medical Care, 37,* 104-111.

Guhan, R. (2010). *The experience of staff working with refugees and asylum seekers in the United Kingdom: A grounded theory exploration.* Unpublished doctoral thesis. University of Coventry.

Silove, D., Sinnerbank, I., Field, A., Manicavasagar, V., & Steel, Z. (1997). Anxiety, depression and PTSD in asylum-seekers: associations with pre-migration trauma and post-migration stressors. *The British Journal of Psychiatry, 170,* 351-357.

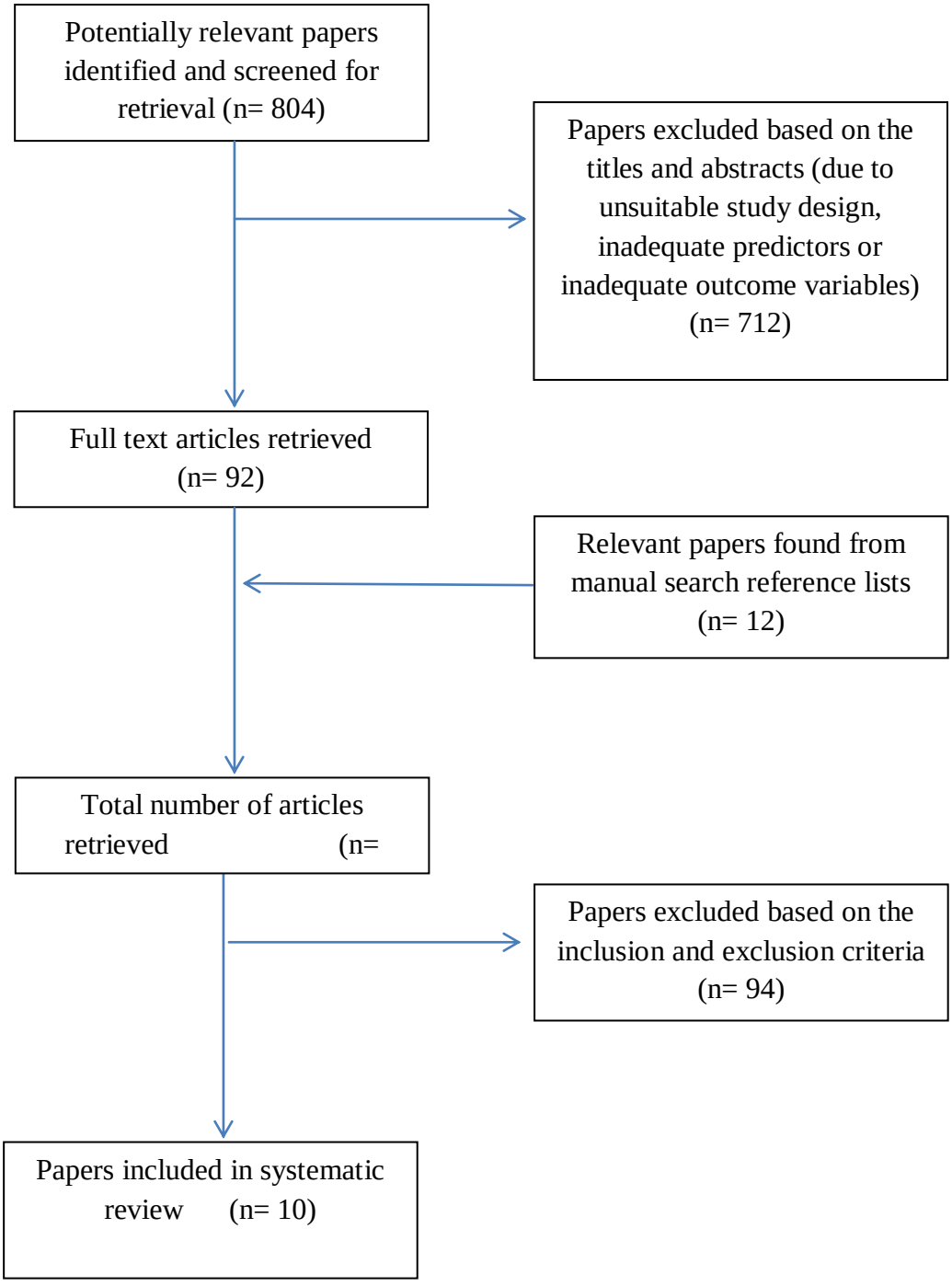
Jones, D. P. (2010). Getting the (Survey) Monkey off your back: considerations for using an increasingly common data collection tool. *Traumatic Stress Points, 24,* (6), 2-4.

Appendix A: Search table for psychological impact of uncertainty associated with the process of seeking asylum

Database	Search Terms	Number of Results
Science Direct (Limits- Journal article)	Asylum AND (psych* OR impact OR well-being) (TITLE-ABSTR-KEY)	69
	Asylum AND (stress OR psychiatr* OR mental health) (TITLE-ABSTR-KEY)	46
	Asylum AND (process OR procedure) (TITLE-ABSTR-KEY)	35
	Asylum AND (uncertainty OR waiting) (TITLE-ABSTR-KEY)	4
Medline	Asylum seeker AND process AND psych* OR impact OR well-being (KEY WORDS)	120
	Asylum seeker AND procedure AND (psych* OR impact OR well-being) (KEY WORDS)	42
	Asylum seeker AND process AND (stress OR psychiatr* OR mental health) (KEY WORDS)	100
	Asylum seeker AND procedure AND (stress OR psychiatr* OR mental health) (KEY WORDS)	36
	Asylum AND (uncertainty OR waiting) (KEY WORDS)	69
PsycINFO	Asylum seeker AND (process OR procedure) AND (psych* OR impact OR well-being) (KEY WORDS)	18
	Asylum seeker AND (process OR procedure) AND (stress OR psychiatr* OR mental health) (KEY WORDS)	20
	Asylum AND (uncertainty OR waiting) (KEY WORDS)	3

PILOTS	Asylum AND (process OR procedure) AND (psych* OR impact OR well-being) (ANYWHERE)	50
	Asylum AND (process OR procedure) AND (stress OR psychiatr* OR mental health) (ANYWHERE)	39
	Asylum AND (uncertainty OR waiting) (ANYWHERE)	11
Web of Science	Cited- author 'Silove, D'; year 1998	57
	Cited- author 'Silove, D'; year 2006	27
	Cited- author 'Laban, C J'; year 2004	30
	Cited- author 'Laban, C J'; year 2005	17
	Cited- author 'Laban, C J'; year 2008	1
	Cited- author 'Ryan D A'; year 2008	4
	Cited- author 'Roth G'; year 2006	6

Appendix B: Flow diagram showing the process of identifying relevant papers



Appendix C: Data Extraction Pro-forma

Article Number:
Review Date:
Title:
Author(s):
Publication date:
Journal:
Volume: Number: Pages:
Keywords / Definitions:
Aims: *(Were Aims Clearly Stated?)*
Design: *(Is design Appropriate?)*
Method: (*Are measures valid? Are Statistical Methods Described?)*
Sampling / Participants: *(Total Number of Subjects? Age Range? Who was studied? Country of research? How sample size obtained? Response Rate?)*
Analysis Used: *(Which statistical tests were run? Was Power Calculated?)*

Results: *(Was the data correctly described? Were the statistics used appropriate? Were significance levels identified?)*
Controls / Validity/ Reliability: *(Were there any confounding difficulties?)*
Conclusions: *(What do findings mean? Is there selection bias present? Are any important effects ignored? Generalisability? Implications?)*
Extra Notes:

Appendix D: Findings in relation to whether an individual is still awaiting an decision for their asylum claim or not

Paper	Comparison groups						Postmigration difficulties	Depression	Anxiety	PTSD	Physical health functioning	Mental health functioning	Sense of coherence	General measure of distress
1. Ryan, Benson & Dooley (2008)	1	Positive legal decision at baseline	2	Positive legal decision received between baseline and follow up	3	Still awaiting a decision at follow up	Postmigration difficulties (as measured by the BLDS) only significantly reduced in group 2- those who had received a positive decision							Distress (as measured by the BSI) only significantly reduced (halved) in group 2- those who had received a positive decision
2. Silove, Steel, McGorry & Mohan (1998)	1	Asylum seekers	2	Refugees	3	Immigrants	Group 1 scored higher on postmigration difficulties (as measured by the PMLD) than groups 2 & 3. Group 3 scores were minimal and group 2's were about half of group 1s.	More depressive symptoms (as measured by HSCL-25) in group 1 than in groups 2 and 3. However, no significant difference between groups 1 & 2.	More anxiety symptoms (as measured by HSCL-25) in group 1 than in groups 2 and 3. However, no significant difference between groups 1 & 2.	More PTSD symptoms (as measured by HTQ) in group 1 than in groups 2 and 3. However, no significant difference between groups 1 & 2.				
3. Roth & Ekblad (2006i)	1	In Sweden at 1.5 year follow up	2	Voluntarily returned to Kosovo at 1.5 year follow up	3	ŕ		Significantly more depressive symptoms and clinical depression (as measured by the HSCL-25, GHQ-28 and SCID) in group 1 than in group 2					Significantly lower sense of coherence scores (as measured by the SOC-12) in group 2 than in group 1	
4. Roth & Ekblad (2006ii)	1	In Sweden at 1.5 year follow up	2	Voluntarily returned to Kosovo at 1.5 year follow up	3	ŕ				85% of group 1 met the criteria for a PTSD diagnosis (using the SCID) compared to 52% in group 2				
5. Momartin, Steel, Coello, Aroche, Silove & Brooks (2006)	1	Temp visa holders	2	Perm visa holders		ŕ	Postmigration difficulties (as measured by the PMLD) were significantly higher in group 1	Depression scores (as measured by the HSCL-25) were significantly higher in group 1. Temporary status was strongest predictor of depression.	Anxiety scores (as measured by the HSCL-25) were significantly higher in group 1. Temporary status was strongest predictor of anxiety	PTSD scores (as measured by the HTQ) were significantly higher in group 1. Temporary status was strongest predictor of PTSD	Physical health (as measured by the SF-12) was higher but not significantly in group 2	Mental health (as measured by the SF-12) was significantly higher in group 2		Significantly higher distress scores (as measured by the GHQ-30) in group 1 than in group 2
6. Steel, Silove, Brooks, Momartin, Alzuhari & Suslick (2006)	1	Temp visa holders	2	Perm visa holders		ŕ	17/22 scores for postmigration difficulties (as measured by the PMLD) were significantly higher in group 1			9/15 PTSD scores (as measured by the HTQ) were significantly higher in group 1				
7. Silove, Steel, Susljik, Frommer, Loneragan, Chey, Brooks, le Touze, Ceollo, Smith, Harris & Bryant (2007)	1	Claim had been accepted at follow up	2	Claim had been rejected at follow up	3	ŕ		Pre and post depression scores (as measured by the HSCL-25) had significantly decreased for individuals in group 1 but not in group 2.	Pre and post anxiety scores (as measured by the HSCL-25) had significantly decreased for individuals in group 1 but not in group 2.	Pre and post PTSD scores (as measured by the HTQ) had significantly decreased for individuals in group 1 but not in group 2.	Physical health (as measured by the SF-12) had improved but not significantly in group 1, whereas group 2's scores remained the same	Mental health (as measured by the SF-12) had significantly improved in group 1 but not in group 2		

Measures key

BLDS- Basic living difficulties subscale of post- arrival concern checklist (PACC)- Silove et al (1997ii)

BSI- Brief Symptom Inventory (Derogatis, 1993)

GHQ-28- General Health Questionnaire (Stuart et al, 1993)

GHQ-30- General Health Questionnaire (Goldberg & Williams, 1988)

HSCL-25- Hopkins Symptom Checklist (Mollica et al, 1987)

HTQ- Harvard Trauma Questionnaire (Mollica et al, 1992)

PMLD- Postmigration living difficulties (Silove et al, 1998)

SCID- Structured Clinical Interview for DSM-IV (American Psychiatric Association, 1995)

SF-12- The Medical Outcomes Study- Short Form (Gandek et al, 1998)

SOC-12- Sense of coherence (Antonovsky, 1993)

Appendix E: Findings in relation to time waiting for an asylum decision

Paper	Comparison groups								Depression	Anxiety	Somatoform disorder	PTSD	Saliva Cortisol levels	Physical health disability	Mental health functioning	Sense of coherence	≥1 psychiatric disorder
8. Laban, Gernaat, Komproe, Schreuders & De Jong (2004)	1	<6 mths	2	>2 years	/		/		Lifetime prevalence of depressive disorders (measured by the CIDI) were significantly lower in group 1	Lifetime prevalence of anxiety disorders (measured by the CIDI) were significantly lower in group 1	Lifetime prevalence of somatoform disorders (measured by the CIDI) were significantly lower in group 1	Lifetime prevalence of PTSD (measured by the CIDI) were lower but not significantly in group 1					
9. Laban, Gernaat, Komproe, van der Tweel & De Jong (2005)	1	<6 mths	2	>2 years	/		/		PMLP scores of individuals with and without a depressive disorder (as measured by the CIDI) were significantly different. Cluster 3 of PMLP was found to be one of the most important contributors to developing depression	Scores on clusters 1-3 of the PMLP for individuals with and without a anxiety disorder (as measured by the CIDI) were significantly different. Cluster 3 of PMLP was found to be one of the most important contributors to developing anxiety	Scores on clusters 1-4 of the PMLP for individuals with and without a somatoform disorder (as measured by the CIDI) were significantly different. Cluster 3 of PMLP was found to be one of the most important contributors to developing a somatoform disorder						PMLP scores of individuals with and without a psychiatric disorder (as measured by the CIDI) were significantly different. Cluster 3 of PMLP was found to be one of the most important contributors to developing a psychiatric disorder
10. Laban, Komproe, Gernaat & de Jong (2008)	1	<6 mths	2	>2 years	/		/							Physical health disability (as measured by the BDQ) was significantly higher in group 2	Mental health functioning (as measured by the BDQ) was significantly lower in group 2		
3. Roth & Ekblad (2006i)	1	Baseline	2	3 month follow up	3	6 month follow up	4	1.5 year follow up	Depression scores (as measured by the HSCL-25 and GHQ-28) increased at each foillow up							Sense of coherence scores (as measured by the SOC-12) significantly decreased at each follow up	
4. Roth & Ekblad (2006ii)	1	Baseline	2	3 month follow up	3	6 month follow up	4	1.5 year follow up				PTSD scores (as measured by the HTQ) significantly increased at each follow up	Saliva cortisol levels increased at each follow up in those with a PTSD diagnosis, and decreased in those without a diagnosis				

Measures key

BDQ- Brief Disability Questionnaire derived from the Medical Outcome Survey Short-Form (SF-36)- Stewart & Ware (1992)

CIDI- Composite International Diagnostic Interview (World Health Organisation, 1997)

GHQ-28- General Health Questionnaire (Stuart et al, 1993)

HSCL-25- Hopkins Symptom Checklist (Mollica et al, 1987)

HTQ- Harvard Trauma Questionnaire (Mollica et al, 1992)

PMLD- Postmigration living difficulties (Silove et al, 1998)

PMLP- Postmigration living problems (Silove et al, 1997ii)

SOC-12- Sense of coherence (Antonovsky, 1993)

Appendix F: The British Journal of Psychiatry- Guide for authors

All published articles are peer reviewed. Contributions are accepted for publication on the condition that their substance has not been published or submitted for publication elsewhere, and this includes web-based documents. Authors submitting papers to the *Journal* (serially or otherwise) with a common theme or using data derived from the same sample (or a subset thereof) must send details of all relevant previous publications and simultaneous submissions.

The *Journal* is not responsible for statements made by contributors. Material in the *Journal* does not necessarily reflect the views of the Editor or The Royal College of Psychiatrists.

Manuscripts accepted for publication are copy-edited to improve readability and to ensure conformity with house style.

Online submission

Manuscripts for publication must be submitted online at http://submit-bjp.rcpsych.org. A unique account will be created for each contributor using his or her email address as identification. (Note for contributors with more than one email account: please ensure you use the same email address whenever logging on to the manuscript submission website.) Contributors may track the progress of their submissions at any time via this website. For assistance with online submission, please email bjp@rcpsych.ac.uk or telephone +442072358857. A cover letter should be included with the submission explaining why you consider the submitted article suitable for publication in the *Journal*.

To submit a letter to the Editor, see below.

Fast-track assessment

Authors have the option of submitting articles for fast-track assessment. Those wishing to take this route should state this in the first or second sentence of their cover letter, together with the reasons for rapid assessment. A decision whether to approve the fast-track route will be made within 10 days of submission; those papers that are not selected for this route will be assessed in the normal way unless the authors state specifically that they want fast-track assessment only. All papers approved for the fast-track route will be assessed within 4 weeks of submission. Review articles will not be considered for fast-track assessment.

Title and authors

The title should be brief and relevant. Subtitles should not be used unless they are essential. Titles should not announce the results of articles and, except in editorials, they should not be phrased as questions.

All authors must sign the copyright transfer and publication agreement, which can be downloaded from http://submit-bjp.rcpsych.org once a manuscript has been accepted. One of the authors should be designated to receive correspondence and proofs, and the appropriate address indicated. This author must take responsibility for keeping all other named authors informed of the paper's progress. The contribution of each author to the paper must be stated at the end of the article; this information may be published online. Authorship credit should be based only on substantial contribution to:

- conception and design, or analysis and interpretation of data
- drafting the article or revising it critically for important intellectual content
- and final approval of the version to be published.

All these conditions must be met. Participation solely in the acquisition of funding or the collection of data does not justify authorship. In addition, the corresponding author must ensure that there is no one else who fulfils the criteria but has not been included as an author. Group authorship is permitted but individuals choosing this option will not be cited personally, as only those listed as authors on the title page of the manuscript and (on acceptance for publication) whose signed copyright agreement has been obtained, qualify for author status. It is the responsibility of the corresponding author to ensure that authorship is agreed among the study's workers, contributors of additional data and other interested parties, before submission of the manuscript.

The names of the authors should appear on the title page in the form that is wished for publication, and the names, degrees, affiliations and full addresses at the time the work described in the paper was carried out should be given at the end of the paper.

Declaration of interest

All submissions to the *Journal* (including editorials and letters to the Editor) require a declaration of interest. This should list fees and grants from, employment by, consultancy for, shared ownership in, or any close relationship with, at any time over the preceding 36 months, an organisation whose interests may be affected by the publication of the paper. It should also list any non-financial associations or interests (personal, professional, political, institutional, religious, or other) that a reasonable reader would want to know about in relation to the submitted work. This pertains to all the authors of the study, their spouses or partners and their children (aged under 18). We recommend use of the disclosure form developed by the International Committee of Medical Journal Editors for this purpose.

Structure of manuscripts

Papers

A structured abstract not normally exceeding 150 words should be given at the beginning of the article, incorporating the following headings: Background; Aims; Method; Results; Conclusions; Declaration of interest. The abstract is a crucial part of the paper and authors are urged to devote some care to ensuring that all the important findings are within the word limit.

Introductions should normally be no more than one paragraph; longer ones may be allowed for new and unusual subjects. This should be followed by Method, Results and Discussion sections. The Discussion should always include limitations of the paper to ensure balance. Use of subheadings is encouraged, particularly in Discussion sections. A separate Conclusions section is not required.

The article should normally be between 3000 and 5000 words in length (excluding references, tables and figure legends) and normally would not include more than 25 essential references beyond those describing statistical procedures, psychometric instruments and diagnostic guidelines used in the study. All large tables (exceeding half a *Journal* page) will be published only in the online version of the *Journal* (see Online data supplements, below). Authors are encouraged to present key data within smaller tables for print publication. This applies also to review articles and short reports.

Review articles

Review articles should be structured in the same way as regular papers, but the length of these may vary considerably, as will the number of references. Systematic reviews are preferred and narrative reviews will be published only under exceptional circumstances. Reviews done for the Cochrane Collaboration, the National Institute for Health and Clinical Excellence and other groups likely to be published, or already published, elsewhere, should have the submitted paper accompanied by the latest version of the parent review and its status so that an informed decision can be made about the added value of the submitted paper.

Short reports

Short reports require an unstructured summary of one paragraph, not exceeding 100 words. The report should not exceed 1200 words (excluding references, tables and figure legends) and contain no more than one figure or table and up to 10 essential references beyond those describing statistical procedures, psychometric instruments and diagnostic guidelines used in the study. Short reports will not exceed two printed pages of the *Journal* and authors may be required to edit their report at proof stage to conform to this requirement. This may be necessary even if the report does not exceed 1200 words if the figure or table is unduly large.

Editorials

Editorials require an unstructured summary of one paragraph, not exceeding 50 words. Editorials should not exceed 1500 words and may contain no more than one figure or table and up to 10 essential references. Editorials may only exceed two printed pages in length at the Editor's discretion. A good-quality photograph of the lead author for publication alongside the editorial must be submitted with the manuscript, along with brief biographical details (up to 25 words) for all authors.

Reappraisal

This is a section following the structure of Editorials but with up to 15 essential references. These articles are mainly commissioned by the Editor and are concerned with well-known subjects in psychiatry which are going through a period of controversy or re-evaluation. Reappraisals are intended to give a long-term balanced perspective on the subject based on the latest evidence.

Debates

Two debaters have three rounds of debate (1-2-1-2-1-2), responding to each other after each round. Each author may use up to 2000 words and 15 references, divided as they wish between their three rounds. A short introduction will be provided by the Debates Editors post-acceptance.

References

Authors are responsible for checking all references for accuracy and relevance in advance of submission. Reference lists not in the correct style will be returned to the author for correction. From January 2008, all references should be numbered in the order in which they appear in the text and listed at the end of the article using the Vancouver style (see below), in which the names and initials of all authors are given after the appropriate reference number. If there are more than six authors, the first six should be named, followed by 'et al'.

The authors' names are followed by the full title of the article; the journal title abbreviated (in italics) according to the style of Index Medicus; the year of publication; the volume number (in bold type); and the first and last page numbers. References to book or book chapters should give the titles of the book (and the chapter if selected), names of any authors, name of publisher, names of any editors, and year. Examples are shown below.

1 Kapusta ND, Etzersdorfer E, Krall C, Sonneck G. Firearm legislation reform in the European Union: impact on firearm availability, firearm suicide and homicide rates in Austria. *Br J Psychiatry* 2007; **191**: 253-7.

2 Thornicroft GJ. *Shunned: Discrimination Against People with Mental Illness.* Oxford University Press, 2006.

3 Casey P. Alternatives to abortion and hard cases. In *Swimming Against the Tide; Feminist Dissent on the Issue of Abortion* (ed AB Kennedy): 86–95. Open Air Books, 1997.

4 Lancet. Burnished or burnt out: the delights and dangers of working in health (editorial). *Lancet* 1994; **344**: 1583-4.

5 Pharmaceutical Research and Manufacturers of America (PhRMA). *PhRMA Guiding Principles on Direct to Consumer Advertisements About Prescription Medications*. PhRMA, 2005. http://www.phrma.org/publications/policy//2005-08-02.1194.pdf

6 Soni SD, Mallik A, Mbatia J, Shrimankar J. Late paraphrenia (letter). *Br J Psychiatry* 1988; **152**: 719-20.

7 Viding E, Frick P, Plomin R. Aetiology of the relationship between callous-unemotional traits and conduct problems in childhood. *Br J Psychiatry* 2007; **190** (suppl 49): s33–8.

Personal communications need written authorisation (email is acceptable); they should not be included in the reference list. Unpublished doctoral theses may be cited (please state department or faculty, university and degree). No other citation of unpublished work, including unpublished conference presentations, is permissible.

Tables

Tables should be numbered and have an appropriate heading. The tables should be mentioned in the text but must not duplicate information. The heading of the table, together with any footnotes or comments, should be self-explanatory. The desired position of the table in the manuscript should be indicated. Do not tabulate lists, which should be incorporated into the text, where, if necessary, they may be displayed.

Authors must obtain permission from the original publisher if they intend to use tables from other sources, and due acknowledgement should be made in a footnote to the table.

Figures

Figures should be clearly numbered and include an explanatory legend. Avoid cluttering figures with explanatory text, which is better incorporated succinctly in the legend. 3-D effects should generally be avoided. Lettering should be parallel to the axes. Units must be clearly indicated and should be presented in the form quantity (unit) (note: `litre' should be spelled out in full unless modified to ml, dl, etc.). All figures should be mentioned in the text and the desired position of the figure in the manuscript should be indicated.

Authors must obtain permission from the original publisher if they intend to use figures from other sources, and due acknowledgement should be made in the legend.

Colour figures may be reproduced if authors are able to cover the costs.

Statistics

Methods of statistical analysis should be described in language that is comprehensible to the numerate psychiatrist as well as the medical statistician. Particular attention should be paid to clear description of study designs and objectives, and evidence that the statistical procedures used were both appropriate for the hypotheses tested and correctly interpreted. The statistical analyses should be planned before data are collected and full explanations given for any *post hoc* analyses carried out. The value of test statistics used (e.g. *t*, *F*-ratio) should be given as well as their significance levels so that their derivation can be understood. Standard deviations and errors should not be reported as ± but should be specified and referred to in parentheses.

Trends should not be reported unless they have been supported by appropriate statistical analyses for trends.

The use of percentages to report results from small samples is discouraged, other than where this facilitates comparisons. The number of decimal places to which numbers are given should reflect the accuracy of the determination, and estimates of error should be given for statistics.

A brief and useful introduction to the place of confidence intervals is given by Gardner & Altman (1990, *British Journal of Psychiatry*, **156**, 472-474). Use of these is encouraged but not mandatory.

Authors are encouraged to include estimates of statistical power where appropriate. To report a difference as being statistically significant is generally insufficient, and comment should be made about the magnitude and direction of change.

Randomised controlled trials

The *Journal* recommends to authors the CONSORT guidelines (1996, *Journal of the American Medical Association*, **276**, 637-639) and their basis (2001, *Annals of Internal Medicine*, **134**, 663-694) in relation to the reporting of randomised controlled clinical trials; also recommended is their extension to cluster randomised controlled trials (2004, *BMJ*, **328**, 702-708). In particular, a flow chart illustrating the progress of participants through the trial (CONSORT diagram) must be included.

Qualitative research

The *Journal* welcomes submissions of reports of qualitative research relevant to the scope of the *Journal*. These manuscripts will be evaluated in terms of design, conduct and reporting of the study, which need to be of sufficient quality and merit to warrant inclusion in the *Journal*. The Editor recognises that the term 'qualitative research' encompasses diverse methods underpinned by various epistemological or theoretical frameworks. Accordingly, manuscripts will be evaluated on the basis of the appropriateness of the selected framework to the enquiry, the internal coherence of the report and its adherence to quality criteria consistent with the methodology and method as follows:

Epistemological and/or theoretical frameworks

- The epistemological underpinnings and/or theoretical framework is made explicit and applied consistently

Study design and method

- The research goal is clearly articulated, justified with reference to literature, and placed in context
- The approach matches the purpose of research and is justified
- Methods of sampling, data collection, data management and analysis are explicit and consistent with methodology
- Analytical and interpretative processes are described fully

Findings, discussion and implications

- Findings represent the depth and breadth of data
- Findings and interpretations are supported by the data

- Direct quotations, exemplars or other data presentations are used judiciously in a way that illustrates the findings
- Findings are presented in a way that is consistent with methodology, method and study aims
- Authors are appropriately cautious about knowledge claims
- Findings are explored theoretically and applications discussed

Process issues

- The report provides an account of reflexive practice in keeping with the methodology

The review of the manuscript will determine whether the authors present their research in such a way that the reader can evaluate the relevance, credibility and applicability of the generated evidence.

General

House style

For further guidance, authors may refer to the Royal College of Psychiatrists' house style guide.

Access to data

If the study includes original data, at least one author must confirm that he or she had full access to all the data in the study, and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Registration of clinical trials

The *Journal* recommends that all clinical trials are registered in a public trials registry. Further details of criteria for acceptable registries and of the information to be registered are available at http://www.icmje.org/index.html#clin_trials. For reports supported by industry funds, this is a requirement for the paper to be considered for publication in the *Journal*.

Case reports and consent

If an individual is described, his or her consent must be obtained and submitted with the manuscript. Our consent form can be downloaded here. The individual should read the report before submission. Where the individual is not able to give informed consent, it should be obtained from a legal representative or other authorised person. If it is not possible for informed consent to be obtained, the report can be published only if all details that would enable any reader (including the individual or anyone else) to identify the person are omitted. Merely altering some details, such as age and location, is not sufficient to ensure that a person's confidentiality is maintained. Contributors should be aware of the risk of complaint by individuals in respect of defamation and breach of confidentiality, and where concerned should seek advice. In general, case studies are published in the *Journal* only if the authors can present evidence that the case report is of fundamental significance and it is unlikely that the scientific value of the communication could be achieved using any other methodology.

Online data supplements

Material related to a paper but unsuitable for publication in the printed journal (e.g. large tables) may be published as a data supplement to the online *Journal* at the Editor's discretion. For very large volumes of material, charges may apply.

Abbreviations, units and footnotes

All abbreviations must be spelt out on first usage and only widely recognised abbreviations will be permitted.

Generally, SI units should be used; where they are not, the SI equivalent should be included in parentheses. Units should not use indices: i.e. report g/ml, not gml^{-1}.

The use of notes separate to the text should generally be avoided, whether they be footnotes or a separate section at the end of a paper. A footnote to the first page may, however, be included to give some general information concerning the paper.

Materials, equipment and software

The source of any compounds not yet available on general prescription should be indicated. The version number (or release date) and manufacturer of software used, and the platform on which it is operated (PC, Mac, UNIX etc.), should be stated. The manufacturer, manufacturer's location and product identification should be included when describing equipment central to a study (e.g. scanning equipment used in an imaging study).

Proofs

A proof will be sent to the corresponding author of an article. Offprints, which are prepared at the same time as the *Journal* is printed, should be ordered when the proof is returned to the Editor. Offprints are despatched up to 6 weeks after publication.

Copyright

On acceptance of the paper for publication, we will require all authors to assign copyright to the Royal College of Psychiatrists. You retain the right to use the article (provided you acknowledge the published original in standard bibliographic citation form) in the following ways, as long as you do not sell it (or give it away) in ways which would conflict directly with our business interests. You are free to use the article for teaching purposes within your own institution or, in whole or in part, as the basis of your own further publications or spoken presentations. In addition, you retain the right to provide a copy of the manuscript to a public archive (such as an institutional repository or PubMed Central) for public release no sooner than 12 months after publication in the *British Journal of Psychiatry* (or from the date of publication, if the open access option is chosen, see below). Only the final peer-reviewed manuscript as accepted for publication (not earlier versions, or the final copy-edited version) may be deposited in this way. Any such manuscripts must contain the following wording on the first page: "This is an author-produced electronic version of an article accepted for publication in the *British Journal of Psychiatry*. The definitive publisher-authenticated version is available online at http://bjp.rcpsych.org." If your funding body has a policy regarding PubMed Central deposit, our compliance guidelines are published here.

Letters to the Editor

Letters may be submitted online either as responses to published articles (follow the link 'submit a response' when viewing an article online) or as general letters to the Editor (from the general eLetter submission page). A selection from these eLetters will subsequently be included in the printed *Journal*. Correspondence submitted for publication in the print edition without prior online publication as eLetters should be sent to bjpletters@rcpsych.ac.uk.

Extras

Extras are published at the end of articles where space allows. These comprise a wide range of material considered to be of interest to readers of the *Journal*. Submissions for publication as extras should not be submitted online, but sent by email to bjp-extras@rcpsych.ac.uk.

Open access

There is no submission or publication fee for papers published in the *Journal* in the usual way. All papers published in the *Journal* become freely available online 12 months after publication. In a new initiative to maximise access to original research, authors now have the option to make their papers freely available from the time of publication, on payment of an open access charge. This charge is currently £2500 (or US$4500) per article plus VAT where applicable. If you wish to take up this option, contact the BJP Editorial Assistant once your paper has been accepted for publication. For such papers the requirement for a 12-month delay before release of the manuscript in a public archive is waived, and the final published version may be deposited.

At any time up to 5 years after publication of research in the *Journal*, authors may be asked to provide the raw data.

School of Psychology- Clinical Section

PARTICIPANT INFORMATION SHEET (PILOT)

How are employees of charities who provide support and advice to asylum seekers affected by their work?

Researcher: Miss Kara Davey
kld20@le.ac.uk

What is the purpose of the study?

The current study sets out to explore the positive and negative emotional changes that may occur in employees of charities who provide practical support and advice to asylum seekers. Negative changes may include high levels of stress and the impact this stress has on your daily life. Positive changes may refer to a sense of feeling enhanced in some way, as a result of supporting asylum seekers through their traumatic experience(s). Ways of coping will also be measured.

It is important to understand the emotional impact of providing support to asylum seekers as stress, coping and resilience have implications on well-being. It is hoped that this study will highlight coping mechanisms that build resilience, which can be incorporated usefully into future staff training.

What will be involved if you choose to take part?

There are two stages to this research study currently I am looking to find two volunteers who are willing to take part in the pilot stage of the study.

If you participate in the pilot stage, you will be asked to take part in a semi-structured interview with the researcher, lasting up to an hour. The interview will be audio taped by the researcher. During the interview you will be asked about your history of working with asylum seekers, the emotional responses you have noticed in yourself when providing support to asylum seekers and the impact you feel your work has on you. Following the interview you will asked to complete a participant pack. The participant pack can either be completely by hand or online at www.surveymonkey.com. The pack includes 6 short questionnaire measures and takes approximately 20- 30mins to complete in total. You will then be asked to comment on how useful you feel the questionnaire measures were in comparison to the interview questionnaires. The pilot stage will be used to inform the researcher of how well the questionnaires capture their experience and whether any measures need to be adapted before going ahead with stage two of the research.

If more than two people wish to take part in this stage of research then the first two people will be selected and any other volunteers asked to participate in stage two instead. In addition, if you would like to participate but you would prefer not to complete the interview, then please consider volunteering for stage two of this study. Stage two requires participants to complete a question sheet, which asks a number of questions about you, such as demographic information, current job role, details of any training received and whether you have suffered any trauma yourself, followed by the six questionnaire measures.

What will happen with the information I provide?

All participant packs completed online will be printed out by the researcher. These packs along with the paper copies of the participant packs will be kept securely under lock and key and treated with confidentiality under the data protection act. Consequently, the information will be used solely for the purposes of this research and will not be shared with the charity that you work for or any outside agencies. If the research findings are evidentially published, you will remain anonymous and no identifying details will be included in the article.

All interview data will be transcribed from the audio recording. The audio recording will then be deleted. The transcription will be saved as a participant code number to ensure that you remain anonymous. The file will be saved on a password protected CD, which will also be kept securely under lock and key and treated with confidentiality under the data protection act. The interview data will be used solely for the purposes of this research and will not be shared with the charity that you work for or any outside agencies. As above, if the research findings are evidentially published, you will remain anonymous and no identifying details will be included in the article.

Your rights as a participant

You are under no obligation to take part in this research. Participation is not linked to your employment in anyway. As the interview data and questionnaire responses will all be anonymised it will not be possible to withdraw this data once submitted to the researcher.

£10 Incentive

As an incentive to participate in the pilot stage of the research (interview, participant pack and a brief evaluation of the participant pack) you will be given a £10 gift voucher for any high street store of your choice. This will be posted to you after you have commented on how useful you feel the questionnaire measures were in comparison to the interview questions.

£50 Prize Draw

On completion of the participant pack you will be eligible to enter a £50 prize draw (this is open to participants who take part in the pilot stage or stage two of this study). The participant whose entry form is randomly selected from a hat on 1st October 2010 will receive a £50 gift voucher for any high street store of their choice. Participants who complete the questionnaire pack online will be informed how to enter the prize draw when they submit the final questionnaire on www.surveymonkey.com. Participants who choose to complete the paper participant pack will also be posted a prize draw entry form with the questionnaires. All entry forms will be kept separate from the completed questionnaires to ensure that you remain anonymous, this is applicable to both participants who take part online or on paper.

What if there is a problem?

If you have any difficulties during or after completing this research please feel free to contact me and I will try to help you resolve it. Please also see the heading below 'support available to you'. If you wish to complain, or have any concerns about how you have been treated as a participant in this study then the normal National Health Service complaints mechanisms will be available to you.

Support available to you

The aim of the current study is to help individuals who support asylum seekers. However, should you find that thinking about the stressful aspects of your job is negatively impacting on you in any way, you may wish to seek further support. The guidance below informs you of some of the sources of support available to you.

You may find it useful to seek work based support such as speaking with another team member, a manager, occupational health or a work based counselling service (if applicable).

If you do not perceive work based support to be a useful option for you, then please consider other options such as speaking to your GP or utilising a free support help lines such as:

‘Support Line’ on: 01708 765200 or info@supportline.org.uk
or ‘The Samaritans’ on: 08457 909090 or jo@samaritans.org
Details of local counselling services can also be located via the internet.

In addition, online guides to understanding and reducing stress yourself are available. These can be found by searching online for ‘self-help guides’, for example:
http://stresshelp.tripod.com/id17.html or
http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/

If you have any further questions, please feel free to email me and ask

Thank you
Kara Davey

Appendix H: Participant information sheet (survey)

School of Psychology- Clinical Section

PARTICIPANT INFORMATION SHEET (SURVEY)

How are employees of charities who provide support and advice to asylum seekers affected by their work?

Researcher: Miss Kara Davey
kld20@le.ac.uk

What is the purpose of the study?

The current study sets out to explore the positive and negative emotional changes that may occur in employees of charities who provide practical support and advice to asylum seekers. Negative changes may include high levels of stress and the impact this stress has on your daily life. Positive changes may refer to a sense of feeling enhanced in some way, as a result of supporting asylum seekers through their traumatic experience(s). Ways of coping will also be measured.

It is important to understand the emotional impact of providing support to asylum seekers as stress, coping and resilience have implications on well-being. It is hoped that this study will highlight coping mechanisms that build resilience, which can be incorporated usefully into future staff training.

What will be involved if you choose to take part?

If you agree to participate in this research you will be asked to complete a participant pack. The participant pack can either be posted to you or you can complete it online at http://www.surveymonkey.com/s/XGQCW3C. The pack will ask a number of questions about you, such as demographic information, current job role, details of any training received and whether you have suffered any trauma yourself. It will also include six short questionnaire measures. The pack takes approximately 20 minutes to complete.

What will happen with the information I provide?

All participant packs completed online will be printed out by the researcher. These packs along with the paper copies of the participant packs will be kept securely under lock and key and treated with confidentiality under the data protection act. Consequently, the information will be used solely for the purposes of this research and will not be shared with the charity that you work for or any outside agencies. If the research findings are evidentially published, you will remain anonymous and no identifying details will be included in the article.

Your rights as a participant

You are under no obligation to take part in this research. Participation is not linked to your employment in anyway. As all questionnaire responses will all be anonymised, it will not be possible to withdraw this data once submitted to the researcher.

£50 Prize Draw

On completion of the participant pack you will be eligible to enter a £50 prize draw (this is open to all participants). The participant whose entry form is randomly selected from a hat on 1st February 2011 will receive a £50 gift voucher for any high street store of their choice. Participants who complete the questionnaire pack online will be informed how to enter the prize draw when they submit the final questionnaire at http://www.surveymonkey.com/s/XGQCW3C. Participants who choose to complete the paper participant pack will also be posted a prize draw entry form with the questionnaires. All entry forms will be kept separate from the completed questionnaires to ensure that you remain anonymous; this is applicable to both participants who take part online or on paper.

What if there is a problem?

If you have any difficulties during or after completing this research please feel free to contact me and I will try to help you resolve it. Please also see the heading below 'support available to you'. If you wish to complain, or have any concerns about how you have been treated as a participant in this study then the normal National Health Service complaints mechanisms will be available to you.

Support available to you

The aim of the current study is to help individuals who support asylum seekers. However, should you find that thinking about the stressful aspects of your job is negatively impacting on you in any way, you may wish to seek further support. The guidance below informs you of some of the sources of support available to you. You may find it useful to seek work based support such as speaking with another team member, a manager, occupational health or a work based counselling service (if applicable).

If you do not perceive work based support to be a useful option for you, then please consider other options such as speaking to your GP or utilising a free support help lines such as:

'Support Line' on: 01708 765200 or info@supportline.org.uk
or 'The Samaritans' on: 08457 909090 or jo@samaritans.org
Details of local counselling services can also be located via the internet.

In addition, online guides to understanding and reducing stress yourself are available. These can be found by searching online for 'self-help guides', for example:
http://stresshelp.tripod.com/id17.html or
http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/

If you have any further questions, please feel free to ask me

Thank you
Kara Davey

Appendix I: Consent Form (pilot study)

School of Psychology- Clinical Section

CONSENT FORM (PILOT STUDY)

How are employees of charities who provide support and advice to asylum seekers affected by their work?

Researcher: Miss Kara Davey
Purpose of data collection: Doctoral research

This form should be read in conjunction with the Participant Information Sheet (Pilot Study). Please initial each statement to confirm that you have read it and sign at the bottom if you are happy to participate in this study.

☐ 1. I understand that my participation is voluntary and is not linked to my employment in anyway.

☐ 2. I am aware of what my participation will involve.

☐ 3. I agree to my interview with the researcher being audio taped. This audio recording will be held confidentially and only the researcher and her academic supervisor at the University of Leicester will have access to it. Once the audio recording is transcribed, the tape will be deleted.

☐ 4. This research is being conducted to partially fulfil the criteria of a Doctorate qualification in Clinical Psychology. Consequently I understand that relevant sections of my anonymised data collected during this study may be looked at by individuals from regulatory bodies or from the NHS trust, where it is relevant. I give permission for these individuals to have access.

☐ 5. My data will be kept in a locked filing cabinet for a period of at least five years if it appears in any publications. Any aggregate data (e.g. spreadsheets) will be kept in electronic form for up to one year after which time they will be deleted. In accordance with the requirements of some scientific journals and organisations, my coded data may be shared with other competent researchers. My name and other identifying details will not be shared with anyone.

I am giving my consent for data to be used for the outlined purposes of the present study. All questions that I have about the research have been satisfactorily answered by the researcher and I agree to participate.

Signature of participant _____ Date: _____

Name in BLOCK CAPITALS_____

I confirm that I have explained the nature of this nature as detailed in the participant information sheet (pilot), and in my judgement feel this has been understood by the participant.

Signature of researcher _____ Date: _____

Name in BLOCK CAPITALS_____

Please note that this form will be kept separately from your data

Appendix J: Interview Schedule

1. Background to working with asylum seekers (personal information sheet)

2. What emotions are evoked in you, when you are supporting asylum seekers?

3. Is there a change in the emotions evoked in you, when a client is describing the traumatic event(s) that resulted in their flee to the UK compared to when clients are not describing their trauma?

4. What do you find the hardest to hear your clients talk about? How does it make you feel when you do hear clients talking about these things?

5. Have you ever been surprised by an emotion or the level of emotion that working with an asylum seeker has evoked in you?

6. Do you feel that working with asylum seekers who have suffered severe traumatisation evokes emotions in you that are different to those evoked by clients in other treatment contexts?

7. Do you get a sense of why your work with asylum seekers evokes such different emotions? (If it does!)

8. What do you like most about working therapeutically with asylum seekers?

9. What do you like least?

10. How do you go home feeling after work?

11. Do you have anyone to talk to about these feelings?

12. How do you manage the feelings that it brings up in you?

13. Have you ever felt the same physical symptoms as a client, after supporting them through a particularly difficult experience?

14. Have you noticed any changes in you as a person, since you started supporting asylum seekers?

15. When did these changes become noticeable to you? Are they noticeable to others?

16. Do you think these changes are, OR could in the future, affect your work?

17. What do you think could be done to help and support individuals like yourself who support asylum seekers?

Appendix K: Questionnaire pack

Thank you so much for agreeing to take part in my research. I have supported asylum seekers and so I understand that it can be challenging, as well as very rewarding work. This research explores the positive and negative effects of supporting asylum seekers and/ or refugees, with the aim of improving support and coping.

It will take approximately 20 minutes to answer all of the questions in this pack. Your help with this research is greatly appreciated.

SECTION ONE: PERSONAL INFORMATION

The following questions are to help the researcher find out a little more about you and your current role. Some of the questions are of a personal nature. The questions are designed to help identify factors that aid coping of stressful events.

Please remember that your details will remain confidential, they will not be shared with the charity that you work for and no identifiable details will be included in the write up of this research.

What gender are you?

☐ Male ☐ Female

How old are you?

What ethnicity are you?

What ethnicity are the asylum seekers you help?

How long have you been working with asylum seekers?

What county do you work in?

What does the charity you work for do?

What is your role and what does that role entail?

Do you support asylum seekers, refugees or both?

Do you work for any other organisations? If yes, who?

How many hours per week do you work? If you work for more than one organisation please answer this question for each job role.

How much trauma do you hear about each week? (Please include details for each job role if you work for other organisations too).
The following details would be useful to fully answer this question: number of clients on your caseload, how many hours per week you spend with clients and an estimate of how much discussion of their traumatic experiences takes place- are these in depth discussions?

Do you receive any supervision? By supervision I mean, is there a time that you get to meet with a member of the staff at the charity who is able to support you, discuss cases with you and act as a mentor? If yes, how regular is your supervision?

What training have you received to help you in your current role? Was this compulsory training or did you request it? Have you had any other relevant training at previous organisations?

What previous related job roles have you had? If none, what led you to your current job role?

Have you experienced any significant personal stress in the past six months i.e. trauma, bereavement, serious illness etc? If yes, was this work related stress? Did you take time off work for deal with this stress?

Have you received any counselling or therapy to aid how you cope with stress? If so, was this due to personal difficulties, trauma or work related stress?

What is your mood like today? Please give a number between 1 and 10. Where 10 represents I am the happiest I have ever felt and 1 represents I am the unhappiest I have ever felt.

Is this usual or unusual for you? NB: If it is unusual, please try to answer the questionnaires based on how you would normally feel about your work rather than how you feel today.

What emotions (positive and negative) are evoked in you as a result of helping asylum seekers/ refugees?

Have the emotions evoked in you changed as a result of your work changed from when you first started helping asylum seekers/ refugees? If so how?

Has how these emotions affect you or how strongly you feel them changed from when you first started helping asylum seekers/ refugees? If so how?

SECTION TWO: STRESS

The following is a list of statements relating to the impact of your work. Please rate how accurately each statement describes you over the past **seven days** by circling the corresponding number next to the statement.

Please note:*"Client" refers to the asylum seekers/ refugees that you support.*

	Never	Rarely	Occasionally	Often	Very Often
1. I felt emotionally numb……..…….	1	2	3	4	5
2. My heart started pounding when I thought about my work with clients……..…..….	1	2	3	4	5
3. It seemed as if I was reliving the trauma(s) experienced by my client(s)……..…..	1	2	3	4	5
4. I had trouble sleeping……....	1	2	3	4	5
5. I felt discouraged about the future……..	1	2	3	4	5
6. Reminders of my work with clients upset me……	1	2	3	4	5
7. I had little interest in being around others……..	1	2	3	4	5
8. I felt jumpy…….	1	2	3	4	5
9. I was less active than usual……..…	1	2	3	4	5
10. I thought about my work with clients when I didn't intend to……	1	2	3	4	5
11. I had trouble concentrating…….	1	2	3	4	5
12. I avoided people, places, or things that reminded me of my work with clients……	1	2	3	4	5
13. I had disturbing dreams about my work with clients..	1	2	3	4	5
14. I wanted to avoid working with some clients……..	1	2	3	4	5
15. I was easily annoyed…….....	1	2	3	4	5
16. I expected something bad to happen…….....	1	2	3	4	5
17. I noticed gaps in my memory about client sessions.…	1	2	3	4	5

SECTION THREE: POSITIVE CHANGES

Many people also report noticing positive changes to their life as a result of helping others. For each question, please circle the number that best describes the degree to which of change that you have noticed since supporting asylum seekers/ refugees.

	Not at all	**A very small degree**	**A small degree**	**A moderate degree**	**A great degree**	**A very great degree**
1. I changed my priorities about what is important in life…	0	1	2	3	4	5
2. I have a greater appreciation for the value of my own life	0	1	2	3	4	5
3. I developed new interests……	0	1	2	3	4	5
4. I have a greater feeling of self-reliance……	0	1	2	3	4	5
5. I have a better understanding of spiritual matters…….	0	1	2	3	4	5
6. It's clearer that I can count on people in times of trouble..	0	1	2	3	4	5
7. I established a new path for my life……	0	1	2	3	4	5
8. I have a greater sense of closeness with others……	0	1	2	3	4	5
9. I am more willing to express my emotions……	0	1	2	3	4	5
10. I know better that I can handle difficulties……	0	1	2	3	4	5
11. I am able to do better things with my life…….	0	1	2	3	4	5
12. I am better able to accept the way things work out…….	0	1	2	3	4	5

13. I can better appreciate each day……0 1 2 3 4 5

14. New opportunities are available to me, which wouldn't have been otherwise……0 1 2 3 4 5

15. I have more compassion for others…… 0 1 2 3 4 5

16. I put more effort into my relationships…….0 1 2 3 4 5

17. I am more likely to try to change the things which need changing……..0 1 2 3 4 5

18. I have a stronger religious faith……0 1 2 3 4 5

19. I discovered that I'm stronger than I thought I was…… 0 1 2 3 4 5

20. I learned a great deal about how wonderful people are…0 1 2 3 4 5

21. I better accept needing others…… 0 1 2 3 4 5

SECTION FOUR: EMPATHY

These questions ask about how you interact with clients. For each of the 12 items below, please circle the number that best describes how you are or what you do, when you are with the asylum seekers/ refugees that you support.

	Nearly Always Like	Frequently Like	Quite Often Like	Occasionally Like	Seldom Like	Never Like
1. I attempt to explore and clarify their feelings……	1	2	3	4	5	6
2. I lead, direct and divert them..…….	1	2	3	4	5	6
3. I respond to their feelings…….……	1	2	3	4	5	6
4. I ignore their verbal and non-verbal communication..	1	2	3	4	5	6
5. I explore the personal meanings of their feelings….	1	2	3	4	5	6
6. I am judgmental and opinionated…….	1	2	3	4	5	6
7. I respond to their feelings and the meaning of those feelings……	1	2	3	4	5	6
8. I interrupt and seem in a hurry……...	1	2	3	4	5	6
9. I provide the client with direction…….	1	2	3	4	5	6
10. I do not focus on solutions/ not answer direct questions or I lack genuineness……	1	2	3	4	5	6
11. I use an appropriate voice tone, sound relaxed……..	1	2	3	4	5	6
12. I use an inappropriate voice tone, sound curt…….	1	2	3	4	5	6

Team Support

Please rate how much you perceive that you are supported by your team at work. For each of the 4 questions below, please circle the number that best suits who you feel.

	No	Rarely	Moderately	Mostly	Always
1. Do you feel like a valued member of your team/department?...	1	2	3	4	5
2. Do you feel supported within your team/ department?.....	1	2	3	4	5
3. Are you included in team decisions?.....	1	2	3	4	5
4. Do you feel like you have control over your own work within the team/ department?.....	1	2	3	4	5

Organisational support

The 8 statements below represent opinions that you might have about working at your organization/ charity. Please circle the number that best describes how much you agree with each one.

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Neither Agree Or Disagree	Slightly Agree	Moderately Agree	Strongly Agree
1. The organisation values my contribution…	0	1	2	3	4	5	6
2. The organisation fails to appreciate any extra effort from me……	0	1	2	3	4	5	6
3. The organisation would ignore any complaint that I made……	0	1	2	3	4	5	6
4. The organisation cares about my well-being	0	1	2	3	4	5	6
5. Even if I did the best job possible, the organisation would fail to notice……	0	1	2	3	4	5	6
6. The organisation cares about my general satisfaction at work……...	0	1	2	3	4	5	6
7. The organisation shows little concern for me	0	1	2	3	4	5	6

8. The organisation takes pride in my accomplishments at work……	0	1	2	3	4	5	6

Social support

This scale looks more generally at how much support you have to help you after a difficult day or session. For each of the 7 items below, please circle the number that best describes your situation.

	Always	Nearly Always	Frequently	Quite Often	Occasionally	Seldom	Never
1. Someone willing to listen……	6	5	4	3	2	1	0
2. Contact with people in a similar situation…..	6	5	4	3	2	1	0
3. Able to talk about thoughts and feelings……	6	5	4	3	2	1	0
4. Sympathy and support from others……	6	5	4	3	2	1	0
5. Practical help……..	6	5	4	3	2	1	0
6. I feel let down……..	6	5	4	3	2	1	0
7. Overall satisfaction with support received…..	6	5	4	3	2	1	0

8. How do you think the support that you receive (or other people doing a similar job role) could be improved?

SECTION SIX: COPING

Finally, everybody copes with stress in different ways. Please circle the response that best describes how much you use each of the potential coping strategies listed below to help you cope with your work. Please note that this questionnaire is normally used after a specific traumatic event so some items may not be relevant to you. Please circle "Do not use or N/A" for any items that are not relevant.

	Do Not Use or N/A	Use Somewhat	Use Quite A Bit	Use A Great Deal
1. Concentrate on what I need to do next- the next step……	0	1	2	3
2. Try to analyse the problem in order to understand it better…….	0	1	2	3
3. Turn to work or a substitute activity to take my mind off things…	0	1	2	3
4. Feel that time will make a difference- the only thing to do is wait..	0	1	2	3
5. Bargain or compromise to get something positive from the situation	0	1	2	3
6. Do something that I don't think will work, at least it will mean that I'm doing something……..	0	1	2	3
7. Try to get the person responsible to change his/her mind……	0	1	2	3
8. Talk to someone to find out more about the situation……..	0	1	2	3
9. Criticise or lecture myself……..	0	1	2	3
10. Try not to burn my bridges, but leave things open somewhat……	0	1	2	3
11. Hope a miracle will happen……	0	1	2	3
12. Go along with fate; sometimes I just have bad luck……	0	1	2	3
13. Go on as if nothing has happened……	0	1	2	3
14. Try to keep my feelings to myself……	0	1	2	3
15. Look for the silver lining so to speak/ try to look on the bright side	0	1	2	3
16. Sleep more than usual……	0	1	2	3
17. Express anger to the person(s) who caused the problem……..	0	1	2	3
18. Accept sympathy and understanding from someone……..	0	1	2	3
19. Tell myself things that help me to feel better……..	0	1	2	3
20. Feel inspired to do something creative…….....	0	1	2	3
21. Try to forget the whole thing……..	0	1	2	3
22. Get professional help (see a counsellor/ therapist)……..	0	1	2	3
23. Change or grow as a person in a good way……	0	1	2	3
24. Wait to see what will happen before doing anything……	0	1	2	3
25. Apologise or do something to make it up……..	0	1	2	3
26. Make a plan of action and follow it……..	0	1	2	3
27. Accept the next best thing to what I wanted……	0	1	2	3
28. Let my feelings show somehow……...	0	1	2	3

29. Realise that I brought the problem on myself……. 0 1 2 3
30. Come out of the experience better than I went in……. 0 1 2 3
31. Talk to someone who can do something concrete about the problem 0 1 2 3
32. Get away from it for a while, try to rest or take a vacation…….. 0 1 2 3
33. Try to make myself feel better by eating, drinking, smoking,
using drugs or medication…….. 0 1 2 3
34. Take a big chance or do something risky……. 0 1 2 3
35. Try not to act too hastily or follow my first hunch…….. 0 1 2 3
36. Find new faith……... 0 1 2 3
37. Maintain my pride and keep a stiff upper lip…… 0 1 2 3
38. Rediscover what is important in life…….. 0 1 2 3
39. Change something so things will turn out right…… 0 1 2 3
40. Avoid being with people in general…….. 0 1 2 3
41. Don't let it get to me, refuse to think about it too much……... 0 1 2 3
42. Ask a relative or friend I respect for advice…….. 0 1 2 3
43. Keep others from knowing how bad things are/ I feel…….. 0 1 2 3
44. Make light of the situation, refuse to get too serious about it…… 0 1 2 3
45. Talk to someone about how I'm feeling…… 0 1 2 3
46. Stand my ground and fight or what I want/ believe…….. 0 1 2 3
47. Take it out on other people (maybe unintentionally)…… 0 1 2 3
48. Draw on my past experiences, have I been in similar situations?..... 0 1 2 3
49. Know what has to be done, so double my efforts to make it work… 0 1 2 3
50. Refuse to believe what has happened……. 0 1 2 3
51. Make a promise to myself that things will be different next time….. 0 1 2 3
52. Come up with a couple of different solutions to the problem…… 0 1 2 3
53. Accept it, nothing can be done…… 0 1 2 3
54. Try to keep my feelings from interfering with things too much……. 0 1 2 3
55. Wish I could change what happened or how I felt…….. 0 1 2 3
56. Change something about myself…….. 0 1 2 3
57. Daydream or imagine a better time/ place than the one I was in…… 0 1 2 3
58. Wish that the situation would go away or somehow be over…….. 0 1 2 3
59. Have fantasies or wishes about how things may turn out…… 0 1 2 3
60. Pray…… 0 1 2 3
61. Prepare myself for the worst……. 0 1 2 3
62. Go over it in my mind i.e. what I would do/ say differently…… 0 1 2 3
63. Think about how a person I admire would handle the situation
and use that as a model…… 0 1 2 3
64. Try to see things from the other person's point of view……... 0 1 2 3
65. Remind myself of how much worse things could be…… 0 1 2 3

66. Jog or exercise…… 0 1 2 3

67. Please list any other coping strategies that you use below:

This is the end of the questionnaire pack.

Thank you very much for helping me with my research. Your help is greatly appreciated.

If you would like to be entered for the £50 prize draw as described in the participant information sheet, please email me on kld20@le.ac.uk or return the enclosed form with your responses. (Your prize draw entry form will not to linked to your responses).

Thank you again for participating

Kara

School of Psychology- Clinical Section

£50 prize draw entry form

I confirm that I have completed a participant pack and would like to be entered in the £50 prize draw.

If my name is selected at random in the October 2010 prize draw, I would like to receive a £50 gift voucher for the following high street store _____

My email address (so that you can contact me if I win) is _____

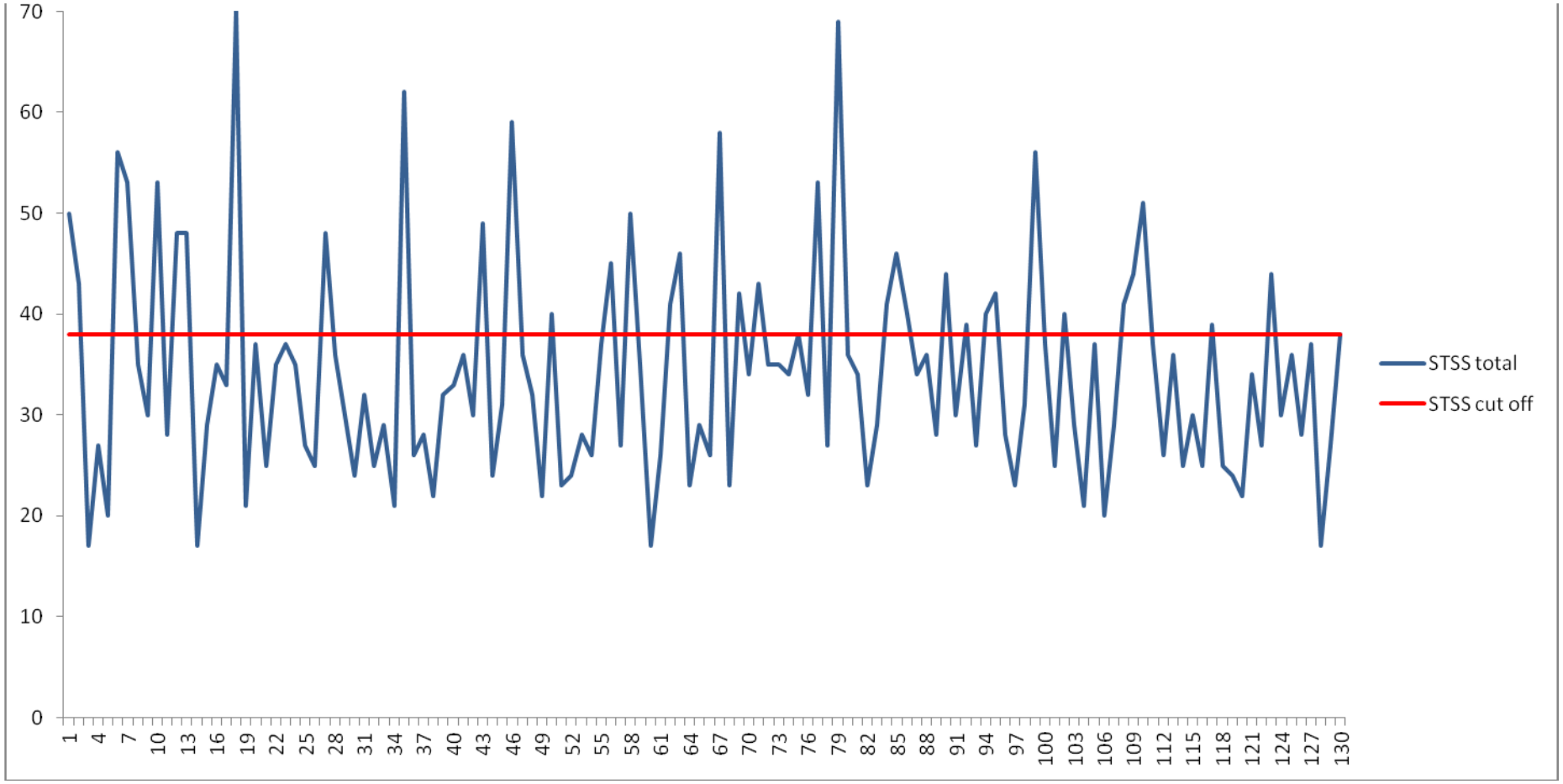
Participant's signature: _____

Participant's name (please print): _____

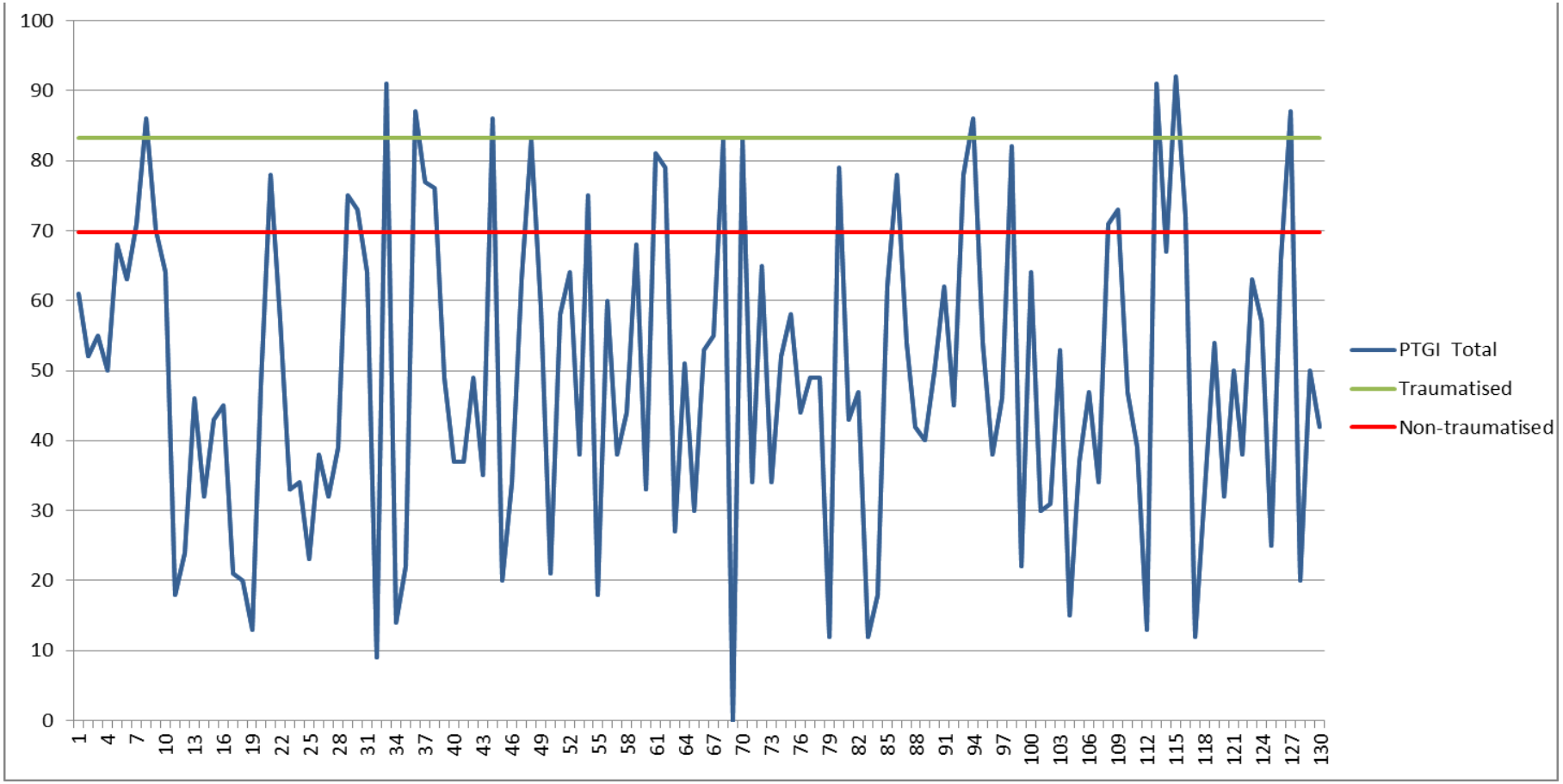
Date: _____

Please note that this form will be kept separately from your data

Appendix L: Range of respondents trauma scores as measured by the STSS



Appendix M: Range of respondents adversarial growth scores as measured by the PGTI



Appendix N: Ethics letter

NHS
National Research Ethics Service

Leicestershire, Northamptonshire & Rutland Research Ethics Committee 1
1 Standard Court
Park Row
Nottingham
NG1 6GN

Telephone: 0115 8839428
Facsimile: 0115 9123300

10 June 2010

Miss Kara Davey
Trainee Clinical Psychologist
80 Biddle Road
Leicester
LE3 9HH

Dear Miss Davey

Study Title: **Secondary traumatisation and adversarial growth: how are employees of charities who provide support and advice to asylum seekers affected by their work?**
REC reference number: **10/H0406/33**
Protocol number:

Thank you for your letter of 28 May 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

The Committee Chair would like to thank you for the amount of hard work that you have put in to make the submission of a consistently high quality, especially in light of the fact that this was voluntary review.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk. *Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.*

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Covering Letter		13 April 2010
REC application	44840/113191/1/452	16 February 2010
Protocol	5	13 April 2010
Investigator CV	1	13 April 2010
CV - Academic Supervisor		13 April 2010
Interview Schedules/Topic Guides	1	13 April 2010
Internal Peer Review Form		17 January 2010
Email - Request for voluntary submission of research for ethical review		13 April 2010
Questionnaire: Secondary Traumatic Stress Scale	© 1999	
Questionnaire: Crisis Support Scale - Short Form		
Questionnaire: Eight item survey of Perceived Organizational Support		
Questionnaire: Posttraumatic Growth Inventory		
Questionnaire: Reynolds Empathy Scale		
Questionnaire: Ways of Coping (revised)		
Email: Public liability insurance		25 February 2010
Personal Information		
Team Support Scale		
BJ50 prize draw entry form	1	13 April 2010
BJ10 gift voucher for completing the pilot study	1	13 April 2010
Support available to you	1	13 April 2010
Participant Information Sheet: Pilot	2	28 May 2010
Participant Information Sheet: Survey	2	28 May 2010
Participant Consent Form: Pilot	2	28 May 2010
Evidence of insurance or indemnity		06 August 2009
Response to Request for Further Information		28 May 2010

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H0406/33	**Please quote this number on all correspondence**

Yours sincerely

pp

Dr Carl Edwards
Chair

Email: jeannie.mckie@nottspct.nhs.uk

Enclosures: "After ethical review – guidance for researchers" *SL- AR2 for other studies*

Copy to: *Mrs Noelle Robertson*

R&D office for NHS care organisation at lead site – LPT

Appendix O: Statement of epistemological position

There is a good evidence base for STS and PTG in a wide range of individuals who support trauma survivors. In addition, it has been investigated qualitatively in an unpublished thesis. It was not necessary therefore to build theory or explore lived experiences in this research. AS a result the researcher used a quantitative methodology from a relativist position as this was most appropriate to answer the proposed research questions.

Appendix P: Chronology of research process

June 2009	Research proposal submitted and panel attended
Dec 2009	Peer review process
May 2010	Ethical submission and panel
Aug 2010	Collected pilot data
Sept 2010- Jan 2010	Collected survey data
Feb 2011	Literature review
March 2011	Data analysis
April 2011	Writing of thesis