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# **Post-Traumatic Stress Symptoms, Professional Quality of Life and Exposure to Violence Among Milieu Therapists in Child and Adolescent Mental Health Care Units**

A Cross-Sectional Study

Master's thesis in Child and Adolescent Mental Health

Trondheim, February 2014

**Post-traumatic stress symptoms, professional quality of life and  
exposure to violence among milieu therapists in  
Child and Adolescent Mental Health care units:  
a cross-sectional study**

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Master Thesis in Child and Adolescent Mental Health

Trondheim, February 2013

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## **Summary:**

**Background:** The level of aggression in child and adolescent mental health care (CAMH) can be high, leading to adverse feelings and negative workplace experiences among caregivers. If this then leads to burn-out and posttraumatic stress, it could interfere with the caregivers' therapeutic relationships and alliances which are known to be imperative for results in CAMH care. Various CAMH units organise themselves in different ways in order to optimize therapeutic relations. Therefore it could be hypothesized that there are differences between institutions with regard to professional quality of life and adverse reactions when exposed to aggression.

**Objective:** to explore the differences between professional quality of life, symptoms of post-traumatic stress and exposure to violence among milieu therapists in two differently organised CAMH units.

**Methods:** The study was cross-sectional using two questionnaires: the Post Traumatic Check List – Civilian version (PCL-C) and Professional Quality of Life Scale (ProQoL). The survey was administered anonymously among milieu therapists at two CAMH units. Correlation and linear regression methods were applied to explain differences.

**Results:** There were significant differences between the two institutions. In the institution with high exposure to violence, burnout scores and symptoms of post-traumatic stress were significantly lower than in the institution with low exposure to violence. These differences were not explained for by differences in sex, age, length of professional experience and exposure to violence on the two institutions.

**Conclusion:** There are differences in burnout and posttraumatic stress symptoms between the two institutions which are not explained for by the level of exposure to violence. It is concluded that other factors must be of importance to explaining the differences. It is speculated that the staffs' amount of continuous face-to face contact with users of the facilities and differences in user characteristics could induce this high symptom load.

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## 1. THEORY

Milieu therapy is widely practised in child and adolescence mental health (CAMH) care in Scandinavia today. Based on psychotherapy it has been developed through experience with therapeutic communities for poorly integrated children and adolescent all the way back to the 1950s. Milieu therapeutic theory with child and adolescent in Scandinavia today has a wide angle of approach and many perspectives (1).

Common features in the milieu therapeutic approach with children and adolescent nevertheless are that the primary task is to facilitate the environment (milieu) for them to the extent that they are given opportunities to work towards transformation and development. This is made possible by the institution through a distinct organizational structure and a set of therapeutic relationships, which are contextually credible enough for the young people so that they may develop greater independence and to enhance their social skills as indicated by increased mutual respect and empathy (2).

### **The milieu-therapeutic organisation**

The concept of milieu therapy can be viewed as a dual construct, with a “therapy”-part and a “milieu”-part (2). The “therapy”-part involves the understanding the work that leads to change and development. The “milieu”-part involves a distinct organizational structure which involves facilitating the environment in various ways. It is about how we actually are solving the primary milieu therapeutic mission. This implies that milieu therapy represents a given *task* and an *organisational approach* to implement the aims. This approach is ideally based on a set of professional values and views that should be more or less theoretically founded. For example these include different educational or caring theories, views on life and an overriding concept of understanding or beliefs that define ones professional position. These different professional views impact in huge amount on the kind of approach we may choose to solve the milieu therapeutic task which lies ahead (2).

In a child- and adolescent psychiatric care unit different sorts of rotation schemes may be one example of an *approach* based upon different professional views. This also emphasizes the mutual bond between the milieu therapeutic task, the milieu therapeutic organisation and the professional views that are the basis for the milieu therapeutic work (2).

### **Therapeutic relationship**

There is much literature about precisely how the therapeutic relationship and alliance have been specified as key factors for the success of psychotherapy (3). The concepts of relationship and alliance are perhaps used somewhat interchangeably in everyday language. In psychotherapy though, including milieu therapy, it is important that the therapist has an idea about the major differences and does not look at the terms as synonyms (4). In short we can say that the therapeutic relationship uses every possible interaction between client and therapist. The alliance however is what occurs when the client and therapist form a common understanding of the objectives of the therapy and share the experience of success in achieving the goal together as partners. Bordin in Repål and Berge (5) believes that the alliance consists of three important factors: agreeing on objectives, agreement on how this should be done and an emotional bond of trust and confidence.

During the first meetings between the child or adolescent and the therapist it is important to be attentive to the development of a good therapeutic relationship and alliance. It can be an important moment for establishing a successful collaboration. «First impressions» can affect both parties and it is at this stage that it is most likely that the child or adolescent in mental care settings can “bond” in such a way that the therapeutic process may be successful. Despite this, overt aggressive behaviour is one of the most common reasons for referral to child and adolescent mental care units and episodes of aggression are not uncommon during admission (6). This fact would

undoubtedly limit the possibilities for developing the all-important therapeutic alliance with the child or adolescent by the milieu therapists

## **Workplace violence**

The term “workplace violence” is widely used all over the world. It is associated with the concept of occupational hazard and there are many different definitions of the term. Often it is defined in accordance with criminal codes or cultural settings. Those behaviours that are not recognized within a country’s legal system are not likely to be reported and investigated (7). This may lead to many underreported incidents that in other countries would fall under the term “workplace violence”.

Widely used terms in association with “workplace violence” are assault, attack, abuse, bullying, sexual or racial harassment, threats, physical violence and psychological violence (8).

Some definitions are very basic such as “actual or attempted assault” (9), but there is evidence, and it has long been accepted, that non-physical abuse, verbal abuse and threats may cause severe psychological and career consequences (10).

A tripartite subsidiary organization of the United Nations, the International Labour Office (ILO), has developed a *Code of Practice* (11) in response to increasing reports of workplace violence. In the draft manuscripts and the development of this *Code of Practice* a definition of “workplace violence” is stated as:

*..both physical and non-physical or psychological violence, in the form of verbal abuse, physical assault up to and including homicide, bullying, mobbing, harassment and mental stress. Workplace violence can be internal (within the enterprise, among managers, supervisors and workers); but there is also external violence (between workers and intruders, as well as between staff, clients, patients, students, suppliers, and the general public) (8)*



This statement was heavily debated by the panel of experts at a meeting to develop a code of practice on *Violence and Stress at Work in Services: A Threat to Productivity and Decent Work* (Genève, October 2003). The panel group consisted of representatives of governments, employers and workers from a range of countries. Employer experts mainly sought to limit the Code of Practice to only acts of physical violence, and to exclude the “psychological” part entirely. Finally a compromise was found for the final draft and the present Code of Practice states:

*Any action, incident or behaviour that departs from reasonable conduct in which a person is assaulted, threatened, harmed, injured in the course of, or as a direct result of, his or her work (11).*

This rather diminished definition has been criticized subsequently for weakening the legitimacy of the emotional and psychological consequences following violence at work (7).

Since 2004 the problem of workplace violence has received significant attention at a scientific, economic and policy level. At a recent ILO labour statisticians’ conference (Geneva, 2013), experts discussed again how to define work related violence and its inclusion in existing surveys (12). New definitions have arisen from the need for a more workable concept of the term. The main goal is to find a workable definition is suitable statistical measurement, understanding the different types of work-related violence and identifying different types of offenders. Also it is important to find ways in which to include questions on work-related violence into existing surveys to improve data comparability across the globe. The result of this work will be an agreed definition including detailed aspects of the term “workplace violence”

In the meantime, the European Commission (1994) provides a working definition of workplace violence as:

*Incidents where staff are abused, threatened or assaulted in circumstance related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being and health (13)*

This definition is nowadays widely used by the European Commission and by other organisations and researchers. It includes three important elements; different types of violence, a definition on *workplace*; and specification that the violence directly or indirectly has a potential impact on safety, well-being and health.

### **Workplace violence in health care settings**

Milieu therapists in CAMH care may often experience violence in their workplace (6). From adult psychiatry it is reported that 70 % of psychiatric nurses and milieu therapists experience violence against their person in the course of their career (14). In 2006 the National Institute of Occupational Health (NIHO) published a quality of life survey which reported that almost half of the working population of social educators and child-care workers exposed to violence, or threats of violence, one or more times each month (15).

Being required to manage violent patients often evokes negative feelings and creates adverse workplace experiences (16). This often leads to feelings of fear and anxiety (17, 18). It has been shown that a substantial number of psychiatric health care workers from adult settings have signs of burnout. In a study by Robinson (2003) more than 20% of registered psychiatric nurses reported intrusive memories from adult patient assaults (19). Findings from 2006 indicate high levels of emotional exhaustion among community mental health nurses, but this may be reduced by regular clinical supervision (20).

Compassion fatigue and burnout are important phenomena for other health care and social workers, and the relationships between different aspects of job satisfaction, compassion fatigue and risk for burnout have been explored (21, 22). It has been argued

that the amount of violence nurses are forced to handle, promotes burnout, especially in combination with low job satisfaction (23). Violence directed towards health care workers has been shown to have a severe psychological impact on the persons affected (24). Experiencing violence also increases the risk of more long term adverse psychological consequences. The risk of having to leave the health care profession due to such consequences is substantial (25), and the potential for post-traumatic stress disorder (PTSD) after assaults against nurses is high (26).

Thorgaard writes, that as milieu therapist in psychiatric care, we may witness unimaginable suffering in very large doses (27). If we do not have the right tools-of-the-trade to deal with this phenomenon, we may slowly and unnoticeably lose part of our humanity and subsequently our compassion skills. We may even not be aware that we slowly roughen and petrify our self until at last we just burn out (27).

There is reason to believe that these phenomena are also common among milieu therapists working in CAMH care where a high level of threats and violence occur. One of the most important factors for success in the therapeutic environment of CAMH care is the relational and therapeutic alliance between the carer and the child or adolescent (2). Stress, fear and anxiety from exposure to workplace threats and violence may affect the carer's professional quality of life and damage or impair the therapeutic relationship (28). This may in turn limit the child- or adolescents potential to receive effective treatment.

In mental health care settings for children and adolescents, milieu therapists attempt to adjust the therapeutic environment to promote maturation, growth and education. With children it is believed this may be accomplished precisely through good relational experience (29).

A recent study found that there were high rates of exposure to aggression amongst staff employed within CAMH care. This was associated with a range of negative emotional and professional sequelae which subsequently affected the therapeutic relationship between carer and patient (6).

**Aim of study:**

In summary, different models of therapeutic relating are used to the best of one's ability and professional beliefs, to solve the task. The milieu therapeutic task is still very much the same, but the way the therapists arrange themselves to best solve this task is approached in different ways. Different structures of shift rotations are perhaps one of the main ways of varying therapeutic milieu approaches.

It is therefore interesting to see what kind of impact these different structural settings might have on milieu therapists working in CAMH care settings. We can thus cautiously hypothesize that different milieu therapeutic organisation/structuring (e.g. type of work rotation), leads to total different kinds of therapeutic alliance and varying exposure to violence. In this context it is therefore reasonable to assume that therapeutic milieu approaches in differently organised structure may lead to variations in levels of professional work quality and perhaps stress symptoms.

Surprisingly, in spite of being a high risk exposure environment(6, 15, 30), the inter-relationships between job satisfaction, burnout and symptoms of stress due to traumatic or threatening experience has rarely been explored in child- and adolescence mental health care in a Norwegian setting.

**The aim of this study therefore is to explore the differences between professional quality of life, symptoms of post-traumatic stress and exposure to violence among milieu therapists in two differently organised CAMH units.**

## **2. METHODS**

### **Procedures**

Questionnaires were distributed anonymously, without data requested on the respondent's specific age or profession in order to minimise the risk of bias in self-reporting of symptoms possibly related to the workplace situation. Data on age and professional experience were instead requested in broad categories. There were six age groups (25 years or below, 25-34 years, 35-44 years, 45-55 years, 55-64 years and 65 years or more) and five professional experience categories (0-3 years, 4-6 years, 7-9 years, 10-12 years, 12 years or more).

Categorical data on gender, workplace unit and any exposure to workplace violence were requested. Data were collected by an online survey service using a well validated survey provider called QuestBack (31).

No identifiable information which could lead back to the individual respondent were given to the surveyor during the electronic collection of the data. Oral and written information relating to the study was given electronically to all participants and in addition through meetings with leaders of the units and with employee representatives and personnel safety representatives. All participants were recruited on a voluntary basis and consent was deemed as obtained if the person registered onto the electronic survey system.

### **Measures**

The study used a cross-sectional design with two well-known and validated questionnaires: the *Post Traumatic Check List – Civilian version* (PCL-C)(32, 33) and the *Professional Quality of Life Scale* (ProQoL) applied in a child and adolescent mental health care setting (34).

The PCL-C (32, 33) is a self-report measure developed to assess symptoms of post-traumatic stress according to DSM-IV criteria. Respondents are requested to rate on 5 point Likert scales the extent to which they have been bothered in the past month by 17 symptoms of PTSD grouped in the following DSM-IV symptom clusters: re-experiencing, avoidance/numbing, and arousal. Weathers et al. (33) suggested that a symptom should be considered as meeting the threshold criterion if an individual reports that it has bothered him or her 'moderately', 'quite a bit', or 'extremely' (i.e., an item endorsement of 3 or greater on the Likert scales).

According to Ruggiero et al the PCL-C scale has good internal consistency, with a Cronbach's alpha coefficient of .94 reported for the PCL total score (32). In this study, the Cronbach's alpha coefficient for the PCL-C total score was .85, suggesting very good internal consistency (35)

Assessment of professional quality of life was made using the Professional Quality of Life Scale (ProQOL) (34), which is a validated revision of the Compassion Fatigue Test (36). ProQOL is a 30 item self-report instrument which measures the following dimensions: compassion satisfaction, burn-out and secondary traumatic stress. The compassion satisfaction (CS) dimension measures pleasure derived from being able to do one's work well. High scores represent greater satisfaction related to one's self-perceived ability to be an effective caregiver. The burnout (BO) sub-dimension is one of the two dimensions related to compassion fatigue (CF) and is associated with feelings of hopelessness and difficulties in dealing with one's work. Higher scores are related to a higher risk of burnout. The secondary traumatic stress (STS) dimension is the second sub-dimension related to compassion fatigue and measures work-related, secondary exposure when caring for people who have experienced extremely or traumatically stressful events. The negative effects of STS may include fear, sleep difficulties, intrusive images, or avoiding reminders of the patient's traumatic experiences.

Stamm reports good internal consistency for the ProQoL scales, with Cronbach's alpha coefficient of .88 for the CS scale, .75 for the BO scale and .81 for the STS scale. In this

study, Cronbach's alpha reliability coefficient was .83, .71 and .72 for the CS, BO and STS scales respectively, suggesting good internal consistency (35).

## **Setting**

The study was conducted among milieu therapists at two child- and adolescent mental health care units: the Child and Adolescence Psychiatric Health Care unit (BUP) and the Kvamsgrindkollektivet (Kvamsgrind). Both units have high level of aggression but also have very different organizational structures for supporting the work of milieu therapists working with poorly developed children and adolescents or their disintegrated childhood.

### Characteristics of BUP:

The Child and Adolescence Psychiatric Health Care Clinic (BUP) is a specialist service provider at St. Olav's University Hospital. The clinic consists of three inpatient wards and eight outpatient facilities located throughout the Central Norway Regional Health Authority area. The main units that were included in this study were the three inpatient wards: the emergency unit, the diagnostic unit and the treatment unit. These three units have a total of 17 beds. In 2012 only 5 of 183 adolescents were subjected to coercive measures (37). The three inpatient units adopt milieu therapeutic principals with a systematic and thoughtful adaptation of the psychological, social and physical conditions of the environment in relation to the individual youth and the patient group's situation and needs. The purpose of this is to promote opportunities for learning, coping strategies and personal responsibility (2, 38). The milieu therapists' working schedule rotated two 8-hour daytime shifts, morning or evening, with a separate group of milieu therapists working only night shifts.

Throughout the whole BUP in central Norway, there were in 2012 approximately 4600 in- and outpatient treated at the unit. For the three units included in this study, the main reason for referral (over 50 referrals annually) was suspicion on behavioural disorders,

attention deficit hyperactivity disorder ADHD, eating disorders, depression, anxiety, post-traumatic stress and severe suspicion of neglect for children under the age of 6 years (37).

#### Characteristics of Kvamsgrind:

The Kvamsgrind Community is a unit for treatment of substance abuse among child and adolescent users. It is a multidisciplinary with staff from a wide range of health professions.

In this study all professionals are considered to be milieu therapists as defined earlier in this paper. Most service users are adolescents and young adults between 16 and 24 years old at the time of referral.

The unit consists of 22 beds plus three emergency beds. Expected treatment length is approximately 18 months. The main treatment focus at this unit is community living where “students” and milieu therapists live together for an extended period of time. This is based on a work rotation platform over a period of 8 weeks including two weeks “time off”.

The treatment ideology is therefore based on long term and close face-to-face relationships with the user or “student” to ensure the best possible therapeutic alliance. Furthermore, the Kvamsgrind unit adopts a voluntary, comprehensive and broad treatment approach encompassing school, employment and leisure activities to strengthen social skills (39).



## **Statistics**

Descriptive statistics were calculated and then stress symptoms as rated with the PCL-C were correlated with the three dimensions of the ProQOL scale, units and years of experience in mental health care settings. Linear regression was used to examine differences between the units.

To determine statistical significance an alpha level of  $< .05$  was used in all analyses. All analysis was conducted using the Predictive Analytics Software, SPSS 21.0 for Windows and STATA 12.1

## **Ethics**

The Regional Committee for Medical Research Ethics in Norway granted approval for this study (REK 2010/2044). Participants were free to withdraw consent at any stage of the data collection.

It was anticipated that participation in the survey would have any negative consequences for the participants although systems were set in place to assist those that might be in need of professional support due to possible re-experiencing of traumatic events.

### **3. RESULTS**

This section reports descriptive analysis of socio-demographic characteristics, rate of response, total severity score from the PCL-C questionnaire and the ProQoL scales. It then reports the results of four linear regression models to examine relationships between the major variables.

#### **Participants:**

After one reminder, 56 of 102 participants responded to the survey (54.9%). Twenty six per cent (15) were male and 73.2% (41) were female. Fifteen of 29 responded from the Kvamsgrind unit (52%) and 41 of 73 from the BUP unit (56%). Seventy one per cent was in the 35-55 age group (71.4%), 10.7% were aged 55 to 64 years and 17.9% were aged 25 to 34 years old. No respondents were younger than 25 years or older than 65 years old.

#### **Length of professional experience:**

The two most common categories of workplace experience were 0-3 years and 12 years or more with respectively 28.6% and 33,9% of respondents. Over two thirds of the respondents (37.5%) had between 4 and 12 years of experience.

#### **Exposure to violence:**

Forty of the 56 respondents (71.4%) met criterion A (exposure) for the PTSD diagnosis in DSM-IV, reporting within duration current employer i.e. they either a) were exposed to real threats containing serious physical violence (kicking, beatings etc.) b) witnessed others exposed to serious physical violence or c) self being exposed to serious physical violence (40). Violence exposure was reported as low from the Kvamsgrind unit with only 5 of 15 respondents (33%). The BUP unit reported a much higher with 35 of 41 participants exposed (85.4%). This difference in exposure between the two groups was highly significant ( $p=.00035$ , Fisher's exact test).

## **PCL-C:**

The majority (75%) of the participants did not report any sign of stress symptoms on the PCL-C with zero score on every item. None of the respondents met the criteria for a full PTSD diagnosis as defined by at least 1 B item (questions 1-5, re-experience), at least 3 C items (questions 6-12, avoidance), and at least 2 D items (questions 13-17, increased arousal) (40).

Fourteen (25%) reported at least one symptom occurring within either cluster B, C or D. Five (8.9%) reported at least one symptom occurring moderately (i.e. scoring at least 3 on the Likert scale) in each of cluster B, C and D (re-experience, avoidance, increased arousal) and thus met the criteria for a possible partial diagnosis of PTSD as defined by Stein et. al. (41). Four of these respondents were from the Kvamsgrind unit.

The Kvamsgrind Unit mean total severity score on the PCL-C, indicating overall stress symptoms, was 25.6 (sd 6.37). At the BUP unit this mean score was 20.2 (sd 3.8). This difference was statistically significant (Mann-Whitney  $U=139$ ,  $N_1=41$ ,  $N_2=15$ ,  $p=.002$ ,  $z=-3.152$ ,  $r=-.42$ )

The suggested PCL cut-point score is estimated to be 30 for civilian primary care or general population samples where estimated prevalence of PTSD is 15% or below (42). Even though there were large differences in symptom severity between the two units only 10.7% (6) of all respondents reported a total severity score above 30. All of these respondents were from the Kvamsgrind unit. This difference was highly statistically significant ( $p=.000154$ , Fisher's exact test).

## **Professional Quality of Life Scale**

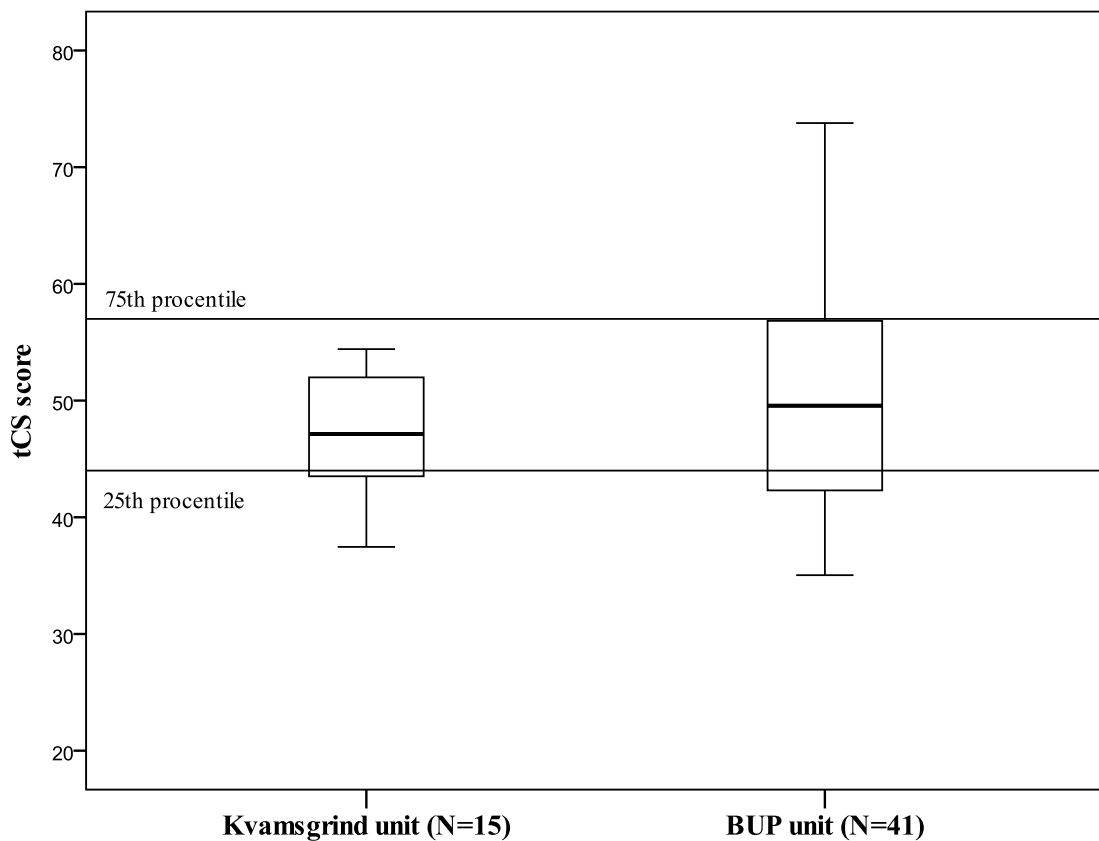
Raw sub scores from the Professional Quality of Life Scale were calculated according to the manual. Five items were reversed before inclusion in the calculation of the respective sub scale scores. Individual raw scores were then converted to standardized t-scores (tSC, tSTS and tBO) with mean score 50 and standard deviation of 10 as suggested in the manual (34). This allows comparison across studies and different versions of the ProQoL.

Compassion satisfaction:

The mean tCS scores at the four units were mainly within the mid-range according to the normative data from the ProQoL manual which provides a cut score at 44 for the 25<sup>th</sup> percentile and 57 for the 75<sup>th</sup> percentile (fig1). The Kvamsgrind Unit mean tCS score was 46.3 (sd 8.0, 95% CI 41.9-50.8) and slightly higher at BUP with a combined mean tCS score across all units of 51.3 (sd 10.4, 95% CI 48.1- 54.6).

There was no significant difference between the two units on this variable ( $t = -1.68$ , NS, equal variances assumed).

**Fig 1: Compassion satisfaction scores (CS)**

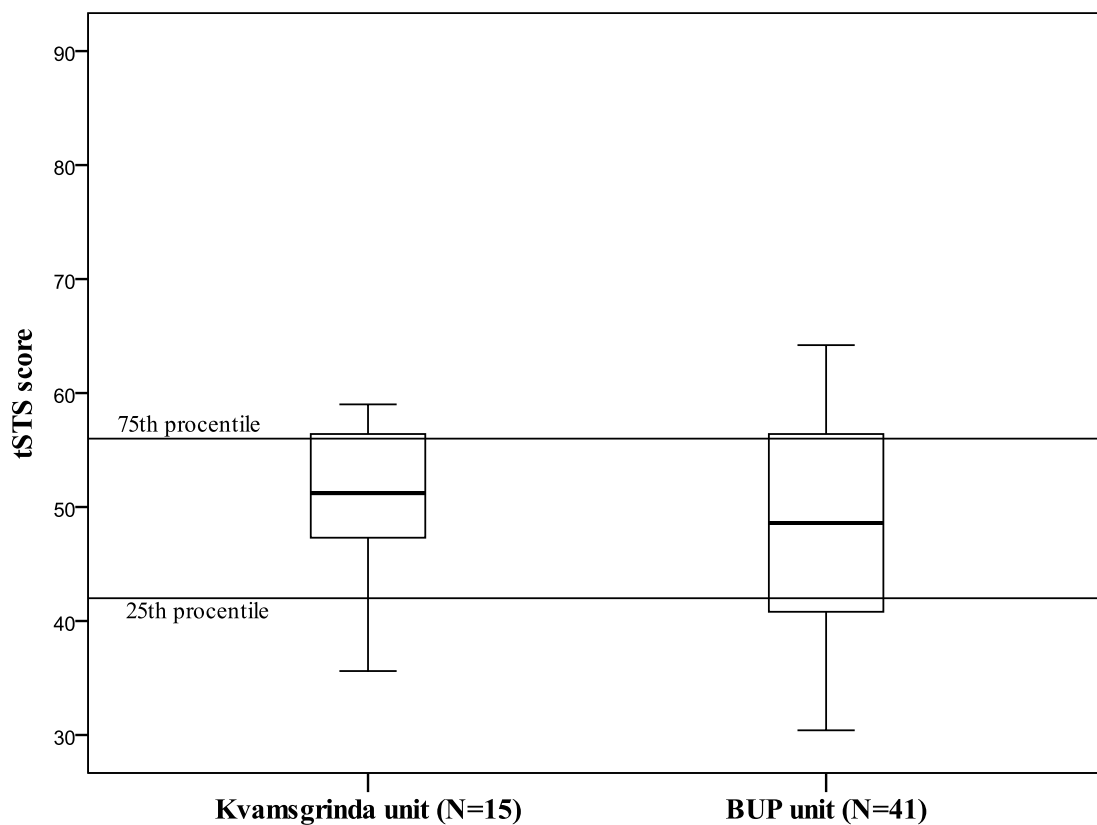


Secondary traumatic stress:

The mean tSTS scores at the four units were mainly within the mid-range according to normative data from the ProQoL manual which provides cut score at 42 for the 25<sup>th</sup> percentile and 56 for the 75<sup>th</sup> percentile (fig 2). The Kvamsgrind Unit mean tSTS score was 52.6 (sd 10.8, 95% CI 46.6-58.6) and slightly lower at BUP with a combined mean tSTS score across all units of 49.6 (sd 9.6, 95% CI 46-52.1).

There were no significant differences between the two units on this variable ( $t= 1.17$ , NS, equal variances assumed).

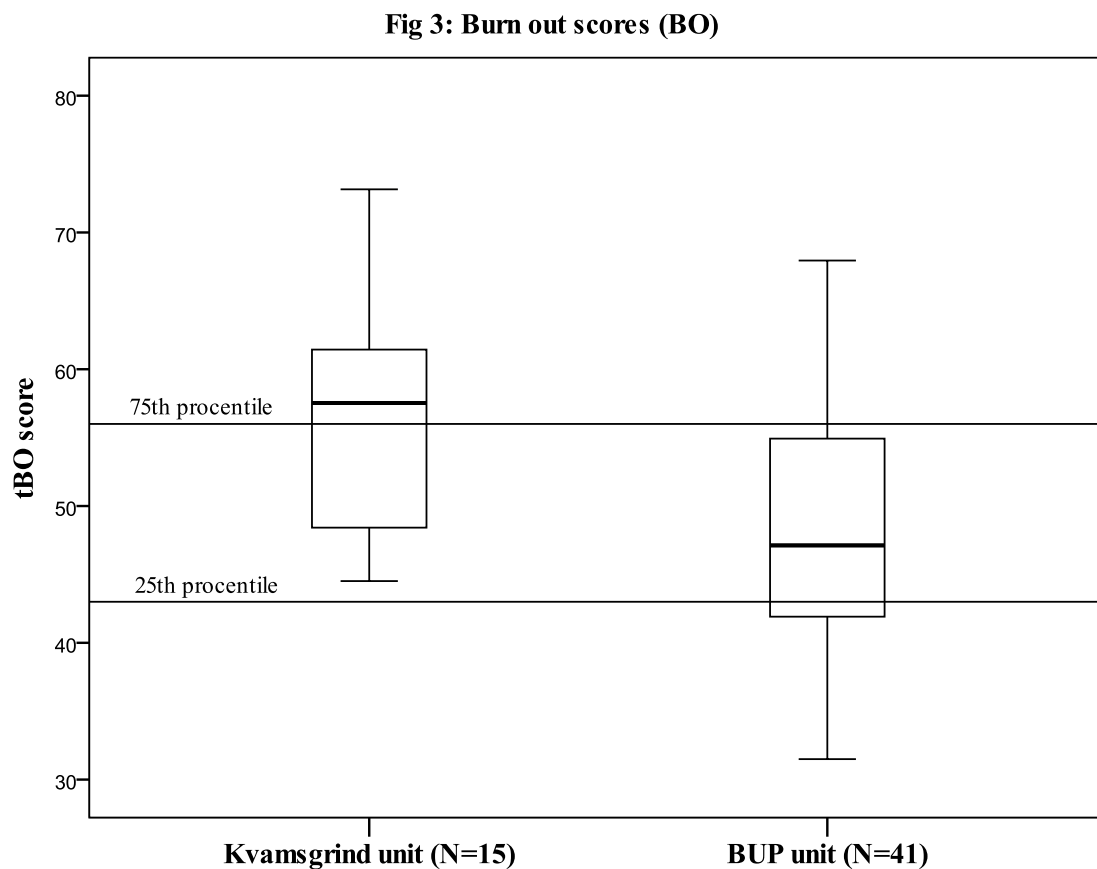
**Fig 2: Secondary traumatic stress scores (STS)**



Burnout:

The mean tBO scores at three of the four units mainly were within the mid-range according to normative data from the ProQoL manual which provides a cut score at 43 for the 25th percentile and 56 for the 75th percentile (fig 3). The Kvamsgrind Unit mean tBO score was 55.6 (sd 9.6, 95% CI 51-60.3) and slightly lower at BUP with a combined mean tBO score across all units of 47.9 (sd 9.8, 95% CI 44.8-51).

There was a significant difference between the two units on this variable ( $t= 2.68$ ,  $p=0.0096$ , equal variances assumed).



## Linear regression:

In order to examine whether the differences between the units in PCL-C scores and burnout scores (tBO) could be affected by other factors which varied between the two units, four separate multiple linear regression models with the main outcomes were tested. PCL-C total, tCS-scores, tBO-scores and tSTS-scores was set as a dependent variable in each of these models and sex, age, length of professional experience and exposure to violence as covariates. Unit was dichotomous variable with the Kvamsgrind unit assigned the value 0 and the BUP unit assigned the value 1. As shown in table 1, the differences between the units in PCL-C scores and BO-scores remained significant when controlling for these covariates.

Table 1: Linear regression models – BUP vs Kvamsgrind

dependant variable	Unadjusted				Adjusted*			
	Coef.	p	95% CI		Coef.	p	95% CI	
Model 1 tCS	4.99	.098	-0.95	10.95	5.71	.106	-1.26	12.68
Model 2 tSTS	-3.54	.244	-9.57	2.49	-2.38	.520	-9.75	4.99
Model 3 tBO	-7.68	.010**	-13.41	-1.94	-9.31	.006**	-15.79	-2.83
Model 4 PCL	-5.43	.000**	-8.21	-2.64	-6.41	.000**	-9.77	-3.04

\*Adjusted for sex, age, length of professional experience and exposure to violence. None of these covariates contributed significantly to any of the four tested models.

\*\*  $p \leq .01$



#### 4. DISCUSSION

This cross-sectional study was based on the response of 54 milieu therapists in two different child and adolescent mental health care units and aimed to ascertain if there were any differences in job satisfaction or stress based on different milieu therapeutic structures.

The response rate was 54% which is adequate given the study's voluntary nature. The results could be compromised by a self-selection bias for participation, but this would imply extreme bias which is not believed to be in place. The response rate is comparable to that in other similar published studies (14, 16).

The rate of exposure to violence or threats of violence was significantly different in the two units. In the Kvamsgrind unit only 5 of 15 staff reported exposure to violence during the preceding 30 days, but the overall frequency of reported violence was 71.4% based from the study's total number of responders (both from the BUP unit and the Kvamsgrind unit combined). Other studies have reported similar levels of violence in both CAHM care and adult mental health care with estimates ranging from 70% to 95% (6, 43, 44). Svalund reported that over 40% of child and adolescents therapists experience violence one or several times each month (30).

Here, only 33% of the Kvamsgrind unit reported violence during the last 30 days. This seems low, especially when compared to the reported occurrence of violence (84.4%) on the BUP unit, but is in accordance with Svalund's findings. Still, a violence exposure rate of 33% during last 30 days is high compared to any other occupation (30).

On the other hand, these results may be affected by the study's cross-sectional design. Non-responders or potential responders who were unable to participate due to personal circumstances (e.g. sick leave, career change) could have different experiences and thus change the results if they had responded to this survey.

The prevalence of post-traumatic stress symptoms was generally low in spite of high reported exposure to violence and/or threats of violence. Three quarters of the study

group, 75%, rated zero for all items in the PCL-C. This was perhaps lower than expected. The findings from studies of post-traumatic stress disorder among nurses after exposure to violence are ambiguous (45), but some studies indicate that up to 17% of respondents meet the criteria for a PTSD diagnosis (26, 45). These samples may, or may not, be comparable to settings in child and adolescent mental health care, but it is suggested that workers dealing with children and families in trauma experience higher levels of burn-out symptoms than any other groups of helping profession staff (34) and therefore higher stress levels.

Interestingly, most of the reported stress symptoms in this study were from the Kvamsgrind unit which had the lower reported frequency of exposure to violence. This raises the question of why this difference occurs. Results from this study may shed some light on factors *not* contributing to this difference.

The overall professional quality of life measured by the ProQoL scale showed no exceptional values in these units when compared to the normative data from Stamm's extensive study of 1187 people (34). The findings were also in accordance with prior Norwegian studies using the ProQoL scale although these were unfortunately from adult psychiatry (43, 46).

The slightly elevated burnout values at the Kvamsgrind unit may imply underlying disruptive factors (e.g. personal conflicts, insecurity of therapeutic role, management style) but as suggested by Stamm one must be cautious in interpreting ProQoL at the group level and especially for staff working with children and families in trauma as they tend to have higher levels of BO than any other group within health care occupations (34). Nevertheless, the significant difference in BO and PCL-C scores between the two units raises questions that need further investigations.

Milieu therapists at Kvamsgrind reported less exposure to violence compared to those from BUP. Despite this, the Kvamsgrind unit showed relatively higher symptoms of pressure with more indicators of stress and burnout. Adjusting for sex, age and professional experience did not change this relationship. Other explanations may be

found in factors not included in this study. It would be interesting to identifying these factors in future similar studies in CAMH care units.

One can only speculate when suggesting what the other variables might be, but as discussed in the introduction, different types of therapeutic milieu organisation could be one important factor. Leadership of therapeutic milieu units can be a complex and demanding task which is based on both administrative, organisational and therapeutic insight. This is not only relevant in relation to the child or adolescent, but also in relation to the care and wellbeing of the staff members as well.

Therapeutic work culture may also have an impact on the therapeutic milieu atmosphere. Dean reported that most respondents in her study felt that dealing with aggressive behaviour was an inevitable part of working in a child and adolescent mental health unit, but at the same time the level of aggression was unacceptable (6). One might suggest that if these feelings and attitudes are not addressed in a professional manner, but silently accepted as “sacrifice for work”, this could lead to feelings of ineptness and decreased job satisfaction.

Future studies which focus on what impact different level of regular clinical supervision among milieu therapist in CAMH care units has on job satisfaction and stress levels would be interesting as this shows to reduce negative impact in adult psychiatry where workplace violence is rated high (20).

It could be argued that differences in referral processes and criteria for admission between the two units are so great that comparison is meaningless. The Kvamsgrind unit is described as more specialized with a focus on substance abuse therapy, and that this kind of work has a different impact on the milieu therapist at that unit (47, 48).

Nevertheless, the main organisational difference in therapeutic milieu approach between the two units is of interest as it may have an impact on the therapists. One unit has a traditional shift rotation for the staff whilst the other has emphasised the need for

enhanced therapeutic alliance with the users and has supported this by using a long term rotational shift system and higher face-to-face time with the users.

It is argued that units organised in this way have higher rate of success due to their extensive relational involvement with the child or adolescent (47). It can be suggested that even though this approach can be highly effective it may have increased impact on stress levels and compassion fatigue for the milieu therapist. It may further be suggested that if the relationship between the child and the therapist develops into a counterproductive conflict, the therapeutic alliance may even deteriorate because neither child nor therapist can have time apart in such long intensive settings (47).

## **5. CONCLUSION**

Prior research suggests that exposure to violence at work impacts on professional quality of life in a significant way. This study shows that violent exposure alone is not necessarily associated with professional quality of life among milieu therapists in CAMH care settings. Neither does this study show clear indications that therapists exposed to violence in CAMH care are more prone to be traumatized than groups in other mental health care settings. Future studies may endeavour to more thoroughly focus on factors impacting the therapeutic milieu in CAMH care units.

The study may assist decisions about organisation of therapeutic milieu and management of individual therapists to improve the identification of relational difficulties in the therapeutic environment. It may contribute to improvements in obtaining acknowledgment for the complicated task of managing workplace violence, raising awareness of the topic and need to work together to find solutions for more positive therapeutic relations with children and adolescents. Such awareness may also contribute to a better understanding of the interaction between milieu therapists and their young patients.

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## **Appendix**

Appendix A: Questionnaires – ProQoL and PCL-C

Appendix B: Letter of information and consent

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## **“Vold og stress blant miljøterapeuter i barne- og ungdomsinstitusjoner”**

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**Vold og trusler er ikke uvanlig i det miljøterapeutiske arbeid i institusjoner. Statistikk viser at opp til 50% av miljøarbeidere i en barnevernsinstitusjon opplever vold, eller trusler om vold, en eller flere ganger i måneden (SSB, LKU 2006).**

**En av våre fremste redskaper i arbeidet med barn og ungdom er oss selv; miljøterapeuten. Vår relasjon og allianse med barnet kan bli påvirket av nivået av vold og trusler om vold. Kunnskap og bevisstgjøring av denne problematikken er viktig arbeid for å håndtere dette på best mulig måte.**

**Vi vil gjere spørre deg om å delta på en undersøkelse som vil prøve å søke mer kunnskap om yrkeslivskvalitet og stress på en arbeidsplass med mye trusler og vold.**

**I epostinvitasjonen finner du et mer utfyllende informasjonskriv.**

**Takk for ditt bidrag!**

Vennlig hilsen

Christian Lauvrud,



Din identitet vil holdes skjult.

Les om retningslinjer for personvern. (Åpnes i nytt vindu)

### **Bakgrunnsdata for kategorisering**

**1) \* Kjønn**

Kvinne  Mann

**2) \* Alder**

- <-25 år  
 25-34 år  
 35- 44 år  
 45-54 år  
 55-64 år  
 65 -> år

**3) \* Hvor lang tid har du arbeidet ved en heldøgns institusjon**

0-3 år  4-6 år  7-9 år  10-12 år  over 12 år

**4) \* Stillingsandel:**

50% eller mindre  mer enn 50%

**5) \* Har du blitt utsatt for følgende i løpet av ditt arbeidet ved institusjonen:**

Ja Nei

Vitne til at andre blir truet eller utsatt for fysisk vold? (slag, spark o.l)

Selv blitt utsatt for fysisk vold?

Selv opplevd trusler om alvorlig fysisk vold?



### Første del av spørreundersøkelsen omfatter yrkeslivskvalitet

Å arbeide i en hjelperprofesjon setter deg i direkte kontakt med andres liv.

Du har sannsynligvis opplevd at din medfølelse for dem du arbeider med har både positive og negative sider.

Nedenfor er en del spørsmål om dine opplevelser, både positive og negative, i forbindelse med ditt arbeid.

Vurder hvert av følgende spørsmålene om deg og din nåværende situasjon.

Velg det alternativet på hvert spørsmål som best mulig beskriver hvor ofte du har opplevd disse tingene i løpet av de **siste 30 dagene**

	Aldri	Skjelden	Noen ganger	Ofte	Veldig ofte
1. Jeg er glad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Jeg er mentalt opptatt av flere enn en av de jeg hjelper	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Jeg kjenner tilfredsstillelse ved å hjelpe de jeg møter i mitt arbeid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Jeg føler samhørighet med andre	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Jeg skvetter veldig av uventede og høye lyder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Jeg kjenner meg styrket etter å ha hjulpet de jeg møter i mitt arbeid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Jeg finner det vanskelig med å skille privatliv fra yrkesliv som hjelper	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Jeg jobber ikke så effektiv fordi jeg mister søvn pga de traumatiske opplevelser mennesker jeg hjelper har hatt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Jeg tror at jeg kan ha blitt påvirket av det traumatiske stresset klientene mine har opplevd	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Jeg føler meg som fanget i en felle av mitt arbeid som hjelper	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



	Aldri	Sjelden	Noen ganger	Ofte	Veldig ofte
11. På grunn av jobben min har jeg kommet "på kant" med andre om ulike saker	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Jeg liker arbeidet mitt som hjelper	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Jeg føler meg deprimert på grunn av klientens traumatiske	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## opplevelser

- |  |                       |                       |                       |                       |                       |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 14. Jeg føler det som om jeg opplever traumene til noen jeg hjelper                      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 15. Jeg har verdier/livssyn som gir meg styrke   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 16. Jeg er fornøyd med hvordan jeg er i stand til å holde tritt med faglig oppdateringer | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 17. Jeg er den personen jeg alltid ønsket å være   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 18. Arbeidet mitt gjør meg tilfreds  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 19. Jeg føler meg sliten på grunn av mitt arbeid som hjelper                             | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 20. Jeg tenker og føler godt om de jeg hjelper, og om hvordan jeg kan hjelpe dem         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |



- |  | Aldri                 | Sjelden               | Noen ganger           | Ofte                  | Veldig ofte           |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 21. Jeg føler meg overveldet fordi arbeidsmengden virker endeløs   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 22. Jeg tror jeg kan utgjøre en forskjell gjennom mitt arbeid  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 23. Jeg unngår visse aktiviteter eller situasjoner fordi de minner meg om skremmende situasjoner mennesker jeg hjelper har opplevd | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 24. Jeg er stolt av det jeg kan gjøre for å hjelpe   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 25. Pga mitt arbeid som hjelper får jeg påtrengende/skremmende tanker  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 26. Jeg føler meg fastlåst pga systemet på jobben  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 27. Jeg tenker at jeg er en fremgangsrik miljøterapeut   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 28. Det er viktige deler av arbeidet mitt med traumatiserte klienter som jeg ikke kan huske  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 29. Jeg er en meget omtenkstom person  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 30. Jeg er glad for at jeg valgte denne jobben   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |



Siste del av spørreundersøkelsen omfatter **indikatorer på posttraumatisk stress.**

Dette er reaksjoner som alle mennesker kan få på grunn av vedvarende stress og/eller krise i sitt liv.

Nedenfor er en liste problemer og vansker som vi noen ganger får som reaksjoner på ubehagelige, overveldende eller skremmende opplevelser. Påstandene er i fra et standardisert skjema som er mye brukt for å finne indikasjoner på stress etter hendelser (PTSD Check List - Civilian version).

Les hver enkelt nøye, og sett et kryss i boksen for å markere hvor mye du har vært plaget av det enkelte symptom **den siste måneden**

	Ikke i det hele tatt	Litt	Moderat	Mye	Svært mye
Gjentatte, ubehagelige minner, tanker eller bilder av en oppskakende eller skremmende opplevelse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gjentatte, forstyrrende drømmer (mareritt) om en ubehagelig eller skremmende hendelse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Plutselig opplevelse eller følelse av at en ubehagelig/skremmende hendelse skjer igjen? (som om den gjenoppleves)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Å bli svært oppbrakt når noe minner deg om en ubehagelig/skremmende opplevelse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Får fysiske reaksjoner (som hjertebank, pustevansker, svette) når noe minner deg om en ubehagelig/ skremmende hendelse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unngår å tenke eller snakke om en ubehagelig/ skremmende hendelse eller unngår å føle noe rundt den?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unngår aktiviteter eller situasjoner fordi de minner deg om en ubehagelig/ skremmende hendelse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vansker med å huske viktige deler av en ubehagelig/skremmende hendelse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tap av interesse for aktiviteter som du brukte/ bruker å sette pris på?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Følelse av å være fjern eller avsondret fra andre mennesker?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



	Ikke i det hele tatt	Litt	Moderat	Mye	Svært mye
Følelse av emosjonelt nummenhet eller ikke å være i stand til ha varme følelser overfor andre mennesker?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Følelse av som om framtiden er avkortet?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vansker med å sovne eller hyppige eller tidlige oppvåkninger?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irritabilitet eller sinne ut over det vanlige?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vansker med konsentrasjon?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Være mer "på vakt" eller i beredskap?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Være mer skvetten eller nervøs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Forespørsel om deltakelse i forskningsprosjektet:

---

## “Vold og stress blant miljøterapeuter i barne- og ungdomsinstitusjoner”

---

**Vold og trusler er ikke uvanlig i det miljøterapeutiske arbeid i institusjoner. Statistikk viser at opp til 50% av miljøarbeidere i en barnevernsinstitusjon opplever vold, eller trusler om vold, en eller flere ganger i måneden (SSB, LKU 2006).**

**En av våre viktigste redskaper i arbeidet med barn og ungdom er oss selv; miljøterapeuten. Vår relasjon og allianse med barnet kan bli påvirket av nivået av vold og trusler, men samtidig er det lite fokus og kunnskap om fenomenet.**

**Vi vil gjerne spørre deg om å delta på en undersøkelse som vil prøve å søke mer kunnskap om yrkeslivskvalitet og stress på arbeidsplasser med mye trusler og vold. Undersøkelsen har ca. 50 spørsmål og det tar ca. 10 minutter å fylle ut svaralternativene. Nedenfor finner du et mer utfyllende informasjonskriv.**

**Studien er godkjent av De regionale komiteer for medisinsk og helsefaglig forskningsetikk (REK), RBUP og DMF,INM**

**Jeg samtykker og ønsker å delta på undersøkelsen:**

[LINK]

Hvis du **ikke** ønsker å delta på undersøkelsen kan du trykke på lenken helt nederst i denne eposten.

---

## Informasjonsbrev:

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### Bakgrunn og hensikt

Dette er et spørsmål til deg om å delta i en forskningsstudie for å undersøke yrkeslivskvalitet og indikasjoner på stress ved arbeidsplasser hvor det forekommer mye vold og trusler. Mer kunnskap om dette vil kanskje gi oss bedre muligheter til å forstå og styrke det miljøterapeutiske arbeid ved slike arbeidsplasser.

### Hva innebærer studien?

Denne e-post vil invitere deg til å delta på undersøkelsen og henvise deg til et elektronisk datainnsamlingsverktøy (Questback). Her skal du svare på noen påstander som er framsatt om stressbelastning knyttet til vold og trusler ved din arbeidsplass. Videre vil det spørres om påstander knyttet til din yrkeslivskvalitet. Svaralternativene delt inn i skalaer fra 1-5. Det er ca. 50 spørsmål og besvarelsen vil ta ca.10 minutter. Du kan velge å avstå fra deltakelse ved å trykke på lenke i slutten av denne eposten.

### Mulige fordeler og ulemper

Fordelene ved deltakelse i studien forventes å være økt kunnskap og forståelse blant ansatte om vold og truslers påvirkning av det miljøterapeutiske arbeidet. Et økt fokus på tematikken ved arbeidsplassen kan også styrke mestringen av slik belastning. Studien forventes ikke å skape ubehag for deltakerne. Skulle likevel din besvarelse vekke ubehag for deg kan du ta kontakt med nærmeste leder som vil bistå videre. Slike ubehag kan være minner om ubehagelige hendelser og kroppslig aktivering. Ved behov ut over din arbeidsplass lokale beredskap og oppfølging, kan psykologspesialist tilknyttet studien bistå videre.

### Hva skjer med besvarelsen og informasjonen om deg?

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Din besvarelse vil være fullstendig anonym. Prosjektgjennomfører vil ikke få tilgang til å knytte den enkeltes e-



postadresse til besvarelsen. Når prosjektet tar slutt vil den nettbaserte spørreundersøkelsen bli slettet og all data knyttet til studien kan ikke gjenopprettes fra QuestBack. Det er kun autorisertpersonell knyttet til prosjektet som har adgang til opplysningene. Ingen av prosjektdeltakerne kan finne tilbake til deg. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

### **Frivillig deltakelse og samtykke**

Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Dette vil ikke få konsekvenser for din videre behandling. Dersom du ønsker å delta, trykker du på invitasjonslenken i e-postinvitasjonen og gir da samtidig ditt samtykke til undersøkelsen. Om du nå sier ja til å delta, kan du senere trekke tilbake ditt samtykke uten at det påvirker din øvrige behandling. Du kan lukke eller avslutte din nettleser uten at svaralternativene blir lagret. Spørreskjemaet vil ikke bli registrert som et svar/respons før alle spørsmål er besvart og en bekreftelsesknapp er trykket inn ved spørreskjemaets slutt. Ved avbrutt besvarelse kan du returnere til undersøkelsen ved å følge invitasjonslenken i e-posten, men da må besvarelsen starte på nytt fra første side. Du har også mulighet på dette tidspunkt å melde seg av undersøkelsen i sin helhet ved å benytte deg av avmeldingslenken i e-postinvitasjonen.

Dersom du har besvart skjemaet og bekreftet innsending er det mer omfattende å trekke sin besvarelse. For å sikre din anonymitet oven forunderteignede som skal analysere dataene, må du kontakte QuestBack direkte og innen rimelig tid. Adressen er: Sommerrogata 13-15, 0255 Oslo, tel +4722027070, fax +4722027071, post@questback.com. Du må henvise til undertegnede som er ansvarlig (kontroller) for undersøkelsen opprettet hos QuestBack (proffessor) og be om at din respons blir slettet. Supportpersonell ved QuestBack vil da slette din respons slik at undertegnede ikke kan hente ut disse dataene for analyse. Alle responser lagret på Questback sine servere blir behandlet høyst konfidensielt. Det er kun autorisert QuestBack-personale som har tilgang til serverne og QuestBack følger til enhver tid gjeldende regler pålagt av Datatilsynet.

Vær likevel oppmerksom på at din respons etter en tid kan ha blitt hentet ut og bearbeidet i det analytiske arbeid. Det vil på dette tidspunkt ikke være mulighet til å trekke sin respons fra studien.

Vennlig hilsen

Christian Lauvrud,

