Mitigating distress in New Zealand police officers exposed to children's accounts of traumatic experiences: Emotion-solving versus problem-solving

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Abstract

Working with children who have been abused can be deleterious. This study examined the impact on state affect after exposure to a child's statement of abuse, assessed which type of solving approach led to less recall of distressing information, and examined which risk factors impacted on state affect and short-term memory tasks. Forty North Island police officers, including a specialised group of forensic interviewers who are trained to interview children who have been abused, participated in this study. Participants showed a decrease in positive affect (PA) and negative affect (NA), measured by the Positive and Negative Affect Schedule (PANAS; Watson, Clark, & Tellegen, 1988), after exposure to one scenario of child abuse. No significant differences on PA and NA were found in relation to whether the scenario of abuse was physical or sexual. Furthermore, no significant differences on the amount of distressing information recalled from the child's statement of abuse were found in those participants who used an emotion-solving approach versus a problem-solving approach. The uniqueness of police work is highlighted, particularly in relation to how they may process distressing information by considering the quality of evidence required to prosecute offenders and recalling details of abuse using criminal offence categories. Limitations of this study are described as well as suggestions for future research directions. Implications for police and forensic interviewing practice are discussed.

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Dedicated with love to my husband, Waki
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CHAPTER 1: INTRODUCTION

"Therapists who work with traumatised people require an ongoing support system to deal with these intense reactions. Just as no survivor can recover alone, no therapist can work with trauma alone"
(Herman 1992, as cited in Berger, 2001, p. 208).

Working with abused children can be rewarding, however the impact on professionals who are exposed to their client's traumatic events may be deleterious. My interest in this area arose while employed as a forensic interviewer with Child, Youth, and Family (CYF) for over five years. This role involved interviewing children who had been sexually and physically abused. Personal accounts from colleagues suggested that while some were able to detach themselves from the emotional impact of the children's accounts, others would find themselves thinking about the information long after it had been collected. It also seemed that there were individual differences in coping styles and in the way information was gathered and reported that influenced the degree of emotional distress that the forensic interview process was likely to engender. In order to examine the interactions of task requirements (what detail was required in reports, for example), coping style, and emotional involvement and subsequent distress, it seemed useful to construct an experimental analogy of the interview process in order to control for the many influences possible. Forensic interviewers would serve as participants, but they would be assessed in a contrived situation that might provide some insights into how the forensic information was being processed. This research was therefore designed to provide some preliminary information in relation to the impact on affect (emotion) and memory (cognitive processing) amongst forensic interviewers and police officers, in a uniquely New Zealand setting. Insights from the research might then allow modification of the way in which they currently manage the impact of their work.

The following section provides a critical review of the literature relevant to this study. This includes an overview of research relevant to forensic interviewing and police work, an analysis of the impact of this work on clinicians with particular consideration to factors which may increase clinicians' risk of developing traumatic effects, and a summary of strategies which may mitigate against the effects of trauma. As this research has New Zealand police officers as its participants, where possible New Zealand and relevant research related to the impact of trauma on police personnel is reported.

In 1989, after an increase in the number of child complainants of sexual abuse and concerns raised in relation to stress encountered by child victims while giving evidence in court, significant changes to legislation relating to how children's evidence is collected were made (Geddis, 1993). The Evidence Amendment Act 1989 allowed children under the age of 17 years to give their evidence-in-chief, or main evidence, by way of a videotaped evidential interview, known today as a **forensic interview**[1] (Wilson, 2002).

Initially the legislation regarding forensic interviewing related only to children who had disclosed sexual abuse. In 1995 the Court of Appeal in **Queen v Moke/Lawrence** (CA 398/95 and CA 399/95) ruled that forensic interviews of children who had disclosed physical abuse could also be admitted in court as evidence (Wilson, 1999). Basher's (2003) recent New Zealand statistics note that at least 75% of forensic interviews are for sexual abuse cases. Over the years, law precedents have provided a broader interpretation about what type of cases can be recorded as forensic interviews. Today forensic interviews of children are conducted not only for physical and sexual complainants but also for children who have witnessed serious sexual or physical abuse, witnessed domestic violence and homicide, or are recent

[1] The term forensic interview, also known as an **evidential interview**, is used to describe a videotaped interview of a child who has made a verbal statement alleging abuse. These terms are often used interchangeably.

complaint witnesses (that is; the first person who is told about a child's alleged abuse).

In New Zealand, child abuse complaints are investigated jointly between CYF and the police (refer to Appendix A for a flowchart and explanation of the process). Forensic interviews are conducted by police officers and social workers employed by CYF who have attended the Evidential Interviewing Training Course, jointly coordinated and funded by both agencies (CYF & New Zealand Police, 1996). Since 2002, notifications of alleged child abuse and neglect to CYF have almost doubled (CYF, n.d.; N. Stevens, personal communication, August 2, 2005). In the year ended 30 June 2005, CYF received a total of 53, 097 notifications of alleged abuse or neglect with almost 82% requiring further action to be taken by CYF (N. Stevens, personal communication, August 2, 2005). Of those notifications investigated by CYF, approximately 8% involved a forensic interview being conducted (Basher, 2004). The referral criteria for forensic interviews include; statements from children alleging abuse, medical evidence, abuse witnessed by others, contact with alleged offenders, conflicting stories from the child and alleged offender, and an adult has admitted abusing a child (Basher, 2003; CYF & New Zealand Police, 1996).

Police officers and forensic interviewers who work with children who have been sexually or physically abused are exposed to graphic details about abusive adult's intentional cruelty to children. Dealing with the pain of abused children, violence against children, and dealing with the grief of families whose children have been abused is distressing (Figley, 1995; Regehr, Goldberg, & Hughes, 2002). As a result, police officers and forensic interviewers during the course of their work may experience secondary traumatic stress. Rather that being the primary person who experienced the trauma as in Post Traumatic Stress Disorder (PTSD), clinicians may experience secondary traumatic stress from knowing about the trauma from the person who primarily experienced it (American Psychiatric Association [APA], 1994; Figley & Kleber, 1995; Jones, 2001). Secondary traumatic stress is a rapid onset of PTSD-like symptoms (Figley, 1995; Jenkins & Baird, 2002;

Salston & Figley, 2003) which are usually less severe (Motta, Chirichella, Maus, & Lombardo, 2004; Motta, Kefer, Hertz, & Hafeez, 1999). Secondary traumatic stress symptoms include re-experiencing the traumatic event through intrusive and distressing imagery or thoughts (Sexton, 1999), restricted range of affect (APA, 1994; Sabin-Farrell & Turpin, 2003), inability to remember salient details of the trauma (APA, 1994; Berger, 2001), detachment or withdrawal from others (Motta et al., 2004), concentration difficulties (Motta et al., 2004), and staying attuned to a child's affect after an interview (Berger, 2001).

The term vicarious trauma is also used to describe the effects on clinicians as a result of being exposed to clients' traumatic accounts. Vicarious trauma was first defined by McCann and Pearlman in 1990 (as cited in Collins & Long, 2003, p. 417) as "the transformation in the inner experience of the therapist that comes about as a result of empathetic engagement with clients' traumatic material". The cumulative nature of vicarious trauma and its focus on changes in cognitive schemata differentiate it from secondary traumatic stress. Not only do major disasters result in posttraumatic symptoms, but also exposure to many smaller and less sensational events (Regehr et al., 2002).

Constructivist Self Development Theory (CSDT) is one theoretical explanation of how individuals adapt to the cumulative effects of trauma. CDST suggests that adapting to trauma is a normal reaction and results from an interaction between life experiences (such as personal history), individual personality style (such as coping mechanisms), and cognitive schemata (Nelson-Gardell & Harris, 2003; Pearlman & MacIan, 1995; Trippany, White Kress, & Wilcoxon, 2004). Exposure to trauma may disrupt the cognitive schemata (Pearlman & MacIan, 1995; Schauben & Frazier, 1995; Steed & Downing, 1998). Horowitz's (1986, as cited in Creamer, Burgess, & Pattison, 1992) cognitive processing model posits that cognitive schemata help people make sense of their world. As we experience new events, information is filtered through the cognitive schemata, which can then be assimilated into already existing schemata, or existing schemata modify to accommodate the new information (Creamer et al., 1992; Sabin-Farrell & Turpin, 2003). Until

information is assimilated, it stays in active memory resulting in intrusive and distressing thoughts.

The impact of being exposed to traumatic information according to CDST affects five main cognitive schemata (Nelson-Gardell & Harris, 2003; Sabin-Farrell & Turpin, 2003; Trippany et al., 2004).

1. Safety. Clinicians with repeated exposure to trauma may feel like there is no safe place from real or imagined threats. As a result, clinicians may be overly cautious about self and family and take practical measures to ensure safety, such as installing home alarms or attending self-defence courses.
2. Trust. Clinicians may experience a reduction in one's level of trust in self and others
3. Esteem. Clinicians may feel inadequate and doubt their abilities, or become disillusioned with people's cruelty to others. Alternatively, clinicians may feel privileged to be working with survivors of traumatic events.
4. Intimacy. Clinicians may feel empty and avoid being left alone, or withdraw from others, or become dependent on significant others.
5. Control. Clinicians may feel helpless or experience intrusive thoughts and use avoidance, numbing, or denial as coping mechanisms.

There is less consistent and conclusive empirical evidence for changes in cognitive schemata (Sabin-Farrell & Turpin, 2003) with some research finding no disruptions in clinician beliefs after being exposed to trauma (Brady, Guy, Poelstra, & Brokaw, 1999; Jenkins & Baird, 2002). Limited evidence related to changes in cognitive schemata and vicarious trauma could be due to its complexity and lack of information about its construct validity and operational definition (Adams, Matto, & Harrington, 2001; Pearlman & MacIan, 1995).

Countertransference refers to reactions by clinicians within the therapy session to statements from both traumatised and non-traumatised clients (Sabin-Farrell & Turpin, 2003; Trippany et al., 2004). There are two types of countertransference (Jones, 2001; Sexton, 1999). First, *avoidance reactions* where the clinician may deny, minimise, or distort information regarding the levels of trauma suffered. In this case, clinicians may take an analytic

approach to avoid what the client is experiencing or dissociate by having difficulty remembering details about the interview (Berger, 2001; Salston & Figley, 2003).

Second, clinicians may *over-identify* with clients and experience physiological reactions either before or during the session. Inexperienced clinicians who over-identify with clients increase their vulnerability to vicarious trauma (Adams et al., 2001; Anderson, 2000; McLean, Wade, & Encel, 2003; Pearlman & MacIan, 1995; Wasco & Campbell, 2002). Enmeshment and excessive client advocacy may also occur especially when working with vulnerable and traumatised children (Berger, 2001). Clinicians may blur boundaries by retaining clients' information or become involved with cases that are not part of one's role (Berger, 2001; Salston & Figley, 2003).

Stephens (1996) found that in a sample of New Zealand police officers, those who were more likely to have higher PTSD symptoms were those who experienced more events that are traumatic and had no educational qualifications. Higher levels of PTSD have also been found in those who work with victims of rape, abuse, or murder (Regehr et al., 2002; Steed & Downing, 1998). Trauma symptoms amongst law enforcement personnel were more likely to be influenced by personal stress, personal trauma history, negative coping mechanisms, and negative responses to investigating child abuse cases (Brady et al., 1999; Follette, Polusny, & Milbeck, 1994). More evidence of secondary traumatic stress and vicarious trauma has been found amongst workers, including the police, who work with sexual abuse victims than other client groups (Brady et al., 1999; Cunningham, 2003; Johnson & Hunter, 1997; Wasco & Campbell, 2002). Furthermore, working with abused children may increase levels of dissociation or intrusive thoughts, may have greater ability to recall specific details about the victim, or may invoke feelings of helplessness and anger (Motta et al., 2004; Regehr et al., 2002). While Schauben and Frazier's (1995) study found that working with sexual violence clients was related to clinicians reporting greater levels of PTSD symptoms, working with sexual violence clients in this study was not related to burnout or negative affect.

Secondary traumatic effects have also been noted amongst clinicians who viewed case records suggesting that traumatic effects can be experienced even when reading traumatic information (Alexander, de Chesnay, Marshall, Campbell, Johnson, & Wright, 1989, as cited in Wasco & Campbell, 2002).

Stephens' and Miller's New Zealand study in 1998 (as cited in Stephens, Long, & Flett, 1999) found that PTSD symptoms amongst police officers were greater amongst those who had experienced a greater number of traumatic events, providing evidence of the cumulative effects of trauma. Cumulative effects of trauma exposure can still be experienced even after leaving the police force, which coupled with loss of usual supports and ability to share experiences with colleagues may exacerbate problems (Paton & Violanti, 1997).

Higher levels of distressing symptoms are related to a greater percentage of trauma clients (Schauben & Frazier, 1995), a greater number of hours with clients (Meyers & Cornille, 2002), and greater exposure to graphic details (Brady et al., 1999). Trippany et al. (2004) recommend limiting the number of trauma clients per week and diversifying caseloads to reduce vicarious trauma. Berger (2001) estimates that one trauma client is the equivalent of two general clients and suggests that the amount of trauma work should be balanced by taking on other non-trauma work, such as community education, projects, or policy work.

The most vulnerable to secondary traumatic stress reactions are young and inexperienced clinicians who have poorly developed coping strategies (Bell, Kulkarni, & Dalton, 2003; Miller, 2000; Sexton, 1999). However, even experienced clinicians, who may have lower levels of distress, can still experience vicarious trauma. Benatar (2001, as cited in Sabin-Farrell & Turpin, 2003) found that experienced trauma therapists had a negative and cynical view of the world, concerns about their safety, negative views about oneself, and isolated oneself from others. Nelson-Gardell and Harris (2003) found that neither years of experience nor age was significantly correlated with risk of secondary traumatic stress. However, while more experienced

clinicians may have lower levels of distress this could be due to inexperienced clinicians who were unable to cope resigning or more experienced clinicians being promoted to supervisor positions where there is less front-line work (Nelson-Gardell & Harris, 2003).

There are aspects of forensic interviewing that increase the probability of developing secondary traumatic stress reactions. First, forensic interviewing is crisis work. Requests for unplanned and urgent interviews require forensic interviewers to work quickly and efficiently in highly emotional situations, often with inadequate client information (Miller, 2000; Wilson, 2002). Second, as usually only one interview is conducted, pressure may be put on forensic interviewers not to make mistakes, and for them to be attentive throughout the entire interview (Wilson, 2002). Third, forensic interviews are always observed. The videotapes are open to scrutiny from lawyers coupled with the threat of media attention and litigation (Eichelbaum, 2001; Wilson, 2002). Fourth, forensic interviewers may work in isolation which may increase vulnerability to vicarious trauma (Jones, 2001; Paton & Violanti, 1997) or face conflictual situations between client and the organisational goals (Berger, 2001).

Having regular, supportive supervision which not only addresses client issues, but has a portion of each session dedicated to working through distressing issues is a necessary requirement for anyone working with trauma clients (Brady et al., 1999; Brough, 2004; Cunningham, 2003; Figley, 1995; Greller, Parsons, & Mitchell, 1992; McLean et al., 2003). Bell et al. (2003) found lower levels of secondary traumatic stress amongst clinicians who received more hours of non-evaluative supervision on a regular basis. While most studies suggest that supervision decreases the risk of developing traumatic reactions, Kassam-Adams (1995, as cited in Sabin-Farrell & Turpin, 2003) found that supervision and support was not related to lower PTSD symptoms in clinicians.

Peer supervision can complement individual supervision. Peer supervision can normalise experiences and provide opportunities for debriefing as well as

sharing coping mechanisms, reaffirming confidence and validation in own work, decreasing feelings of isolation, and increasing levels of objectivity and empathy (Robinson, Clements, & Land, 2003; Trippany et al., 2004). Greller et al. (1992) and Stephens (1996) found that talking with colleagues about their experiences of traumatic incidents, as well as social support and a supportive home environment resulted in fewer traumatic PTSD symptoms amongst police officers. Furthermore, working as part of a team is recommended to reduce the effects of vicarious trauma (Figley, 1995; Pack, 2004; Sexton, 1999). Working in teams allows discussions about inconsistencies between theory, practice, personal beliefs, and agency philosophies (Pack, 2004), as well as opportunities for venting and gallows humour (Berger, 2001; Moran, 2002).

Employers, regardless of whether being exposed to traumatic events is part of core business, have an obligation to mitigate against the negative effects of stress on their employees. In New Zealand, the Health and Safety in Employment Act 1992 is designed to provide for safe workplaces (Department of Labour & Occupational Safety and Health Service [OSH], 1998). This Act is enforced by OSH and places obligations on employers and employees to ensure that workplaces are safe (Department of Labour & OSH, 2003). Stress and fatigue are noted as particular potential problems in workplaces. Furthermore, particular attention is given to workers whose work is "emotionally repugnant or draining (e.g. social work in a clinic for sexually abused children, working in some branches of medicine, police work)" (Department of Labour & OSH, 2003).

The New Zealand Police have clear policies and procedures to managing the impact of trauma on staff (Black, 2001). The New Zealand Police Trauma Policy "provides members of police, both sworn and non-sworn, appropriate psychological support as required by the sometimes traumatic and disturbing nature of police work" (Black, 2001, p. 3). This policy recognises that everyone has different reactions to traumatic events and that staff can be affected cumulatively and after a single traumatic incident. Critical Incident Stress Debriefing (CISD) may be useful for specific, one-off traumatic

incidents but may not address cumulative effects (Ortlepp & Friedman, 2002, as cited in Sabin-Farrell & Turpin, 2003). CISD may be given automatic support by management for events that are viewed as being the most stressful; however, it may not be these events that have the greatest impact on clinicians (Regehr et al., 2002). Although the police in New Zealand have mandatory debriefing available, inconsistent evidence has been found regarding the efficacy of debriefing especially when randomised control trials are used (Sabin-Farrell & Turpin, 2003). Some research has found that debriefing had no effect on reducing levels of distress with some even making clinicians worse (Stephens, 1996). Debriefing has however been found to be more effective when combined with individual sessions (Figley & Kleber, 1995).

Levels of secondary stress amongst forensic interviewers may be reduced as forensic interviewers have the luxury of not having to retain distressing information given that interviews are always videotaped (Wilson, 2002). Additionally, as usually only one interview is conducted, forensic interviewers unlike therapists do not have ongoing contact with children and their families (Cunningham, 2003). Furthermore, there are a number of supports available for New Zealand forensic interviewers. Supervision, whether it be clinical, peer or cultural, is encouraged. Additionally, attendance at an annual national peer tape review to improve and standardise practice, is recommended (CYF & New Zealand Police, 1996). At national peer tape review, all forensic interviewers throughout New Zealand meet and are updated on recent court judgements and experiences in court, updated on relevant research, as well as critiquing each other's videotapes (Wilson, 2003).

While some clinicians will experience adverse effects, most experience only mild symptoms and continue to function well (Pearlman & MacIan, 1995; Ortlepp & Friedman, 2002, as cited in Sabin-Farrell & Turpin, 2003; Schauben & Frazier, 1995). Anderson (2000) found that although clinicians reported concerns about their work environment, the majority expressed a desire to remain in the same job. Clinicians also report that while they continued to have responses to the nature of their work they would continue to work with that client group (Wasco & Campbell, 2002). Brough (2004)

compared New Zealand police, fire, and ambulance officers' reactions to trauma and found that while police officers reported greater levels of stressors, they did not experience more negative health or social problems than fire and ambulance officers. It is possible that the police were desensitised from repeated exposure or were already using effective coping strategies (Steed & Downing, 1998). Additionally, increased feelings of suspicion and distrust could be an appropriate and positive response to type of work (Steed & Downing, 1998). Individual personality characteristics and coping measures may mediate the effects of stress (Greller et al., 1992). For some, stress may produce an optimal level of arousal that allows them to still function effectively (Greller et al., 1992).

Clinicians can employ a number of coping strategies to manage the impact of their work. Coping can involve cognitive processes such as denial as a protective strategy and as a result have blurred recollection about cases (Miller, 2000). Alternatively, clinicians could become detached and distanced from clients in order to deal with distressing feelings (Collins & Long, 2003). Strategies of avoiding and blocking out distressing information may reduce immediate distress but can become maladaptive if relied upon (Creamer et al., 1992; Kopel & Friedman, 1999). Folkman and Lazarus (1988) discussed two types of coping mechanisms. First, problem focussed coping that involved making changes to the stressful event. Second, emotion focussed coping which involved regulating distress caused by the traumatic event. Forsythe and Compas (1987, as cited in Vitaliano, DeWolfe, Maiuro, Russo, & Katon, 1990) noted that distressing symptoms decreased when a problem-solving approach was used for incidents that were perceived as changeable and when an emotion-solving approach was used for events that were perceived as unchangeable. Patterson (1999) found that police officers, overall, tended to use problem-solving strategies to manage traumatic events. Those who used emotion-solving strategies were usually more experienced and had higher levels of distress than those who used problem-solving approaches.

In Schauben and Frazier's (1995) study, using active coping mechanisms and planning was associated with lower levels of distress. Having control over

situations was also positive (Mitchell-Gibbs & Joseph, 1996). Contrary to Schauben and Frazier's (1995) findings, Stevens and Higgins (2002) found that clinicians who used positive problem-solving coping strategies and social supports, did not have lower levels of trauma symptoms and burnout. Likewise, Anderson (2000) found that while most participants used active solving coping strategies, neither this strategy nor using avoidant coping mechanisms lessened the effects of emotional exhaustion. Those who used active solving strategies were less likely to depersonalise clients and more likely to feel a sense of personal achievement.

Current Study and Hypotheses

This thesis focused on issues that I became aware of when working for CYF as a forensic interviewer for over five years. I found that exposure to cases of abuse affected me, with physical abuse cases being more distressing than sexual abuse cases. In addition, I found that the sooner the child's report was completed (as likened to the problem-solving approach) the less recall I had of significant details. Whereas, when I ruminated (as likened to the emotion-solving approach) I often retained a larger amount of distressing information relating to the child's abuse. Prior research has focused on therapists and emergency personnel (such as police and disaster workers) and has tended to use self-report trauma-specific measures to investigate the impact of traumatic information on clinicians. This research aimed to assess forensic interviewers' memory for events using a performance task, rather than a self-report measure. In addition, using a specialised group of clinicians, namely forensic interviewers, who have not been studied in depth before as well police officers hoped to provide some interesting information. As there is little empirical research that has investigated the impact on memory and affect for forensic interviewers as a result of their exposure to children's traumatic disclosures in either New Zealand or overseas, this research aimed to provide some preliminary results.

This study had two main hypotheses. First, it investigated whether there are any differences in affect as a result of being exposed to a child's disclosure of

physical abuse and sexual abuse. It was hypothesised that after exposure to the child's disclosure of abuse, participants will have increased levels of negative affect and decreased levels of positive affect. Furthermore, it was hypothesised that those exposed to the physical abuse disclosure would have a greater increase in levels of negative affect and a greater decrease in levels of positive affect than those exposed to sexual abuse disclosures. Second, it investigated whether there are any differences on memory tasks for those participants who use an emotion-solving approach (that is, ruminating on their emotions and feelings about children being abused) versus a problem-solving approach (that is, focusing on the facts needed to write a professional report). It is hypothesised that those who use an emotion-solving approach will have greater recall of salient details related to the child's disclosure of abuse than those who use a problem-solving approach.