Empowering public authorities and professionals towards trauma-informed leaving care support

REPORT CARE PATH TRAINING NEED ASSESSMENT QUESTIONNAIRE

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Prepared by

Name:	Alberto Zucconi
Authoring Partner:	Istituto dell'Approccio sulla Persona (IACP)
Position:	Director

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Approved on behalf of CarePath

Name:	Panigiotis Sofios
Partner:	ERGO
Position:	Manager and Expert
Date:	10/01/2019

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TRAINING NEEDS ASSESSMENT QUESTIONNAIRE REPORT

Detailed report on all the steps on the design and execution of the Care Path Project Training Needs Assessment Questionnaire

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1. Introduction

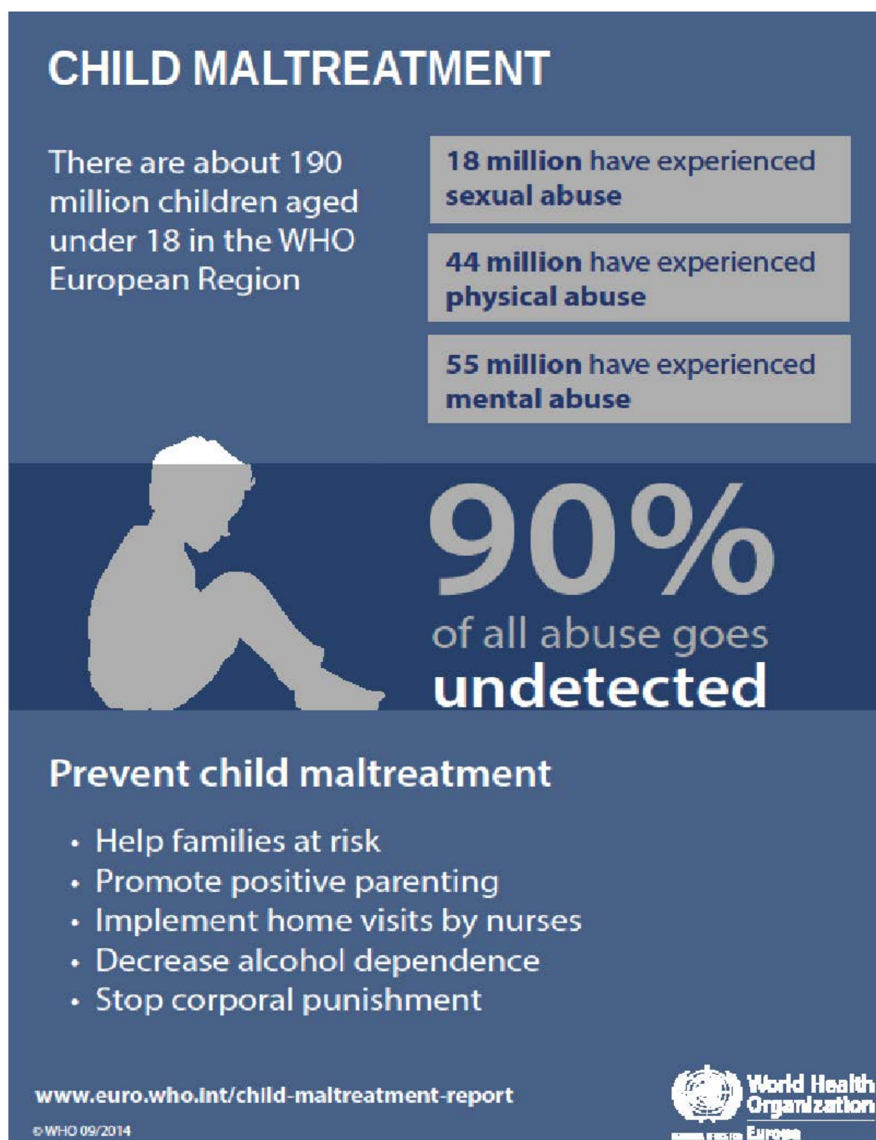
1.1 Training needs Analysis

A Training Needs Analysis (TNA) is a process by which an organization's Human Resources Development needs are identified and articulated. The training needs analysis is needed to ensure that the organization's goals and its effectiveness in reaching these goals are achieved by assuring that the personnel has the knowledge, skills, behaviors and attitudes needed to fulfil their   ethical imperative of always practicing in science and conscience and to actualize the mission of the organization by the identification of:

- Discrepancies or gaps between helping professionals' skills and the skills required for effective professional performance and the prevention of iatrogenic damages;
- Discrepancies or gaps between a helping professional' knowledge, skills, behaviours and attitudes needed to perform the job successfully in the future;
- To identify barriers to quality improvement and to excellence;

The Training needs analysis identifies the unfulfilled needs that prevent a helping professional and an organization to operate effectively and fulfil the ethical imperative of always operating in science and conscience and to deliver services that best protect and promote the rights of the service users, prevent iatrogenic damages and optimize cost/benefits returns.
The Training needs analysis not only helps to identify training needs, but also helps to evaluate the effectiveness of previous training programmes; TNA facilitates benchmarking, increase morale, decrease stress levels in helping professional and personnel, facilitates working alliances and team work and, quality of services and the promotion of best practices.
While several different approaches can be used to identify the training needs of an organisation, we decide to use McGhee's and Thayer's Three-Level Analysis (McGjeer & Thayer, 1961).

The model provides a systematic means of conducting a TNA at three levels: organizational, operational (or task), and individual (or person). The levels of analysis are a hierarchy which descends from the organizational level to the personal level. At the same time as you descend the hierarchy, you also move to a more micro focus in the organization. In the field of offering services to traumatized minors effectiveness is of maximum importance since in this kind of service users population as the World Health Organization reports, in the European region there are 190 millions of minors victims of trauma (WHO, 2014), if you consider that at present the risks of re-traumatization are very high and the retraumatized clients not only suffer additional damages but the related loss of human capital negatively affects not only the retraumatized minors with serious consequences for their health and well-being, increases the need and the costs of additional treatments and the consequent loss of productivity affects also their families, their community and their country. This situation clearly underlines the dear need of programs like the Care Path Project.



1.2 Health, Social and Economic Burden of Trauma

Trauma is among the leading public health issues in economic as well as social impact:

- Adverse childhood experiences (such as abuse, neglect, loss, exposure to violence, etc.) incur risk for lifelong emotional, behavioral, and medical problems, with each additional type of adverse experience exponentially increasing risk (Anda *et al.,* 2006)
- Traumatic experiences at any age (including crime victimization, rape, motor vehicle accident, etc.) potentially cause a range of enduring symptoms such as post-traumatic stress, anxiety, depression, anger, aggression, substance abuse (Friedman *et al.,* 2007).
- Domestic abuse (domestic violence & child abuse) costs the country an estimated $500 billion per year in medical expenses alone, not counting the economic impact of lost work, lost potential, family disruptions, and lowered quality of life (Goldstein, 2014).
- Trauma, broadly defined, causes or contributes to nearly every type of emotional or behavioral problem, including mental illness, suicide, school/work failure, substance abuse, aggression, and crime (*Friedman et al.,* 2007; van der Kolk, 2007).

1.3 Fact Sheet: Understanding, Preventing and Healing Trauma

1.3.1 What is Trauma?

The American Psychiatric Association's (APA) Diagnostic and Statistical Manual (DSM-IV-TR) defines a "traumatic event" as one in which a person experiences, witnesses, or is confronted with actual or threatened death or serious injury, or threat to the physical integrity of oneself or others (APA, 2000).
Trauma is a costly public health problem which happens as a result of physical, sexual or emotional abuse, neglect, violence, war, loss, disaster, and other emotionally harmful experiences (Substance Abuse and Mental Health Services Administration (SAMHSA), 2019). Like individuals, communities can be traumatized as well.
While many people who experience a traumatic event are able to move on with their lives without lasting negative effects, others may have more difficulty managing their responses to trauma. Trauma can have a devastating impact on physical, emotional, and mental well-being.
Trauma affects the developing brain and body and alters the body's stress response mechanisms. Emerging research documents the relationship among traumatic events, impaired brain function and immune system responses. Trauma induces

powerlessness, fear, hopelessness and a constant state of alert, as well as feelings of shame, guilt, rage, isolation and disconnection (SAMHSA, 2019).
Unresolved trauma can manifest in many ways, including anxiety disorders, panic attacks, intrusive memories (flashbacks), obsessive-compulsive behaviors, post-traumatic stress disorder, addictions, self-injury and a variety of physical symptoms. Trauma increases health-risk behaviors such as overeating, smoking, drinking and risky sex. Trauma survivors can become perpetrators themselves. Unaddressed trauma can significantly increase the risk of mental and substance use disorders, suicide, chronic physical ailments, as well as premature death (Vaccaro & Lavick, 2008).

1.4 A New Understanding of Trauma

Until recently, trauma survivors were largely unrecognized by the formal treatment system. The costs of trauma and its aftermath to victims and society were not well documented. Inadvertently, treatment systems may have frequently re-traumatized individuals and failed to understand the impact of traumatic experiences on general and mental health. Today, the causes of trauma—sexual abuse, violence in families and neighbourhoods, and the impact of war, for example—are matters of public concern. Trauma survivors have formed self-help groups to heal together. Researchers have learned how trauma changes the brain and alters behavior. A movement for trauma-informed care has emerged to ensure that trauma is recognized and treated and that survivors are not re-victimized when they seek care. Complementing these changes are programs to promote healthy development of children and healthy behaviors in families, schools and communities that reduce the likelihood of trauma.

1.4.1 Facts about trauma

The Adverse Childhood Experiences (ACE) Study, an observational study of the relationship between trauma in early childhood and morbidity, disability, and mortality in the United States, demonstrated that trauma and other adverse experiences in are associated with lifelong problems in behavioral health and general health (Felitti & Andra, 2010).
More than 6 in 10 U.S. youth have been exposed to violence within the past year, including witnessing violence, assault with a weapon, sexual victimization, child maltreatment, and dating violence. Nearly 1 in 10 was injured (Office of Juvenile Justice and Delinquency Prevention, 2009)
Predicted cost to the health care system from interpersonal violence and abuse ranges between $333 billion and $750 billion annually, or nearly 17% to 37.5% of total health care expenditures (Dolezl, McCollum, Callahan, 2009). A lifetime history of sexual abuse among women in childhood and adulthood ranges from 15 to 25 percent (SAMHSA, 2009). An estimated 5 percent of males under the age of 18 experienced sexual victimization in the past year. In 2008 a RAND study found 18.5 percent of returning

veterans reported symptoms consistent with PTSD or depression (RAND Corporation, 2008). Racially motivated violence and discrimination can be traumatic and have been linked to PTSD symptoms among people of color (Bryant-Davis & Ocampo, 2005). LGBT people experience violence and PTSD at higher rates than the general population (Roberts *et al.,* 2010).

For those who access the public mental health, substance abuse and social services, as well as people who are justice-involved or homeless, trauma is an almost universal theme (Jennings, 2004). Between 75 and 93 percent of youth in the juvenile justice system have experienced some degree of trauma (Adams, 2010). Other estimates are even more compelling: The National Child Traumatic Stress Network (NCTSN) was created by Congress in 2000 as part of the Children's Health Act to raise the standard of care and increase access to services for children and families who experience or witness traumatic events. This unique network of frontline providers, family members, researchers, and national partners is committed to changing the course of children's lives by improving their care and moving scientific gains quickly into practice across the U.S. The NCTSN is administered by the SAMHSA and coordinated by the UCLA-Duke University National Child Traumatic Stress Network (NCTSN, 2020).

The cumulative economic and social burden of complex trauma in childhood is extremely high. Based upon data from a variety of sources, a conservative annual cost of child abuse and neglect is an estimated $103.8 billion, or $284.3 million per day (in 2007 values). This number includes both direct costs—about $70.7 billion—which include the immediate needs of maltreated children (hospitalization, mental health care, child welfare systems, and law enforcement) and also indirect costs—about $33.1 billion—which are the secondary or long-term effects of child abuse and neglect (special education, juvenile delinquency, mental health and health care, adult criminal justice system, and lost productivity to society).

A recent study examining confirmed cases of child maltreatment in the United States found the estimated total lifetime costs associated with child maltreatment over a 12-month period to be $124 billion. In the 1,740 fatal cases of child maltreatment, the estimated cost per case was $1.3 million, including medical expenses and productivity loss. For the 579,000 non-fatal cases, the estimated average lifetime cost per victim of child maltreatment was $210,012, which includes costs relating to health care throughout the lifespan, productivity losses, child welfare, criminal justice, and special education. Costs for these nonfatal cases of child maltreatment are comparable to other high-cost health conditions (i.e., $159,846 for stroke victims and $181,000 to $253,000 for those with Type 2 diabetes). In addition to these costs are the "intangible losses" of pain, sorrow, and reduced quality of life to victims and their families. Such immeasurable losses may be the most significant cost of child maltreatment.

1.5 Data from Italy

A research carried on by Terres des Hommes, CISMAI and Bocconi University in 2010 found the following results regarding trauma:

1.5.1 Direct Costs

Hospitalization	49.665.000 €
Mental Health Care	21.048.510 €
Welfare	214.520.508 €
Law enforcement intervention	3.166.545 €
Juvenile Justice	50.215.731 €
Total Direct costs	338.616.294 €

1.5.2 Indirect Costs

Special Education	209.879.705€
Adult health care	326.166.471€
Adult Criminality	5.380.733.621€
Juvenile Delinquency	152.390.371€
Productivity loss for society	6.648.577.345€
Total Indirect Costs	12.717.747.513€

1.5.3 Total costs and relationship costs/gross domestic product

Total direct costs	338.616.294 €
Total indirect costs	12.717.747.513€
Total costs (direct + indirect)	13.056.363.807€
Total costs/Italian Gross domestic product (Year 2010)	0,84%

1.6 Key Points

The aftermath of trauma is costly to victims and to the whole community. Healing from trauma is possible. Validating the trauma and establishing trust and safety are the first steps. When dysfunctional behaviors are trauma-induced, treating symptoms without understanding their functional value does not fully address the problem. Addressing trauma is a key to successfully treating self-harming and risky behaviors. Coercive and disempowering practices in traditional behavioral health treatment of children and

adults can re-victimize trauma survivors. Trauma-informed care is an approach to engaging people with histories of trauma that acknowledges the role that trauma has played in their lives and treats symptoms as reflecting this experience (Substance Abuse and Mental Health Services Administration, 2019).
Trauma-informed services incorporates knowledge about trauma in all aspects of service delivery and facilitates recovery and empowerment (Harris & Fallot, 2001).
Mental health systems, correctional systems, and other local human service agencies are revamping practices to adopt trauma-informed care.
Ask “what happened to you?” not “what’s wrong with you?”
Data supports the need for broad-based programs and policies that help to reduce child maltreatment as well as enhance positive family functioning.
According to the Substance Abuse and Mental Health Services Administration, addressing individual, family and community trauma requires a comprehensive approach that includes:

- increasing awareness of the harmful effect of trauma in children and adults,
- developing effective preventative, treatment and recovery support services reflecting the needs of diverse populations,
- providing training and tools that help systems identify trauma and intervene early, and
- informing public policy that supports these efforts.

1.7 Who should address trauma reduction and treatment?

The following categories may be able to address trauma reduction and treatment.

1.7.1 Policymakers

Policy makers could:

1. Recognize the toll that unaddressed trauma takes on citizens and society.
2. Encourage the study and adoption of trauma-informed practices by state and local agencies.
3. Promote policies and programs that reduce child maltreatment and interpersonal violence.
4. Promote cost-effective prevention programs in schools and communities to promote healthy behaviors in order to reduce the incidence of trauma.

1.7.2 State Health and Mental Health Directors

State Health and Mental Health Directors may:

1. Educate direct service staff about the signs and behaviors associated with trauma.
2. Eliminate services that re-traumatize individuals (e.g. seclusion and restraint)
3. Screen patients for trauma history.
4. Promote public messages that trauma victims should not suffer silently, and healing is possible.
5. Educate state and local agencies on trauma-informed practices.
6. Support creation of trauma healing groups and peer-led survivor groups.
7. Promote cost-effective prevention programs in schools and communities to promote healthy behaviors in order to reduce the incidence of trauma.

1.7.3 Mental Health Administrators and Human Service Providers

Mental Health Administrators and Human Service Providers could:

1. Understand and recognize the signs and behaviors associated with trauma.
2. Screen for trauma history.
3. Introduce trauma-informed care to change practices and eliminate coercive and disempowering practices.
4. Eliminate re-traumatizing treatments such as seclusion and restraint
5. Establish trauma healing groups and promote peer-led survivor groups.
6. Establish shelters for battered women and other vulnerable groups.

1.7.4 Communities and Community-based Organizations

Communities and Community-based Organizations may:

1. Identify subgroups in your community who have experienced trauma, such as abused and neglected children, victims of violent crime and assault, refugees, veterans and minority groups.
2. Educate the community on reporting child abuse, domestic abuse and hate crimes.
3. Educate young women and other vulnerable groups on safety and self-defense.
4. Strengthen local policies and programs to protect and shelter trauma victims.
5. Recognize trauma experiences among first responders.
6. Learn about prevention programs in the community and schools to promote positive parenting and healthy behaviors in children and adolescents.

2. Preparatory Work

We did a literature search on training needs assessment (TNA).
We searched the literature for effective practices and best practices on trauma treatments, read several researches on outcome and process of trauma treatments.
We searched the literature and websites of the main governmental and scientific organizations dedicated to trauma organizations internationally. We consulted the data about core competencies of health workers to be effective in the treatment of trauma affected clients. We had some vis a vis consultation with trauma experts that are university professors trainers, researchers, directors of Governmental and non-governmental institutions offering services to trauma affected clients, interviewed field workers, examined same of the top training available of the topic, asked feedback of our training need questionnaire to expert and field workers, sent the draft of the Training Needs Questionnaire to all the partners of the Care Path Project and incorporated the useful feedback and suggestions for improvement training needs assessment before writing the final draft of the questionnaire.

2.1 The Questionnaire

The Training Needs Analysis Questionnaire was built with the aim of focusing on different nuances that may be behind each training need.
In fact, being the need analysis, preparatory to the planning of the intervention, it is necessary to produce a questionnaire aimed at understanding what the training needs were in terms of the classical variables of adult education: To know, to know-how to do and to know-how to be. The questionnaire is anonymous to make respondents feel free to express themselves; in any case the data was examined in an aggregate manner. In the questionnaire there are also some items requesting information about the respondents' number of years of field work's experience in order to evaluate the heterogeneity/homogeneity of the group also according to this perspective.

2.2 Socio-demographic variables

In terms of socio-personal data it was considered appropriate to ask for age, gender and professional role; the role, in particular, can help to understand how much the group of respondents is more or less heterogeneous.

2.3 Types of questions

The questionnaire consists of different types of questions that allow the respondents to move from a general perspective to a more specific and particular one. It was decided to include in the questionnaire some closed questions, multiple choice

questions and open questions. The closed questions (with a yes - no answer) make it possible to clarify the presence / absence of certain knowledge or experience and can be used to orient the design of the training program at a macroscopic level. The multiple-choice questions allow to have more details without going down, however, too specifically so as not to waste the information. The open questions are instead finalized to understand, specifically, needs that do not emerge in the closed and multiple-choice questions.

2.4 Mapped areas

Specific mapped areas have been chosen in order to cover the sphere of knowledge, competencies and attitudes.

2.4.1 Relational Area

The items are related to empathy, profound respect, congruence and active listening. The relational aspects have been mapped because as ample scientific research from the helping profession and from the research on trauma informed care (TIC) the work of the operators doing field work is based on their capacities to establish safe, respectful and effective relationship and solid working alliances.

2.4.2 Knowledge Area

In this section, space has been given to focusing on topics that the respondents consider important to do training (especially the sphere of knowledge). In addition to a series of proposed topics derived from a vast search of the literature and research in the helping professions and in particular in assisting victims of trauma, the respondents have the opportunity to indicate other needs in order to facilitate the full expression of their perceived training needs.

2.4.3 Methodologies

in addition to giving space to items specifically related to the sphere of competences, it was asked to indicate also the preferred methodologies in which respondents feel better ability to learn. In training needs, in fact, it is also important to map the methods deemed most effective by respondents.

3. Results

We obtained the following results after administrating the Care Path Training Needs Assessment Questionnaire.

3.1 General data

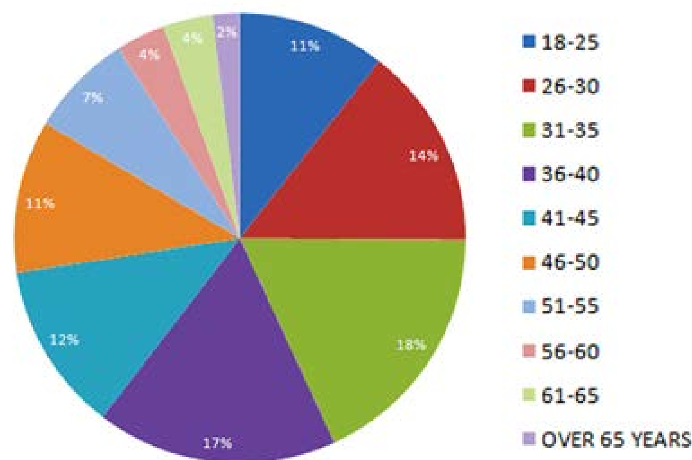
3.1.1 Sample

The sample consist of 255 participants aged between 18 and 65 years.

3.1.2 Age Range

In the sample the age groups are balanced. Respondents over 56 years are less represented, but this is coherent with the target (Figure 1).

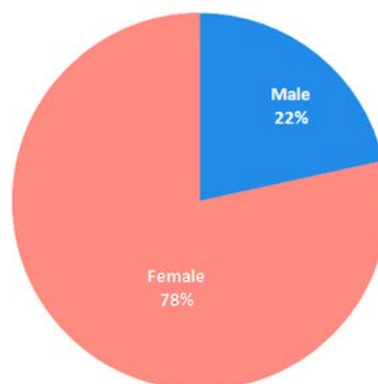
FIGURE 1. AGE RANGE



3.1.3 Gender distribution

There is a prevalence of females (78,4%); But this data representative of the target where women are the vast majority (Figure 2).

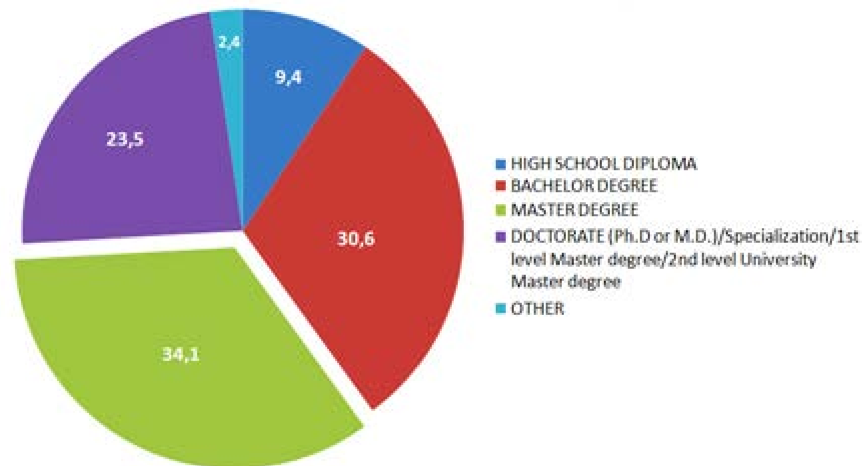
FIGURE 2. GENDER DISTRIBUTION



3.1.4 Education

Education levels of respondents are balanced with a prevalence of "bachelor's degree" (30,6%) and "master's degree" (34,1%) (Figure 3).

FIGURE 3. EDUCATION

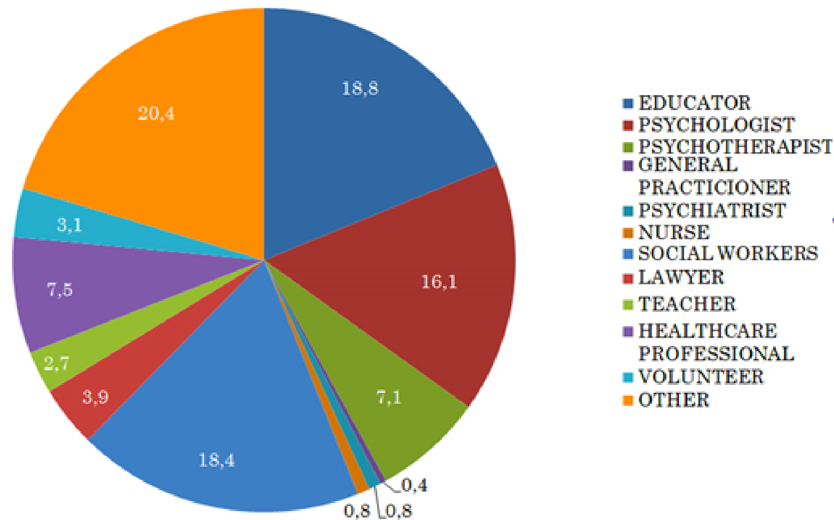


3.2 Reported skills and areas of knowledge

3.2.1 Profession

Most respondents are educators (18,8%) and social workers (18,4%), there are also a lot of responded who indicated "Other" (20,4%); it would be interesting examine in detail the meaning of "Other" (Figure 4).

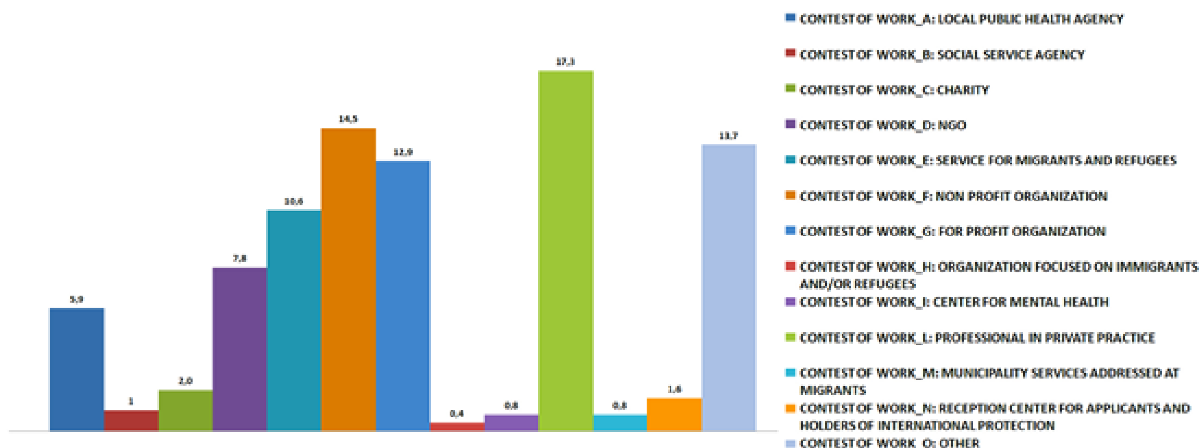
FIGURE 4. CURRENT PROFESSION OR JOB DESCRIPTION



3.2.2 Work Setting

There is no evidences about the respondents main work setting because there isn't a prevalence of a specific variable (Local Public Health Agency, Social Service Agency, Charity, NGO, Service For Migrants And Refugees; Non Profit or for Profit Organization; Organization Focused on Immigrants and/or Refugees, Center For Mental Health, Professional In Private Practice, Municipality Services Addressed to Migrants; Reception Center For Applicants and Holders Of International Protection). Respondents in prevalence wrote "No" regarding every variable (Figure 5).

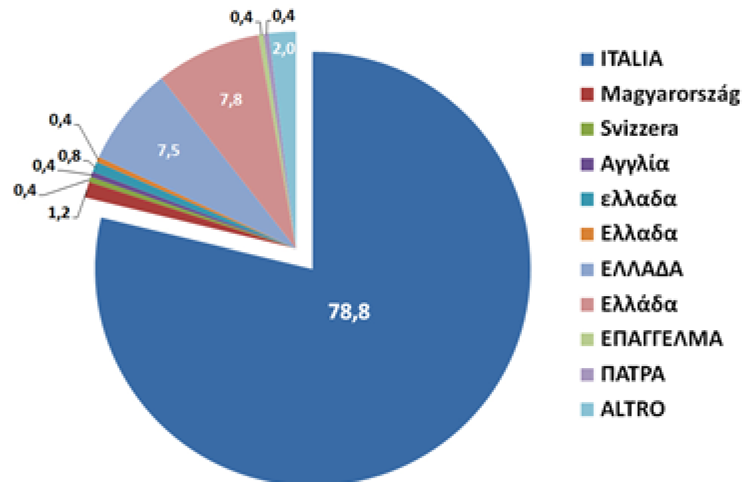
FIGURE 5. CONTEST OF WORK



3.2.3 Nationality

The sample of respondents is composed in prevalence by Italian respondents (78,8%) (Figure 6).

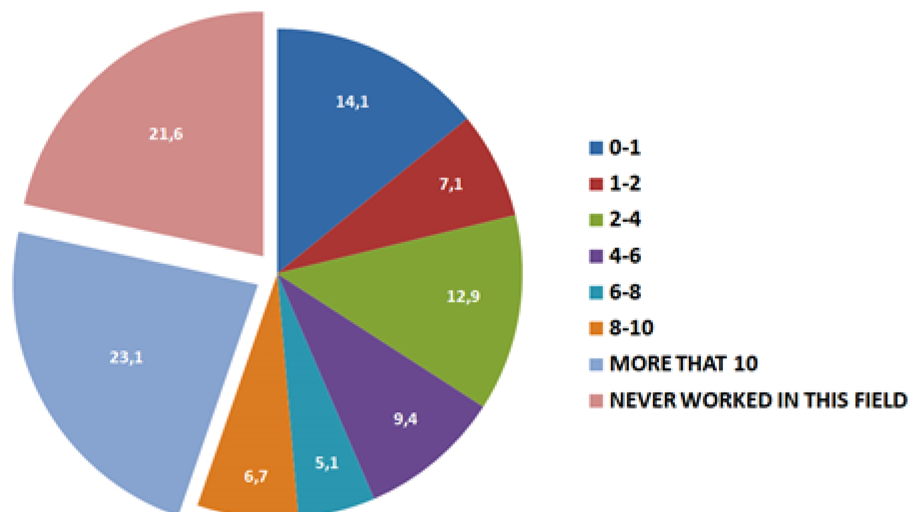
FIGURE 6. NATIONS OF WORK



3.2.4 Years of work with minors affected by trauma:

On the item concerning Years of work with minors affect by trauma many respondents (23,1%) worked for more than 10 years in the field of trauma but part of the respondents (21,6%) answered "never worked" in this field. This is an important data because there are among the respondents' different kind of experiences regarding the kind of work carried out and the kind of specific training received concerning minors affected by trauma (Figure 7).

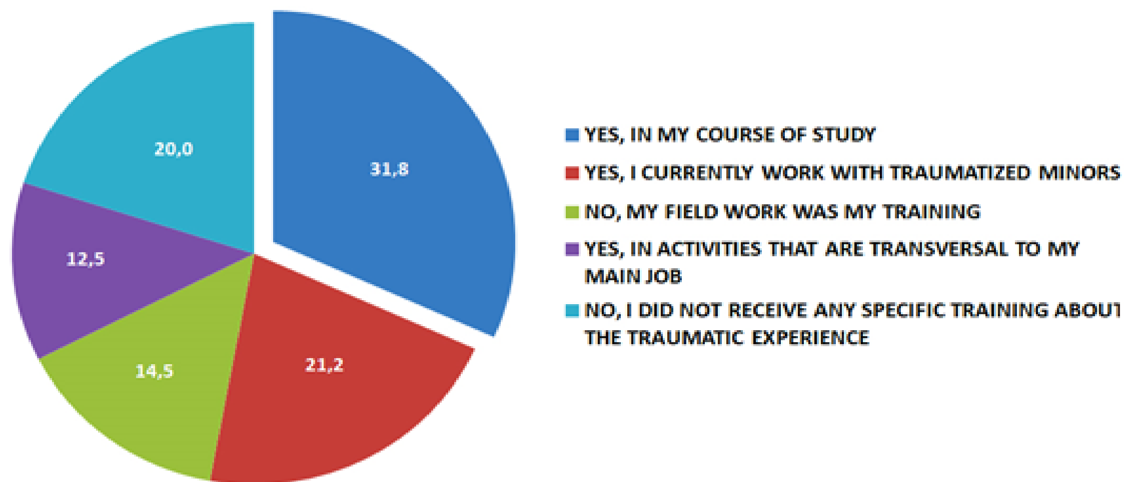
FIGURE 7. YEARS OF WORK WITH MINORS AFFECT BY TRAUMA



3.2.5 Training Experience

the respondents who received a training studied in prevalence “to recognize the signs on traumatic experiences” (58,8%). About “the potential impact of trauma on children and young respondents”, 47,1% studied this topic but 87,8% didn’t study it. Only 10,6% studied “specific interventions for the treatment of trauma”. Many respondents studied “trauma linked to the migratory experience” (31%) (Figure 8).

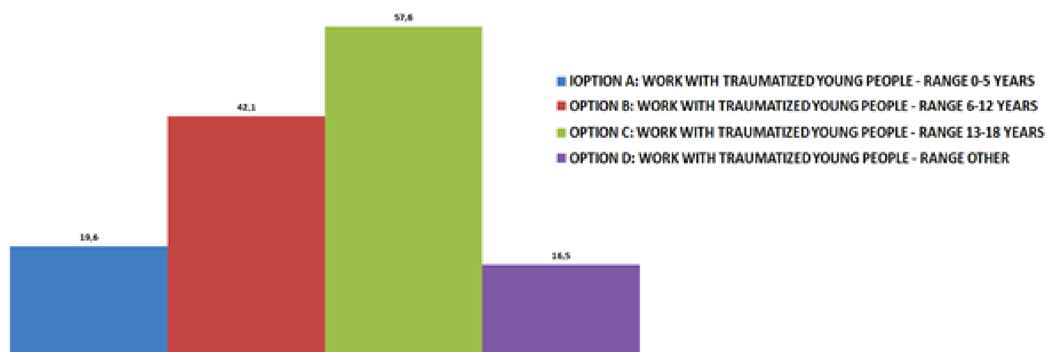
FIGURE 8. SPECIFIC TRAINING ABOUT TRAUMATIC EXPERIENCE



3.2.6 Working with traumatized young respondents

Respondents who worked and work with traumatized young respondents, have experience of working with clients that are 13-18 years old (57,6%) and with 6-12 years old (42%). Less respondents worked or work with clients 0-5 years old (19,6%). It is interesting that 16% of the sample answered “other”. Probably “others” means more than 18 years. (Figure 9)

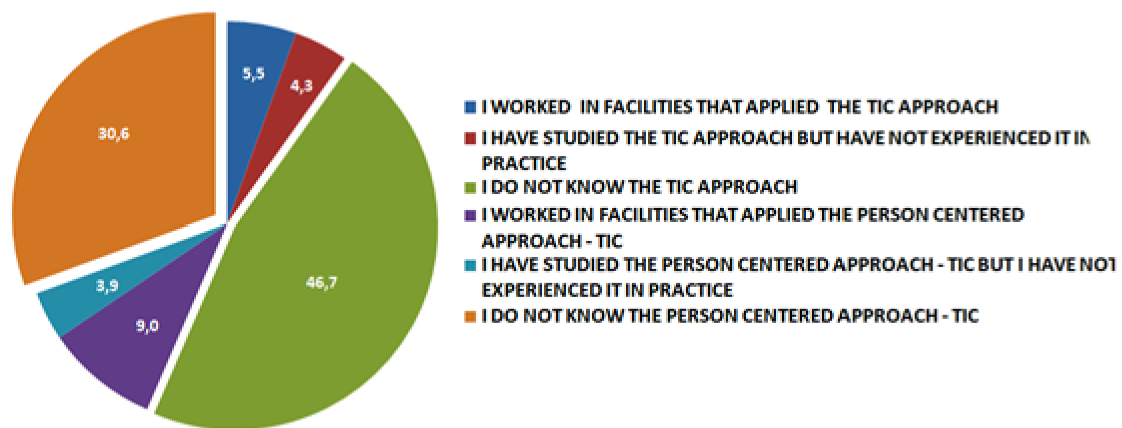
FIGURE 9. AGE RANGE OF TRAUMATIZED YOUNG PEOPLE



3.2.7 Trauma Informed Care (TIC) and Person Centered Approach (PCA)

It is important to notice that more respondents don't know Trauma Informed Care (TIC) (46,7%) and Person Centered Approach - PCA- (30,6%). This tendency is confirmed in the next items focused on good and bad practices regarding TIC and PCA; more of the respondents in fact, indicate that good and bad practices in TIC and PCA are unknown to them (Figure 10).

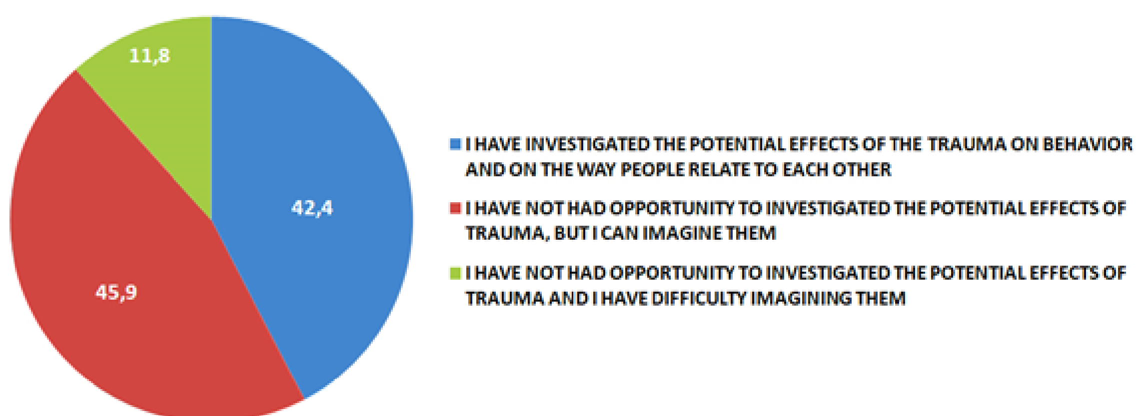
FIGURE 10. TIC AND PCA KNOWLEDGE



3.2.8 Study and Professional Experience about effects of traumatic experience

Many respondents (42,4%) investigated the potential effects of the trauma on behavior and on the way respondents relate to each other while 45,9% not had opportunity to investigate the potential effects of trauma, but they can imagine them. Other respondents (11,8%) had not investigated effects of trauma and have some difficulty to imagining them. So, many respondents don't know precisely about the effects of trauma (Figure 11).

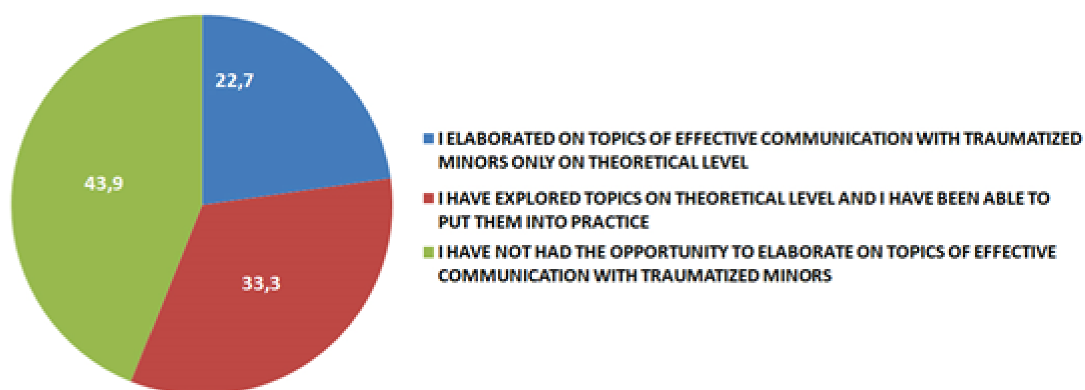
FIGURE 11. STUDY AND PROFESSIONAL EXPERIENCE ABOUT EFFECTS OF TRAUMATIC EXPERIENCE



3.2.9 Communication

Regarding effective communication with traumatized minors, more respondents (43,9%) have not had the opportunity to elaborate on topics of effective communication with traumatized minors. 22% of the sample elaborated on topics of effective communication with traumatized minors only on a theoretical level while 33,3% have explored topics on effective communication on theoretical level, while 43,9% didn't have the opportunity to elaborate on this topic (Figure 12)

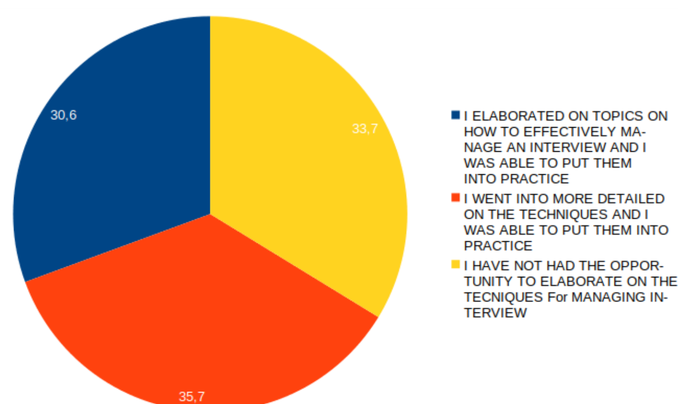
FIGURE 12. COMMUNICATION



3.2.10 Questions

Regarding useful questions most respondents elaborated on topics on how to effectively manage an interview and how they were able to put them into practice (30,6%) and 35% of respondents went into details regarding techniques for interview (Figure 13).

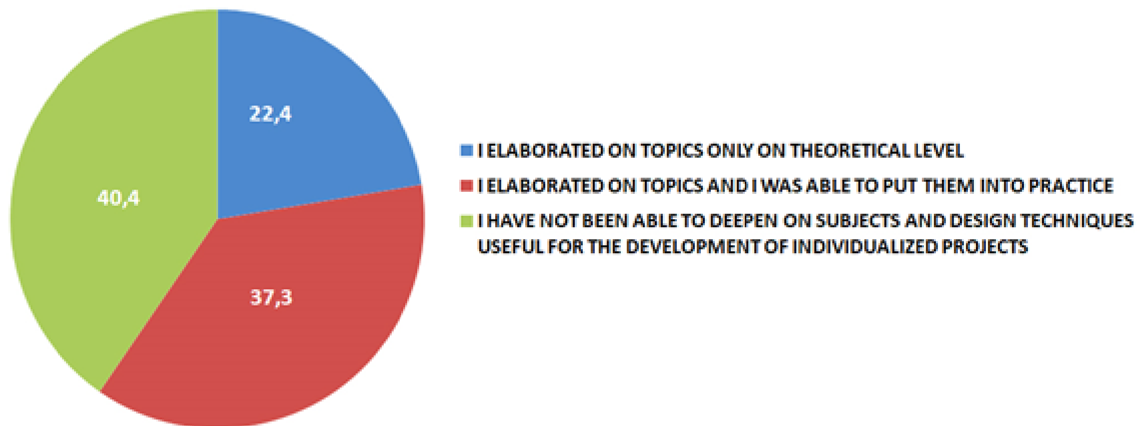
FIGURE 13. STUDY/PROFESSIONAL EXPERIENCE OF HOW TO ASK USEFUL QUESTIONS AND MANAGING INTERVIEWS



3.2.11 individualized and flexible projects

Some respondents have elaborated techniques useful for the development of individualized projects at theoretical level (22,4%) or applied level (37,3%) while more respondents (40,4%) declare to have no experience regarding it (Figure 14).

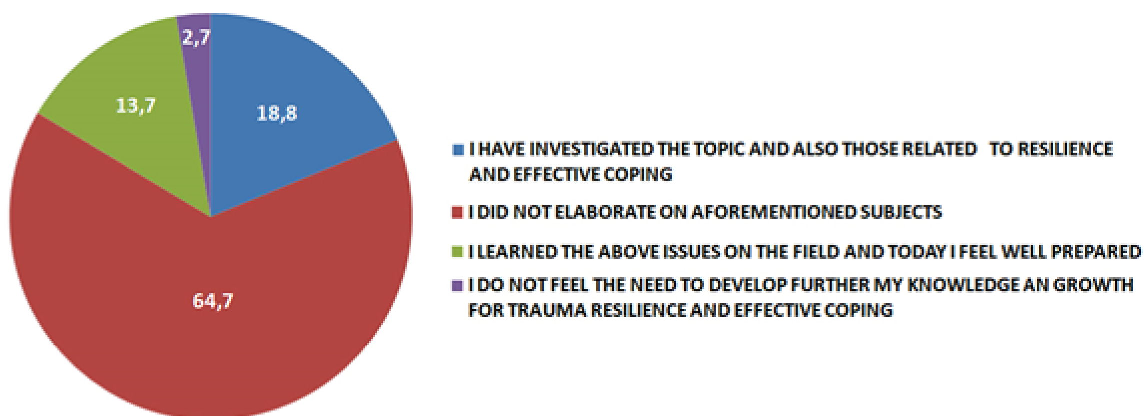
FIGURE 14. STUDY/PROFESSIONAL EXPERIENCE OF HOW TO CREATE INDIVIDUALIZED PROJECT



3.2.12 Growth and Trauma

It is important to notice that most of the respondents (64,7%) didn't investigated the topic Growth from trauma (Figure 15).

FIGURE 15. STUDY/PROFESSIONAL EXPERIENCE OF GROWTH AND TRAUMA



3.2.13 Relationship

Regarding the relationship variables is useful to notice that most of the respondents (72,5%, Figure 16) received feedback regarding their capacities for empathy capacity and deep respect (71,8%, Figure 17).

FIGURE 16. STUDY/PROFESSIONAL EXPERIENCE TO RECEIVE FEEDBACK ON ABILITY TO EMPATHIZE WITH OTHERS

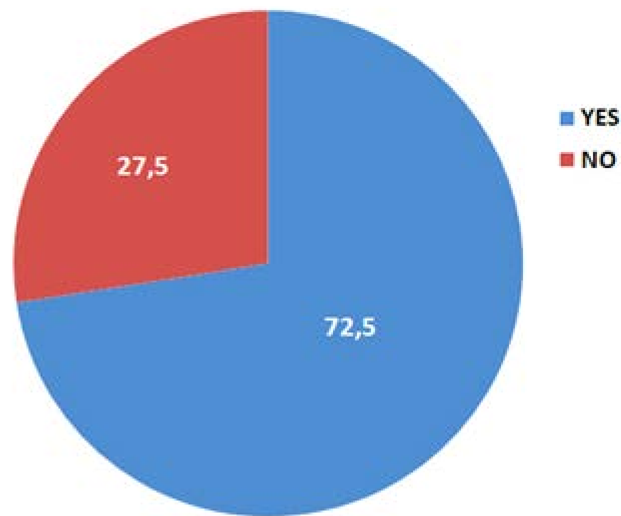
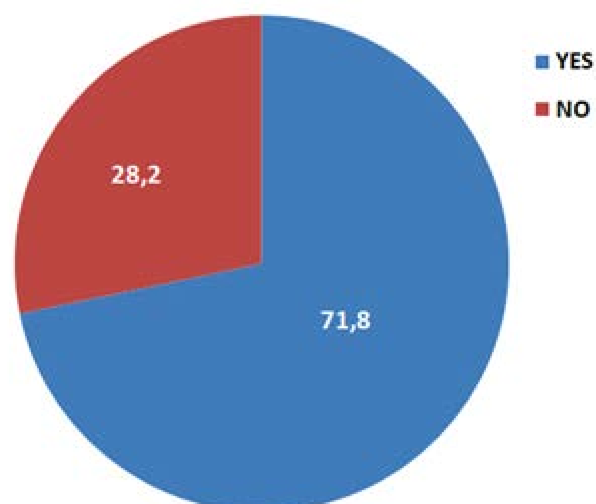


FIGURE 17. STUDY/PROFESSIONAL EXPERIENCE TO RECEIVE FEEDBACK ON ABILITY TO DEEPLY RESPECT OTHERS



3.2.14 Empathy and Deep respect

Most of the respondents (Figure 18) feel that they are sufficiently emphatic (52,2%) or very empathic (25,9%) and most respondents describe themselves as capable of deep respect (55,3% enough; 39,9% very much, Figure 19).

FIGURE 18. LEVEL OF EMPATHY

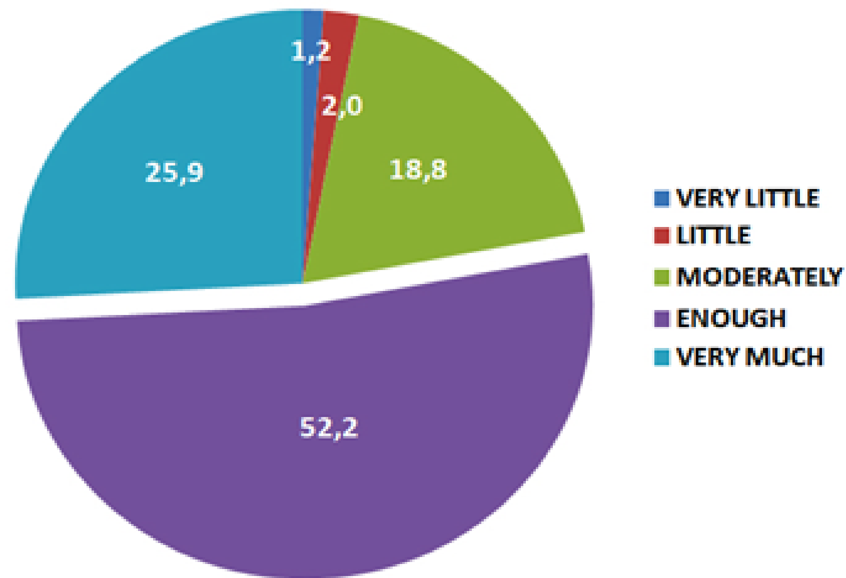
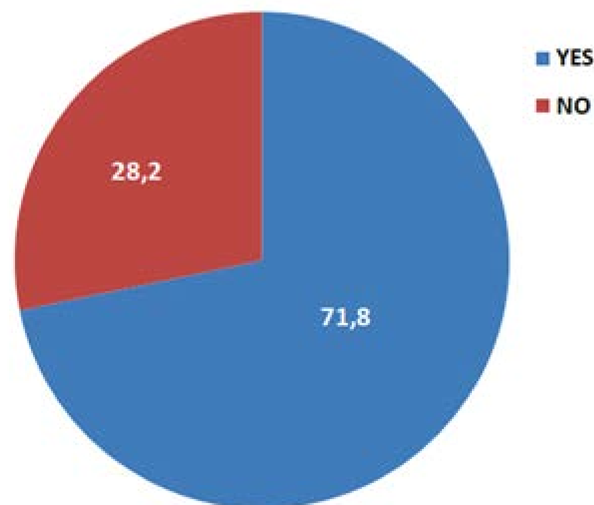


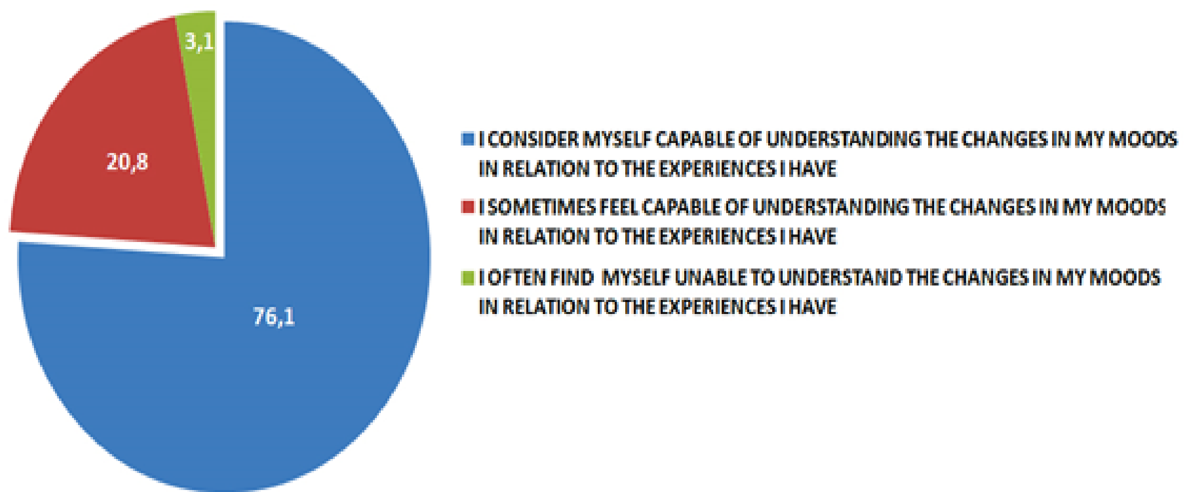
FIGURE 19. STUDY/PROFESSIONAL EXPERIENCE TO RECEIVE FEEDBACK ON ABILITY TO DEEPLY RESPECT OTHERS



3.2.15 congruence

In terms of congruence, most of respondents (76,1%) consider themselves capable of understanding the changes in their moods in relation to their experience (Figure 20).

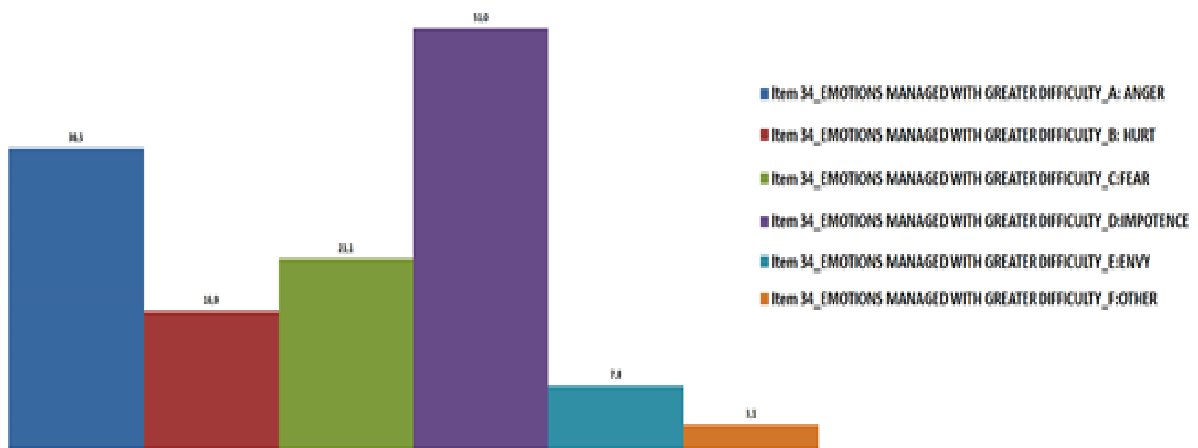
FIGURE 20. STUDY/PROFESSIONAL EXPERIENCE OF CONGRUENCE



3.2.16 Emotions managed with greater difficulty

Regarding emotions, anger is considered by the respondents an emotion difficult to manage (36,5%) but the most difficult emotion to manage is considered Impotence (51%, figure 21).

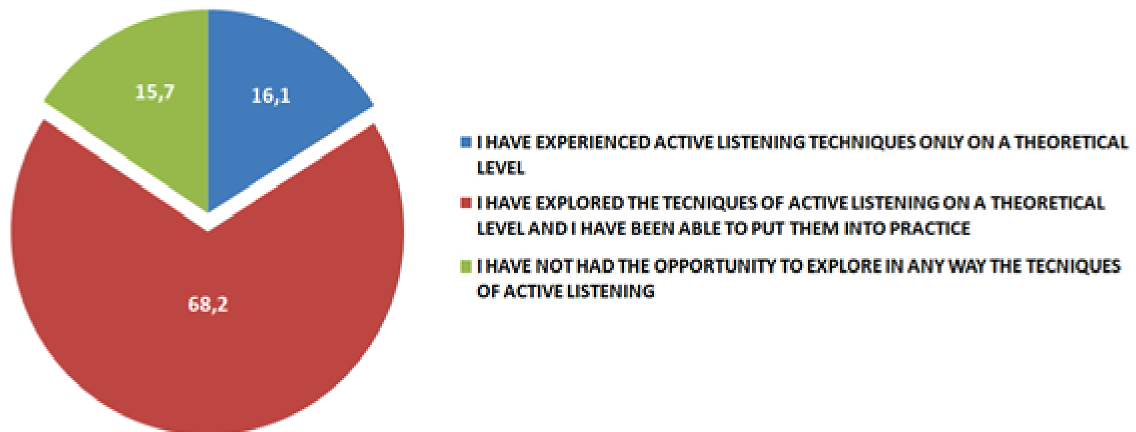
FIGURE 21. EMOTIONS MANAGED WITH GREATER DIFFICULTY



3.2.17 Active listening

Active listening is the competence that the (68,2%) respondent declare to have on a theoretical level (Figure 22).

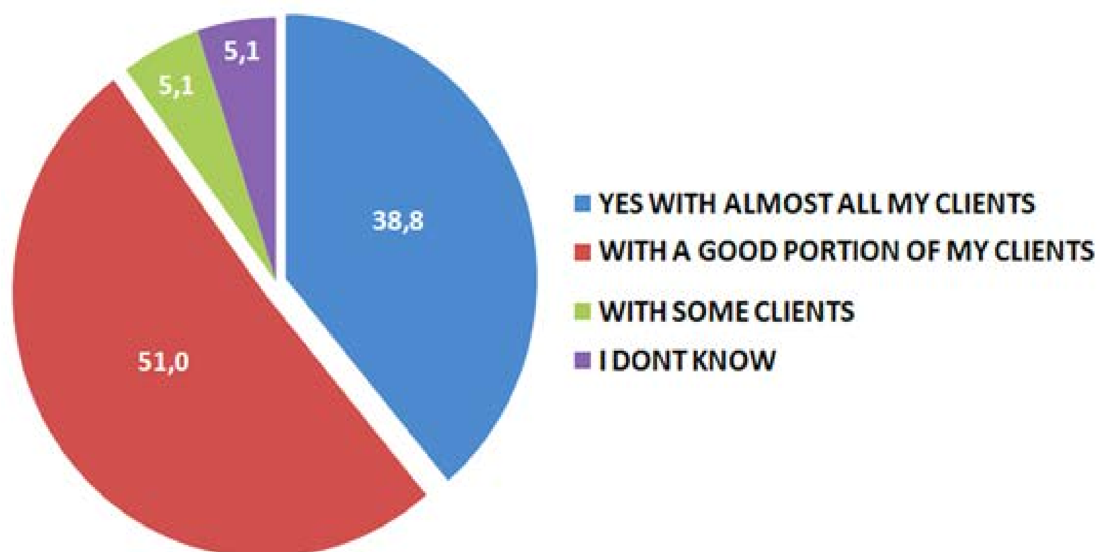
FIGURE 22. STUDY/PROFESSIONAL EXPERIENCE OF ACTIVE LISTENING



3.2.18 Relationship with clients

In terms of being able to establish a good relationship, most of the respondents (51% and 38,8%) declare to be able to establish good relationship with their clients (Figure 23).

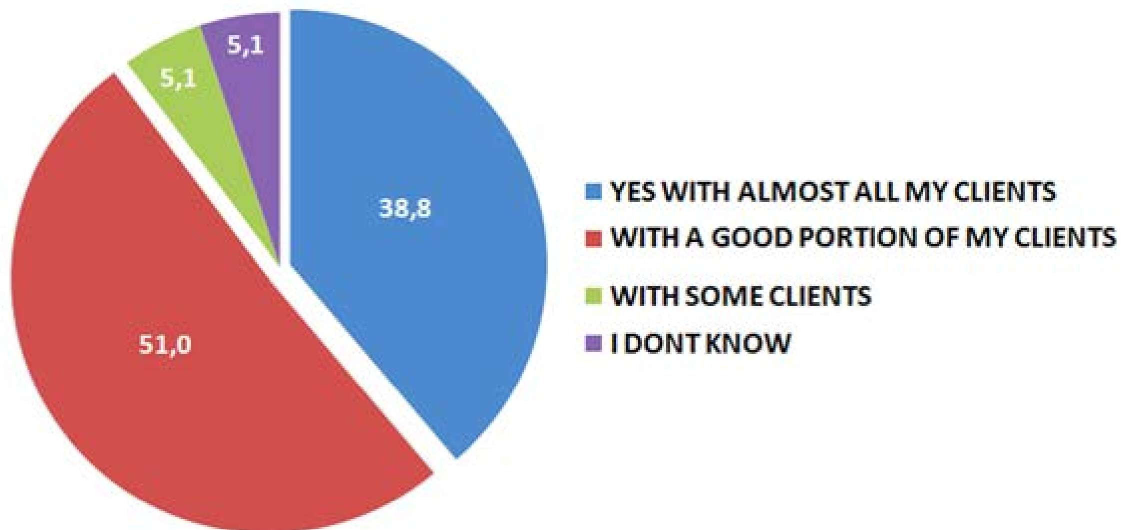
FIGURE 23. STUDY/PROFESSIONAL EXPERIENCE OF ACTIVE LISTENING



3.2.19 Relationship with colleagues

Regarding their relationship with colleagues, most of the respondents (27,1% and 51,4%) declare that they have a good relationship with colleagues (Figure 24).

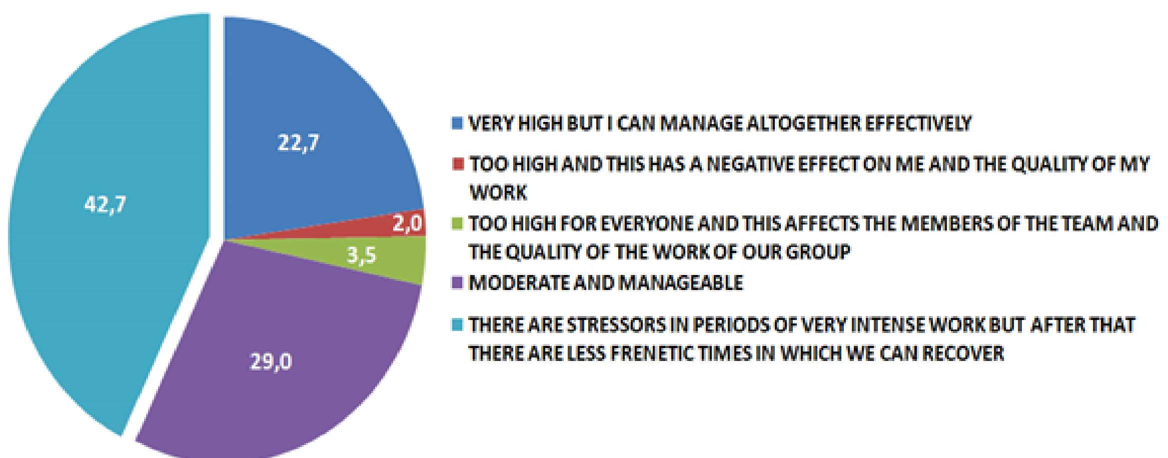
FIGURE 24. RELATIONSHIPS BETWEEN COLLEAGUES IN THE WORK TEAM



3.2.20 Work-related stress

Regarding work-related stress there are different perceptions: 42,7% indicate that for them, there are stressors in periods of very intense work but after that there are less frenetic times, while 29% of the respondents indicate moderate and manageable stress and 22,7% very high stress but that they can manage all together to work effectively. So, stress appears to be an important variable to consider in this sample of respondents (Figure 25).

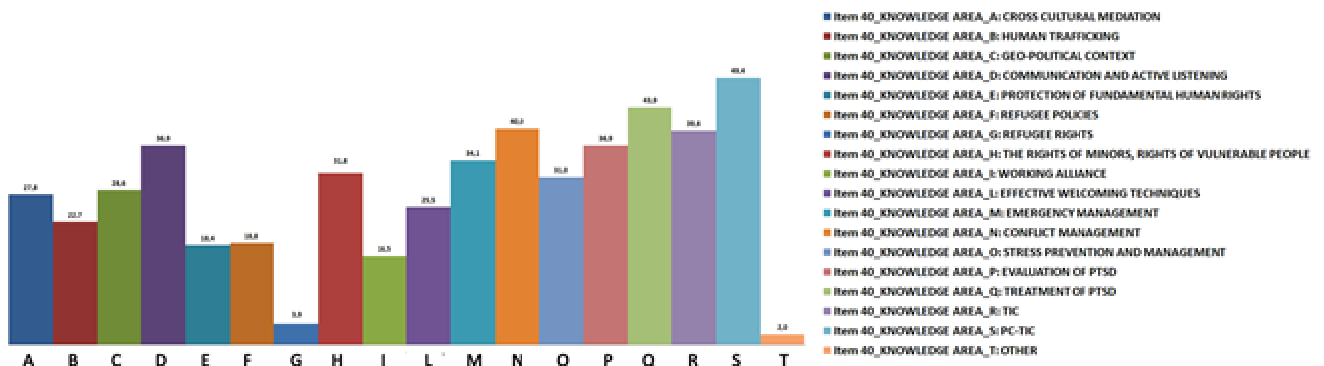
FIGURE 25. WORK-RELATED STRESS



3.2.21 Area of knowledge

Regarding knowledge, every topic is considered important by the sample of respondents except the knowledge about “refugee rights” indicated only by 3,9% of the respondents. It is interesting to notice that most of the respondents indicated as the most effective training method “analysis and discussion of cases” (76,9%), supervision (45,9%), Interactive session (45,9%). So, most of the respondents prefer an interactive method. This data is important, considering that respondents declare, in more fields, a prevalence of theoretical competence (Figure 26).

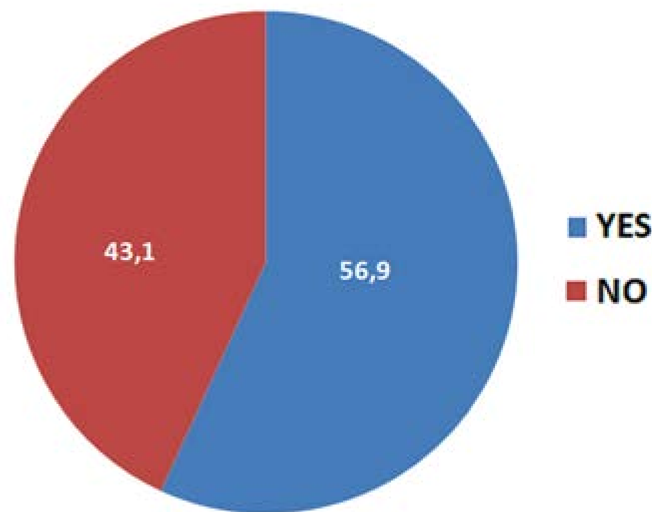
FIGURE 26. AREA OF KNOWLEDGE



3.2.22 Intercultural Communication

In this field, regarding their study/professional experience about young refugees, 48,6% of the respondents, indicated that they had not had the opportunity to further explore it but 32,2% of them have explored it at theoretical level and had also a professional experience.
Regarding topics related to traumatized people, many respondents (78,8%) indicated “psychological trauma of various kind”, 46,7% “living long periods of time without caregivers”, 41% Sexual abuse during the emigration trip, 40% “physical trauma linked to war or accidents” and 39,2% “sexual abuse during the war”. Finally, regarding intercultural communication, many respondents (56,9%) declare that they were able to gain knowledge about the beliefs and customs of different cultures and 43,1% declare that they have no idea on how to gain knowledge on beliefs and customs of different cultures. Regarding method, in 85,4% they prefer “analysis and discussion of cases” (Figure 27).

Figure 27. Intercultural Communication



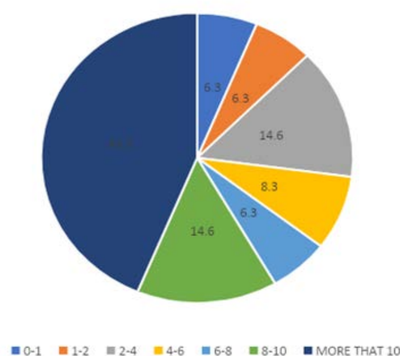
3.3 Professions

The sample is composed by participants who works in different fields, namely educators, teachers, health professionals, volunteers, and psychologists

3.3.1 Educators

48 participants are educators. In the sample, Educators, have mostly more than ten years of experience with traumatized minors (Figure 28).

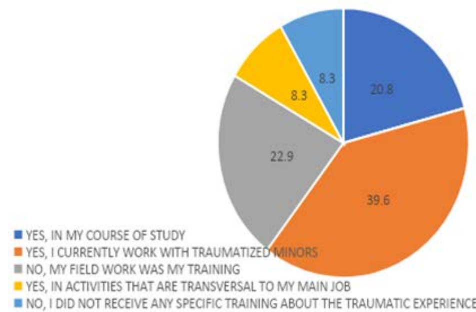
Figure 28. Years of work with minors affected by Trauma



3.3.1.1 Specific training and working experience

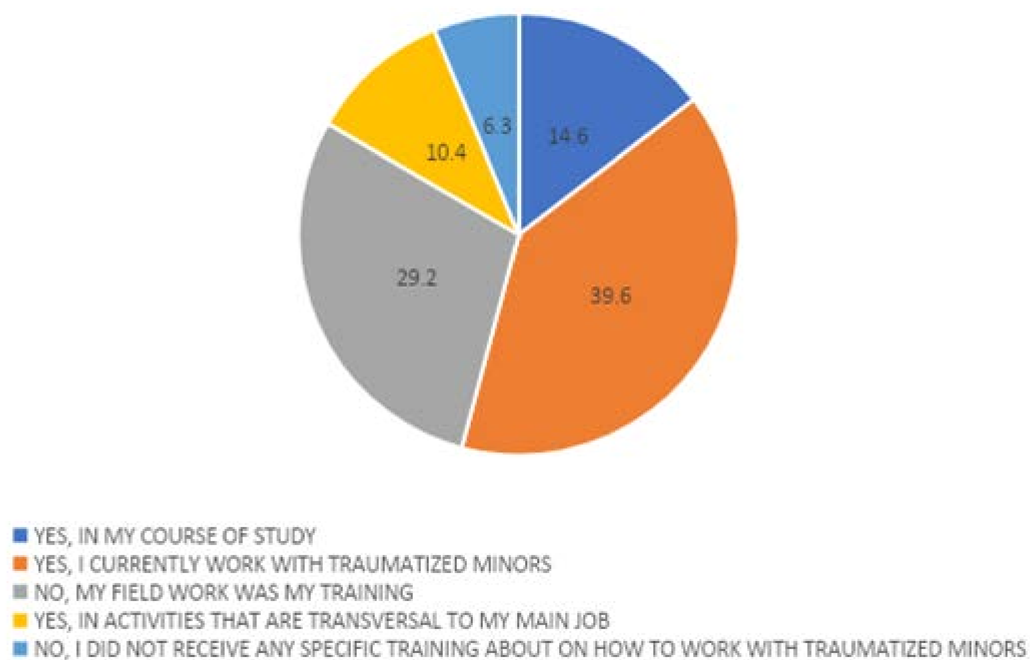
39.6% of educators in the sample are working with traumatized minors, 8.3% are involved with traumatized minors in activities that are transversal with their job, 20,8% received their training in their course of study while 22,9% got their training doing field work; 8.3% have not received any specific training on the topic (Figure 29).

FIGURE 29. SPECIFIC TRAINING ABOUT TRAUMATIC EXPERIENCE



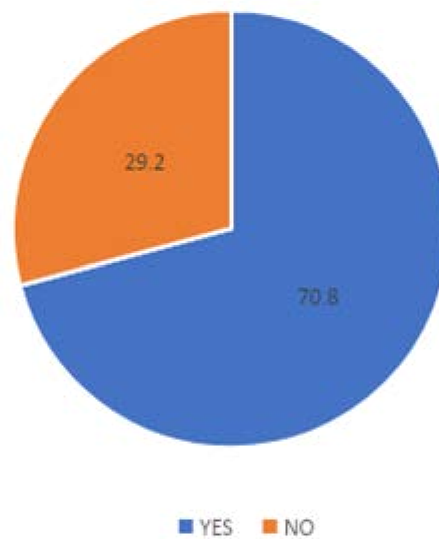
Examining the training received on how to work with traumatized minors only 8.3 % have received some theoretical training in their course of study while 29,2 %did get their learning on their field work (Figure 30).

FIGURE 30. TRAINING ON HOW TO WORK WITH TRAUMATIZED MINORS



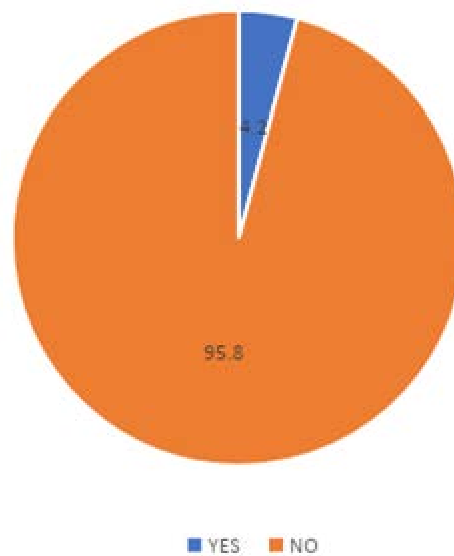
70,8% of respondents in the educators' sample, declares to be able to recognize the signs of traumatic experiences (Figure.31).

FIGURE 31. TRAINING ON HOW TO RECOGNIZE SIGNS OF TRAUMATIC EXPERIENCES



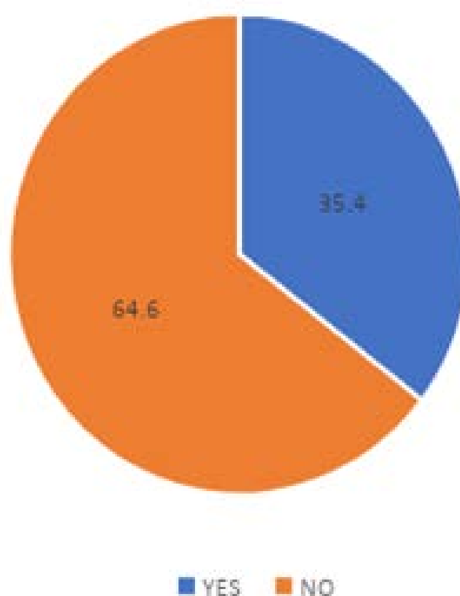
It should be noted that 95.8% of respondents do not know specific interventions related to the trauma; this is relevant because although there is knowledge about the topic of trauma, it is mainly thematic knowledge without a knowledge about the specific interventions (Figure 32).

FIGURE 32. TRAINING ON SPECIFIC INTERVENTIONS FOR THE TREATMENT OF TRAUMA



64% of educators in the sample declares not to have specific knowledge about the trauma related to migratory experience (Figure 33).

FIGURE 33. KNOWLEDGE ON TRAUMA LINKED TO THE MIGRATORY EXPERIENCE



3.3.1.2 Age of clients

Observing in the sample the experience of educators working with traumatized respondents divided by age group, it emerges that most of the educators work with the adolescent group (13-18) (Figure 34), followed by the 06 - 12 group (Figure 35), followed by the pre-school group; therefore it is on this last group of 0-5 years (Figure 36) that the respondents have less experience.

FIGURE 34. EXPERIENCE IN WORKING WITH TRAUMATIZED YOUNG PEOPLE: 13-18 YEARS OLD

FIGURE 35. EXPERIENCE IN WORKING WITH TRAUMATIZED YOUNG PEOPLE: 6-12 YEARS OLD

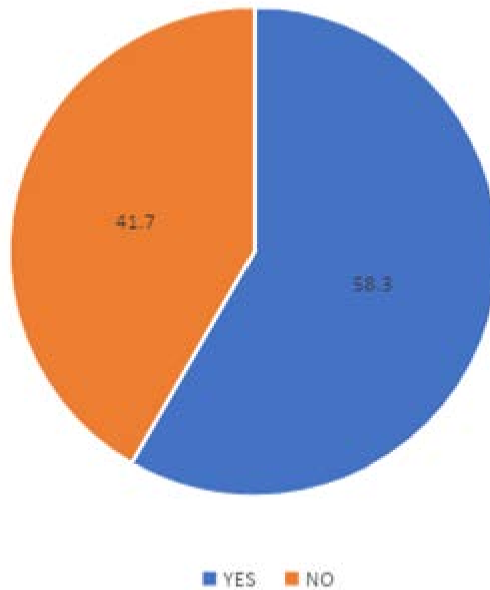
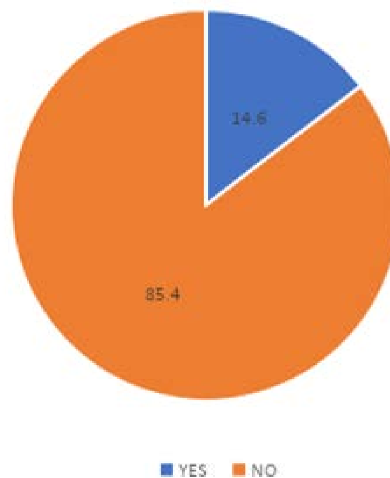


FIGURE 36. EXPERIENCE IN WORKING WITH TRAUMATIZED YOUNG PEOPLE: 0-5 YEARS OLD

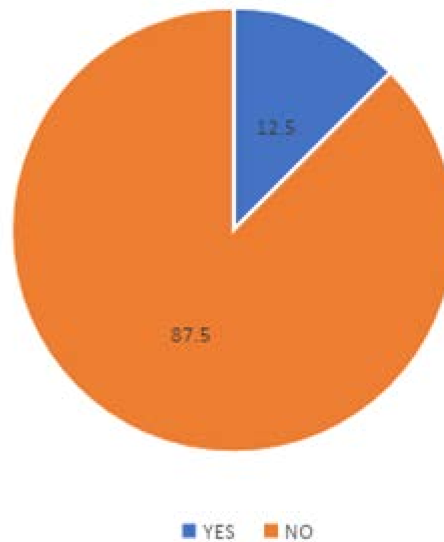


3.3.1.3 PCA and TIC knowledge

Examining the results of the questionnaire emerges that in the educators' sample almost half of the respondents (45.8%) do not know the Trauma Informed Care (TIC) approach, while 31.3% do not know the Person Centered Approach (PCA) either. However, there are 14.6% of respondents who know both the PCA and the ICT approach having worked in facilities that applied such approach (Figure 37).
The subsequent information is consistent with the previous one in that it shows that 87.5% of the educators among the respondents are not familiar with good work

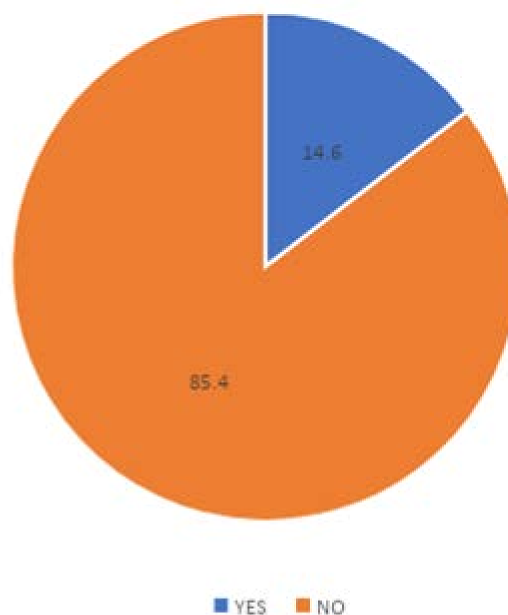
practices in Trauma informed Care since most of the educators are not familiar with this approach (Fig.37).

FIGURE 37. KNOWLEDGE OF TIC GOOD PRACTICES IN THE TREATMENT OF TRAUMATIZED MINORS



Similarly, as many as 85.4% of respondents do not have any knowledge of what the Trauma Informed Care Consider bad practices in the treatment of traumatized minors (Fig 38).

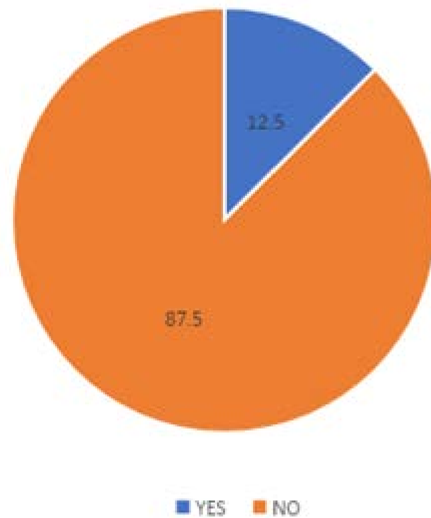
FIGURE 38. KNOWLEDGE OF TIC BAD PRACTICES IN THE TREATMENT OF TRAUMATIZED MINORS



Turning now to the knowledge of the Person-Centered Approach - Trauma Informed Care, there are many (87.5%) among the educators' respondents who are not familiar

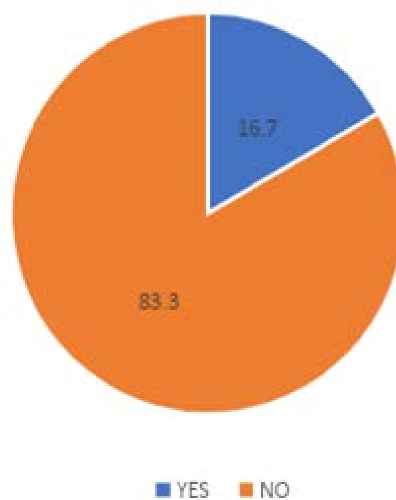
with good practices in the treatment of traumatized minors with person-Centered Approach - Trauma Informed Care (Fig 39).

FIGURE 39. KNOWLEDGE OF PCA - TIC GOOD PRACTICES IN THE TREATMENT OF TRAUMATIZED MINORS



It is not surprising in the fact that 83,3% of the educators responding to this item does not know what the bad practices from the point of view of PCA-TIC in the treatment of traumatized minors are (Figure 40).

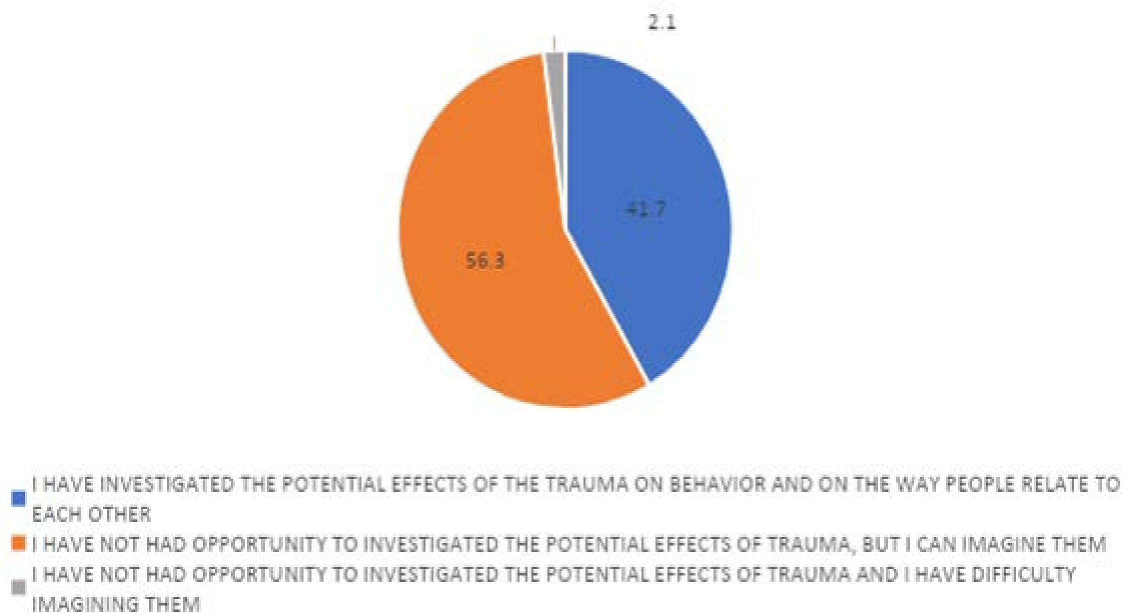
FIGURE 40. KNOWLEDGE OF PCA - TIC BAD PRACTICES IN THE TREATMENT OF TRAUMATIZED MINORS



3.3.1.4 Study and professional experience

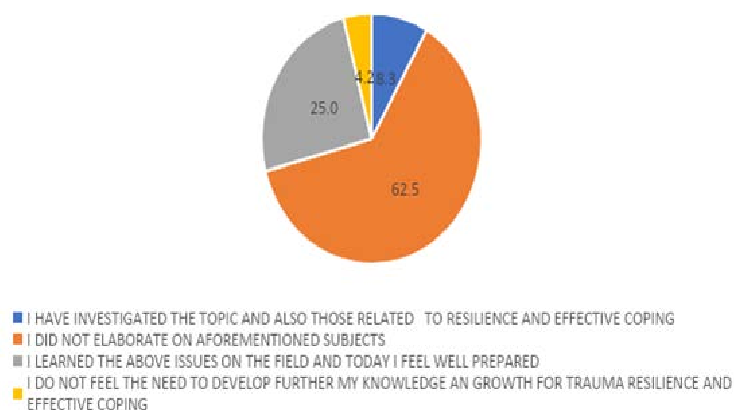
Looking at the course of study-professional experience of the educators sample, related to the consequences of the traumatic experience, it emerges that 56.3% of respondents did not have the opportunity to study the possible effects of trauma and are only able to imagine them while 41,7% stated that they have such study/professional experience (Figure 41).

FIGURE 41. STUDY AND PROFESSIONAL EXPERIENCE ON THE EFFECT OF TRAUMATIC EXPERIENCES



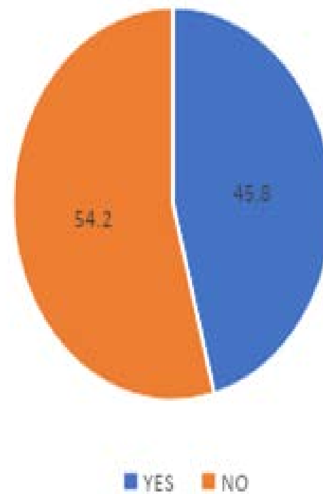
One of the significant aspects of trauma studies is the growth after trauma; but 62% of respondents in the educators' sample, declare that they do not have knowledge or skills in this area, opposed of the 25% that affirm to have both the knowledge and the skills (Fig 42).

FIGURE 42. STUDY AND PROFESSIONAL EXPERIENCE OF GROWTH FROM TRAUMA



Turning now to the potential impact of trauma on young respondents, it emerges that about half of the respondents' in the educators' sample (45,8%) have knowledge about it while 54,2 % does not (Figure 43).

FIGURE 43. STUDY AND PROFESSIONAL EXPERIENCE ABOUT THE POTENTIAL IMPACT OF TRAUMA ON CHILDREN AND YOUNG PEOPLE



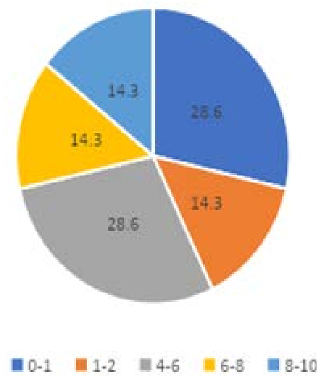
3.3.1.5 Conclusion

Comparing these answers to the questionnaire with the results of many years of research on helping professions effectiveness, or more specifically the research and the guidelines about Trauma Informed Care (TIC), This data seems to point out to the need to offer courses to Educators similar to the Care Path Mooc.

3.3.2 Teachers

Looking now at the respondents that are teachers, it emerges that most of them have more than 4 years' experience working with minors affected by trauma, although 28.6% have only one year's experience. There are 14.3% teachers with 6-8 and another 14,3% with 8 -10 years of experience in working with traumatized children (Figure 44).

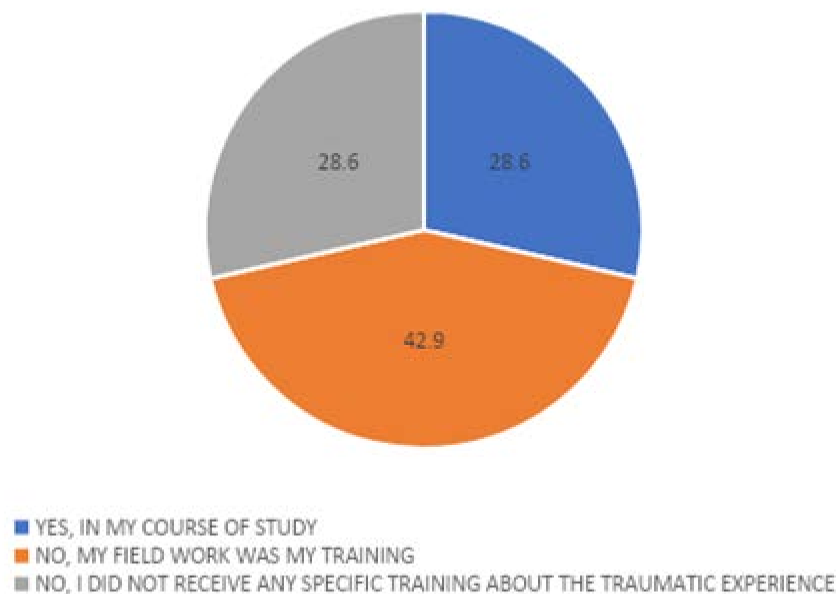
FIGURE 44. YEARS OF WORK WITH MINORS AFFECTED BY TRAUMA



3.3.2.1 Specific training and working experience

Examining the training of the respondents in the teachers' sample, it is shown that 42.9% have learned in the field while 28,6% have received theoretical training and the other 28,6% declares not have specific training on traumatic experiences (Figure 45).

FIGURE 45. SPECIFIC TRAINING ABOUT TRAUMATIC EXPERIENCE

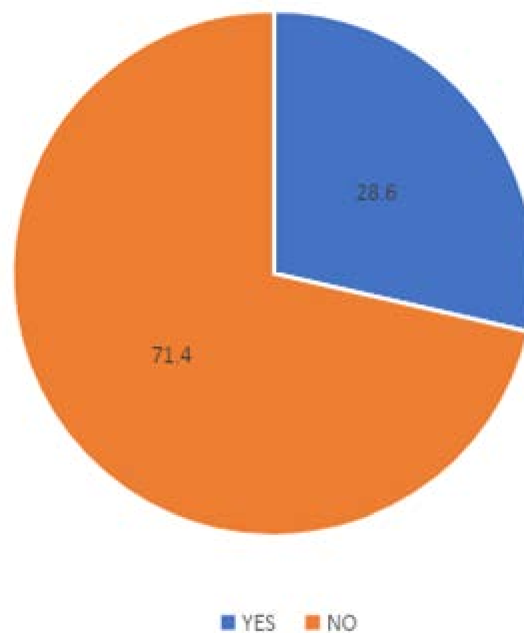


The same trend is observed in the teachers that responded with regard to their learnings on how to work with traumatized minors, 42, 9 % declares that they have learned working in the field, while another 28,6% received theoretical training in their course of study and the remaining 28,6 % does not have any form of training (Figure 46).

FIGURE 46. TRAINING ON HOW TO WORK WITH TRAUMATIZED MINORS

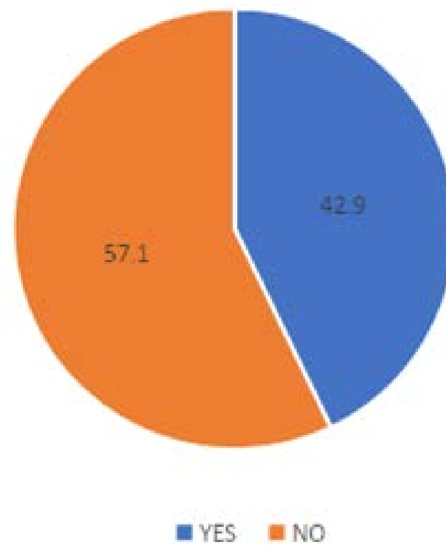
Examining the area related to the ability to recognize the signs of trauma, it emerges that 71.4% of the respondents that are teachers have no specific knowledge (Figure 47).

FIGURE 47. TRAINING ON HOW TO RECOGNIZE SIGNS OF TRAUMATIC EXPERIENCES



Examining the correlation between trauma and migration experience, it emerges that 57.1% of respondents that are teachers, do not have specific knowledge (Figure 48).

FIGURE 48. KNOWLEDGE ON TRAUMA LINKED TO THE MIGRATORY EXPERIENCE



3.3.2.2 Age of clients

Looking at the age of the traumatized children that the respondent of the sample that are teachers, it emerges that none of them worked with the preschool age group (0-5) while 28.6% worked with the 6-12 age group (Figure 49). The remaining 71.4% of respondents have working experience in the 13-18 age group (Figure 50).

FIGURE 49. EXPERIENCE IN WORKING WITH TRAUMATIZED YOUNG PEOPLE: 6-12 YEARS OLD

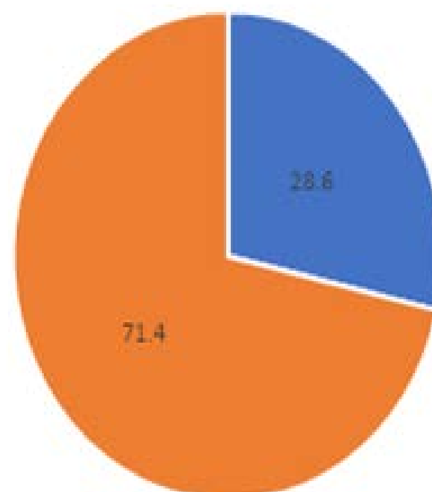
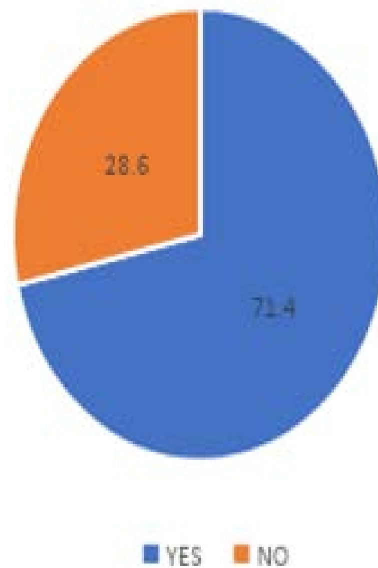


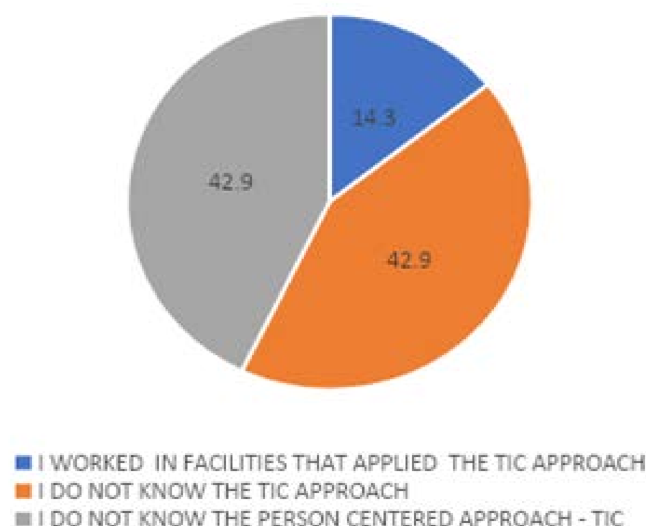
FIGURE 50. EXPERIENCE IN WORKING WITH TRAUMATIZED YOUNG PEOPLE: 13-18 YEARS OLD



3.3.2.3 PCA and TIC knowledge

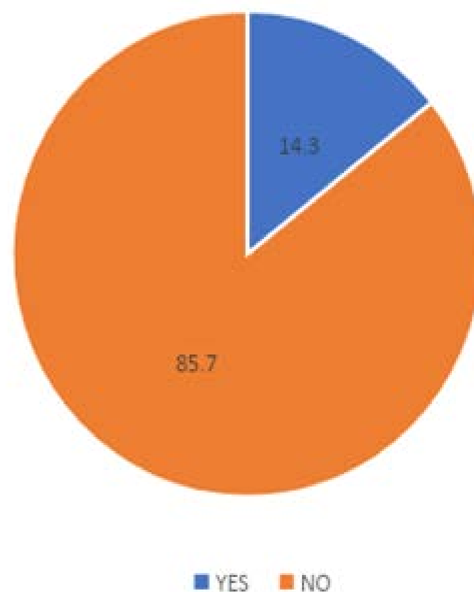
About 42.9% of respondents that are teachers do not know the TIC or the PCA or the PCA/TIC. In fact, only 14.3% of respondents have knowledge in this area thanks to their work experience (Figure 51).

FIGURE 51. STUDY AND PROFESSIONAL EXPERIENCE OF PCA OR TIC



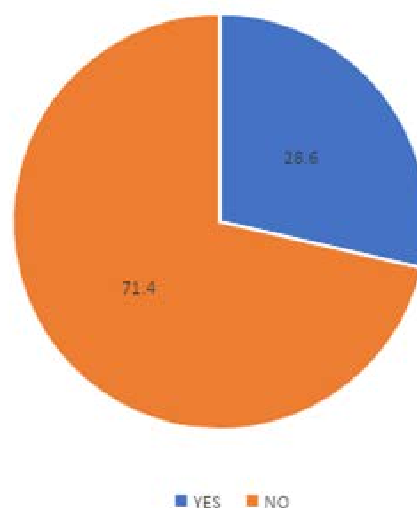
Similarly, regarding the knowledge of good practices on the applications of Trauma Informed Care to minors, it emerges that only 14.3% are aware of it while 85.7% are not aware of what are the good practices in Trauma Informed Care (Figure 52).

FIGURE 52. KNOWLEDGE OF TIC GOOD PRACTICES IN THE TREATMENT OF TRAUMATIZED MINORS



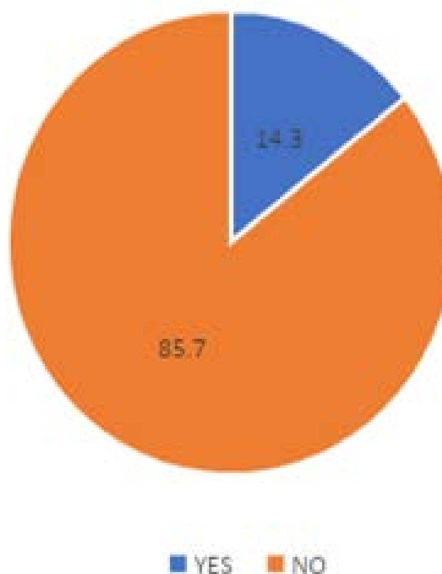
For the respondents, just as good practices are not known, there is also a percentage of 71.4% of the same respondents who do not have awareness or knowledge about the malpractices (Figure 53).

FIGURE 53. KNOWLEDGE OF TIC BAD PRACTICES IN THE TREATMENT OF TRAUMATIZED MINORS



If we also add PCA to TIC the results go in the same direction as 85.7% of the same respondents that are teachers does not know the good practices related to PCA for the treatment of traumatized minors (Figure 54).

FIGURE 54. KNOWLEDGE OF PCA - TIC GOOD PRACTICES IN THE TREATMENT OF TRAUMATIZED MINORS



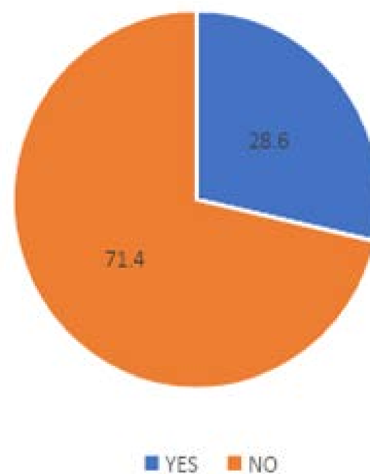
Furthermore 71.4% of the same respondents in the teachers sample, do not even know what are the Bad Practices in the frames of reference of Person Centered-Trauma Informed Care applied to the treatment of traumatized minors (Figure 55).

FIGURE 55. KNOWLEDGE OF PCA - TIC BAD PRACTICES IN THE TREATMENT OF TRAUMATIZED MINORS

3.3.2.4 Study and professional experience

71.4% of teachers report that they do not have specific knowledge about the potential impact of trauma on young respondents and children (Figure 56).

FIGURE 56. STUDY AND PROFESSIONAL EXPERIENCE ABOUT THE POTENTIAL IMPACT OF TRAUMA ON CHILDREN AND YOUNG PEOPLE



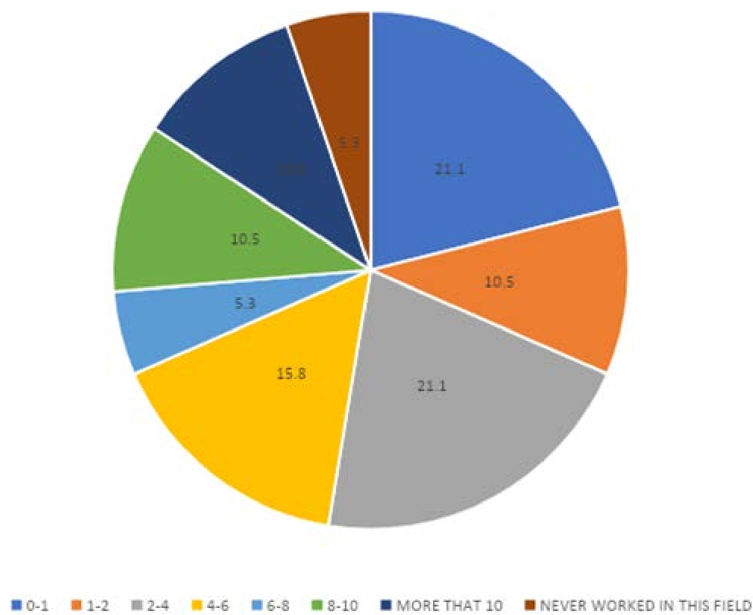
3.3.2.5 Conclusion

These data clearly point out to the relevance of offering to teachers free courses like the MOOC offered by the Care Path Project.

3.3.3 Health Professionals

Looking at what emerged in the sample of health professionals, it emerges that respondents have varying experiences of working with minors affected by trauma. In particular, 21.1% have an experience of about one year of work and another 21.1% have between 2-4 years of work experience; however, there are also other levels of experience, considering that 21% have experience ranging from 8 years and up with 10.5% with more than 10 years of work experience (Figure 57).

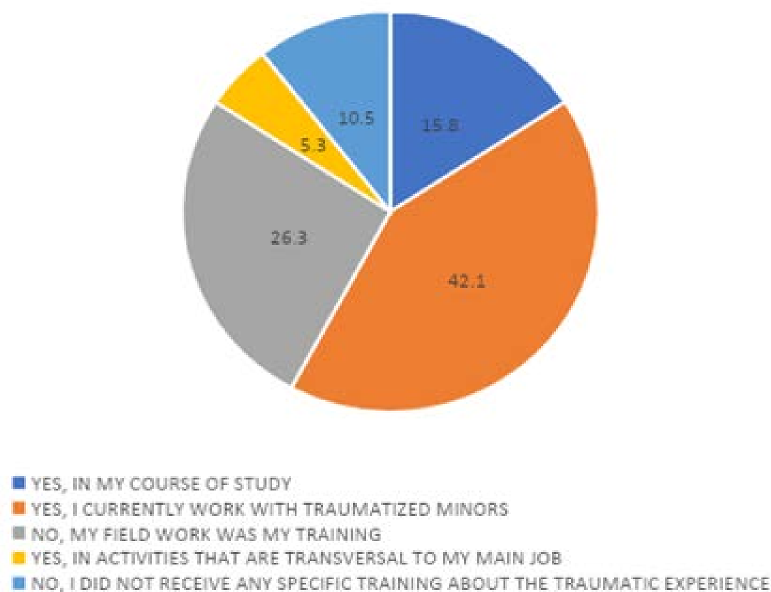
FIGURE 57. YEARS OF WORK WITH MINORS AFFECTED BY TRAUMA



3.3.3.1 Specific training and working experience

Concerning training, the specific training received on traumatic experiences by health professionals' sample, it emerges that 42.1% of respondents currently work with traumatized minors and 26.3% have learned in their field work and 15,8% received training in their course of study (Figure 58).

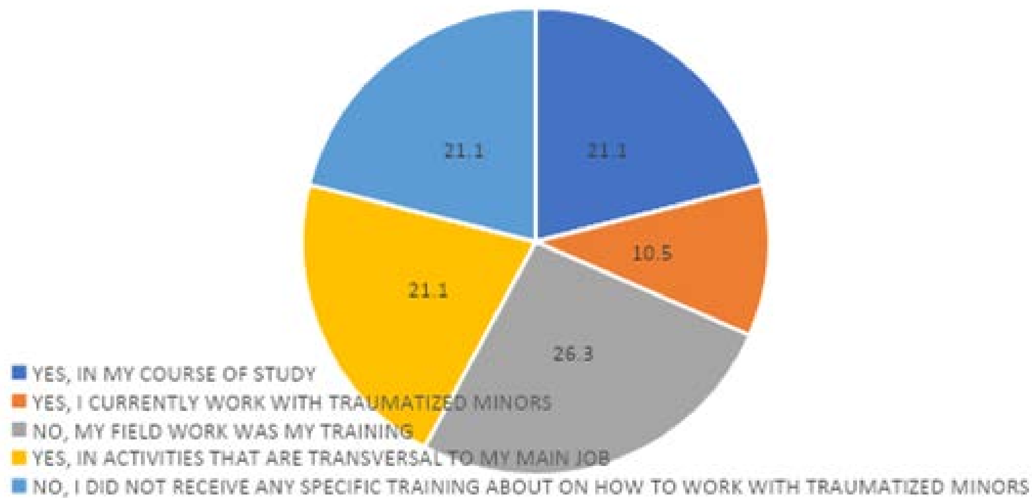
FIGURE 58. SPECIFIC TRAINING ABOUT TRAUMATIC EXPERIENCE



On the item "how to work with traumatized minors", there is almost an even distribution on the different alternatives of responses although the higher percentage

in the health professionals sample 26.3% is due to field work learning, while 21,1% received training in their course of study (Figure 59).

FIGURE 59. TRAINING ON HOW TO WORK WITH TRAUMATIZED MINORS

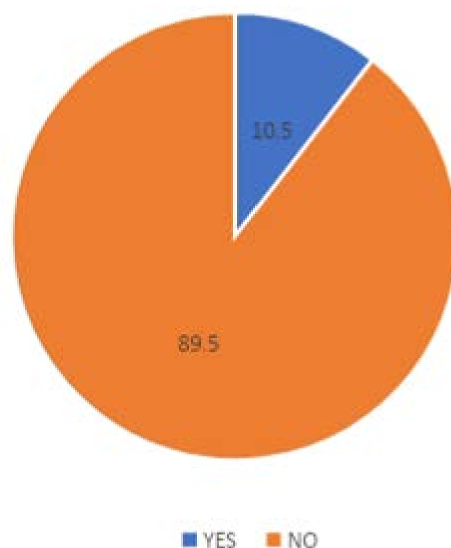


In relation to the ability of the health professional that responded to this item "to recognize the signs of traumatic experiences" about half of respondents, 52,6% say they can recognize the signs of trauma, while the other half point to some lack of ability to do it (Figure 60).

FIGURE 60. TRAINING ON HOW TO RECOGNIZE SIGNS OF TRAUMATIC EXPERIENCES

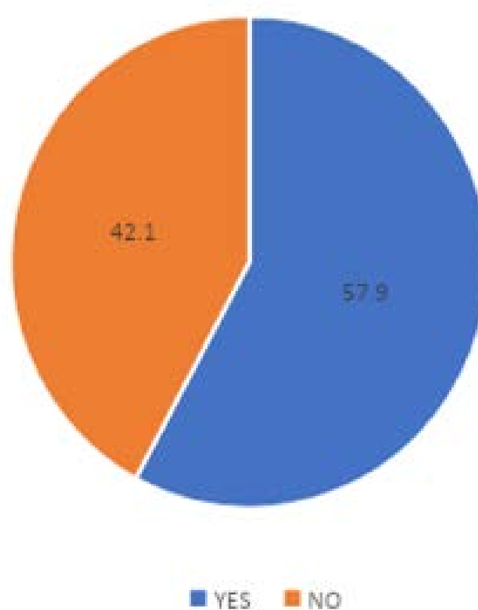
Clearly, moving to the knowledge on the specific interventions for the treatment of trauma almost 90% of the health care respondents precisely 89,5% of them declares to have no knowledge in this area (Figure 61).

FIGURE 61. TRAINING ON SPECIFIC INTERVENTIONS FOR THE TREATMENT OF TRAUMA



By highlighting the aspects of trauma related to the migratory experience, it emerges that most health care respondents (57.9%) have no knowledge of this specific topic (Figure 62).

FIGURE 62. KNOWLEDGE ON TRAUMA LINKED TO THE MIGRATORY EXPERIENCE



3.3.3.2 Age of clients

Moving on now to the age of the respondents with whom the health care respondents work, it emerges that they mostly work with clients in the 13-18 age group (Figure 63). However, there is also a 31.6% who work with the preschool age group (Figure 64).

FIGURE 63. EXPERIENCE IN WORKING WITH TRAUMATIZED YOUNG PEOPLE: 13-18 YEARS OLD

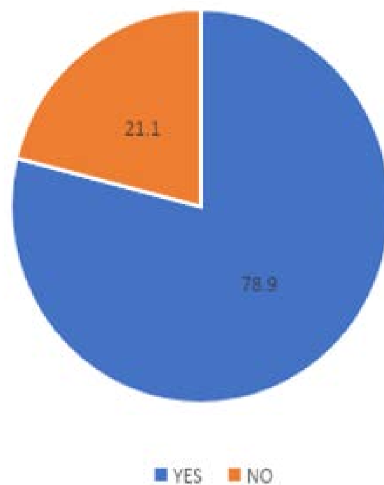
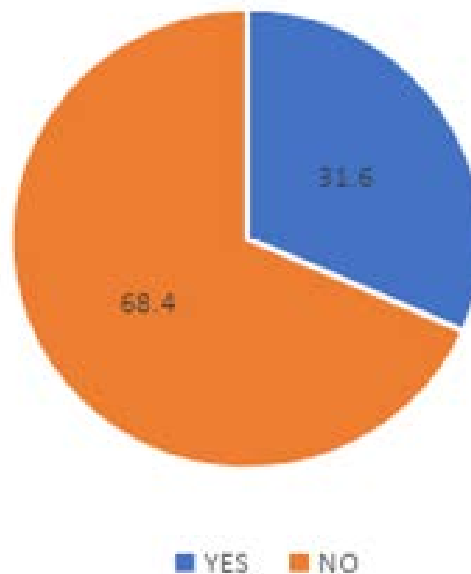
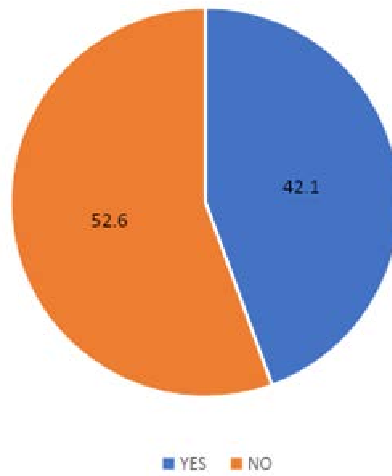


FIGURE 64. EXPERIENCE IN WORKING WITH TRAUMATIZED YOUNG PEOPLE: 0-5 YEARS OLD



Finally, 42,1% of the health care respondents works with clients that are 6-12 years old (Figure 65)

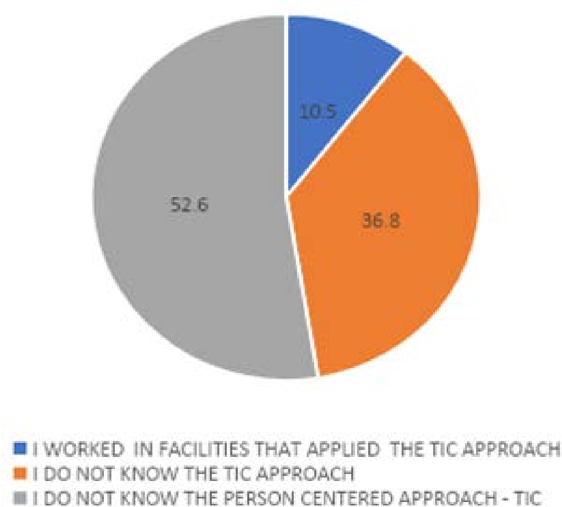
FIGURE 65. EXPERIENCE IN WORKING WITH TRAUMATIZED YOUNG PEOPLE: 6-12 YEARS OLD



3.3.3.3 PCA and TIC knowledge

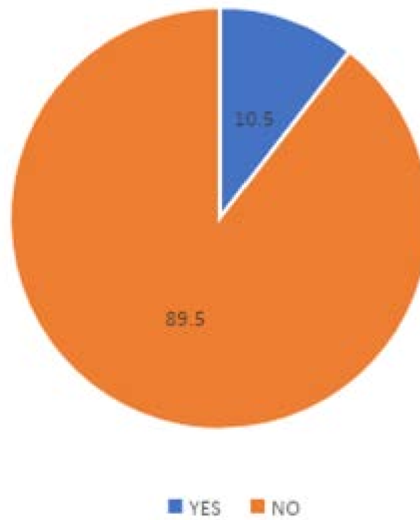
Turning now to specific content, it emerges that 36.8% of the health care respondents do not have specific knowledge about the Trauma Informed Care (TIC) approach and the 52.6% does not know the PCA/TIC approach, only 10,5 knows the PCA/TIC approach since they worked in facilities that where that approach was applied (Figure 66).

FIGURE 66. STUDY AND PROFESSIONAL EXPERIENCE OF PCA OR TIC



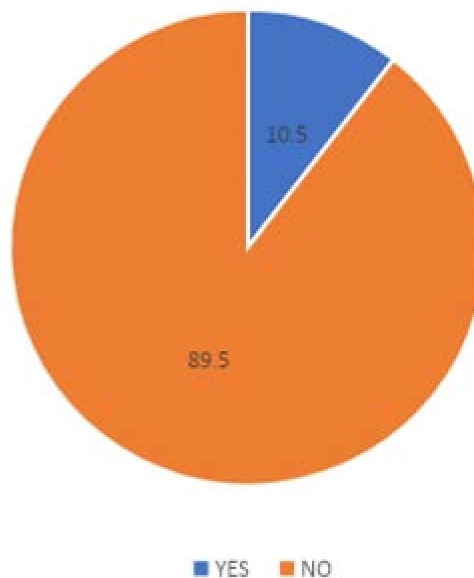
Evidently, not knowing the approach, 89,5% of respondents do not have specific knowledge about good practices and the positive effects of the model (Figure 67).

FIGURE 67. KNOWLEDGE OF TIC GOOD PRACTICES IN THE TREATMENT OF TRAUMATIZED MINORS



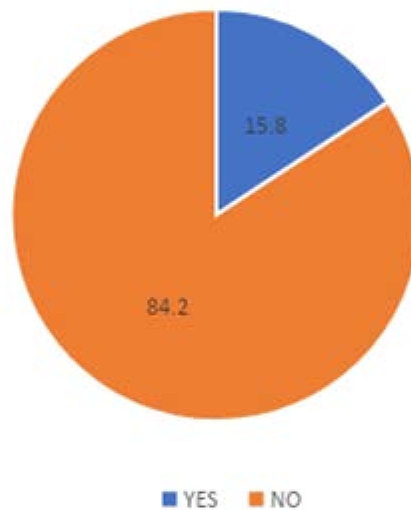
Similarly, the knowledge about the bad practices is lacking in 85% of respondents (Figure 68).

FIGURE 68. KNOWLEDGE OF TIC BAD PRACTICES IN THE TREATMENT OF TRAUMATIZED MINORS



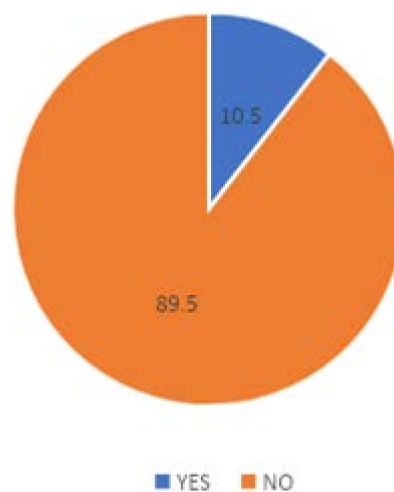
A high percentage of respondents (84.2%) who do not know about good practices of the PCA/Trauma Informed Care Approach in the treatment of traumatized minors offers another confirmation about the importance of offering free courses like the Care Path Mooc (Figure 69).

FIGURE 69. KNOWLEDGE OF PCA - TIC GOOD PRACTICES IN THE TREATMENT OF TRAUMATIZED MINORS



Most respondents (89.5%) do not know what in the PCA/TIC approaches is considered Bad Practices as in the items above, this is a significant finding that raise concerns of possible occurrence of iatrogenic involuntary damages and underlines the need for courses like the Care Path Mooc (Figure 70).

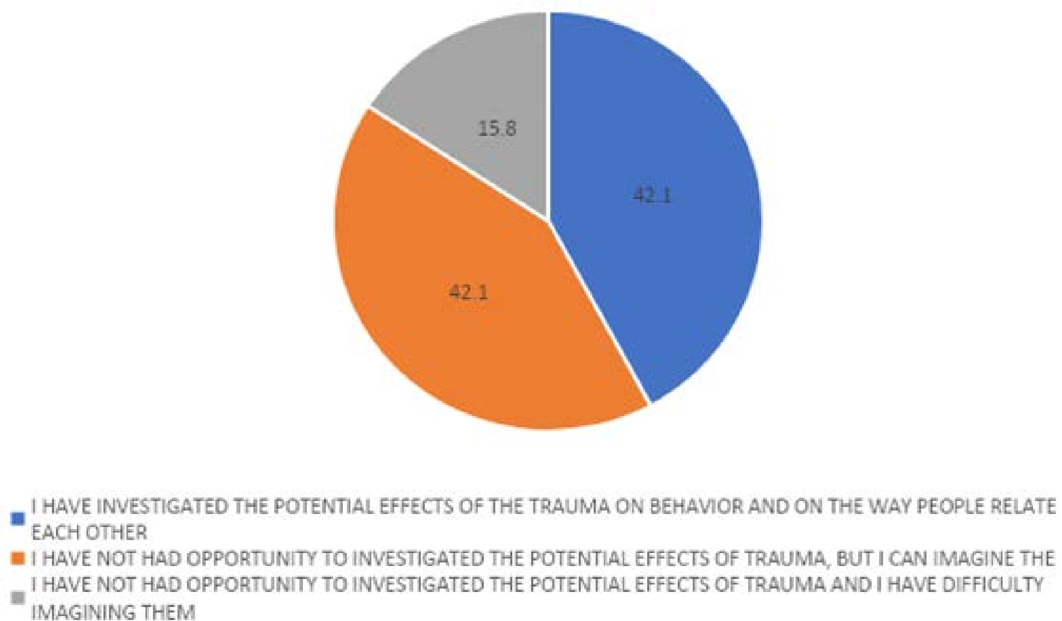
FIGURE 70. KNOWLEDGE OF PCA - TIC BAD PRACTICES IN THE TREATMENT OF TRAUMATIZED MINORS



3.3.3.4 Study and professional experience

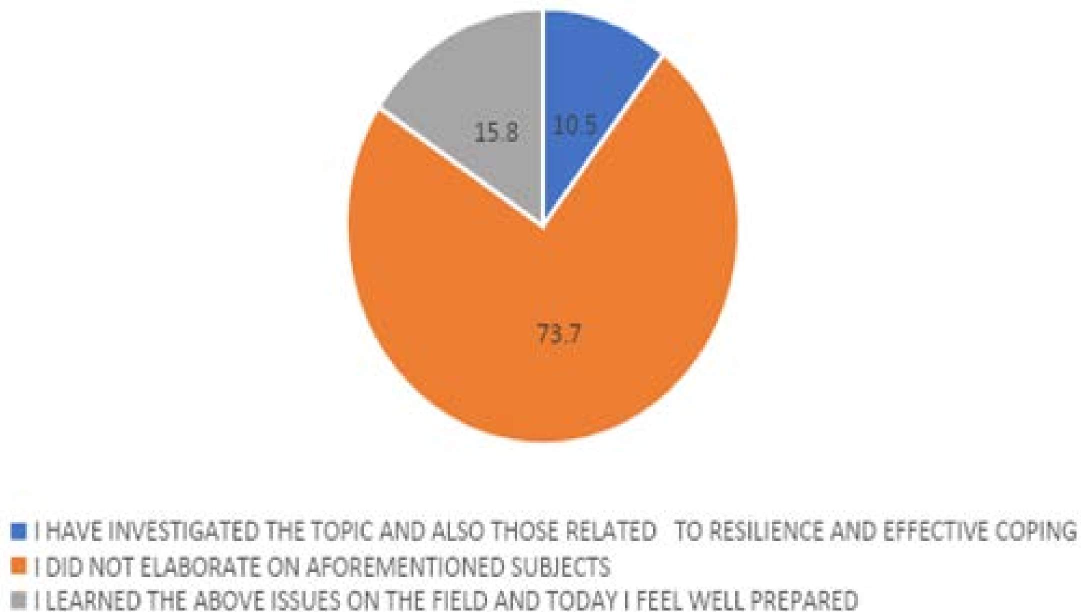
Examining the professional experiences related to the effects of trauma, it emerges that 42.1% of the health care respondents did not have the opportunity to deepen the their knowledge about the potential effects of trauma; and 15,8 of them did not have an opportunity for gaining knowledge and furthermore has not any idea about the effects of trauma; while the 42.1% of the respondents had the opportunity to deepen them in their professional and study experiences (Figure 71).

FIGURE 71. STUDY AND PROFESSIONAL EXPERIENCE ON THE EFFECT OF TRAUMATIC EXPERIENCES



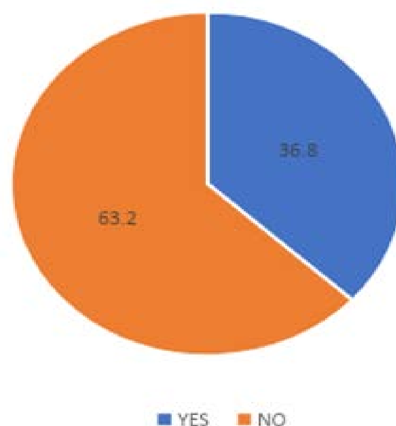
Concerning the topic of growth after trauma, 73.3% of the respondents do not know this very important topic and the body of research in this field; only the rest of the respondents knows the topic and only 15, 8 % of them feel competent and well prepared. This is another indication of the usefulness of offerings like the free Mooc of the Care Path Project (Figure 72).

FIGURE 72. STUDY AND PROFESSIONAL EXPERIENCE OF GROWTH FROM TRAUMA



Finally, 63.2% of the health professionals reported a lack of knowledge or professional experience regarding the potential impact of trauma on children and young people. This data points out to the need to help needed to fill such gaps and the usefulness to provide free courses like the Care (Figure 73).

FIGURE 73. STUDY AND PROFESSIONAL EXPERIENCE ABOUT THE POTENTIAL IMPACT OF TRAUMA ON CHILDREN AND YOUNG PEOPLE



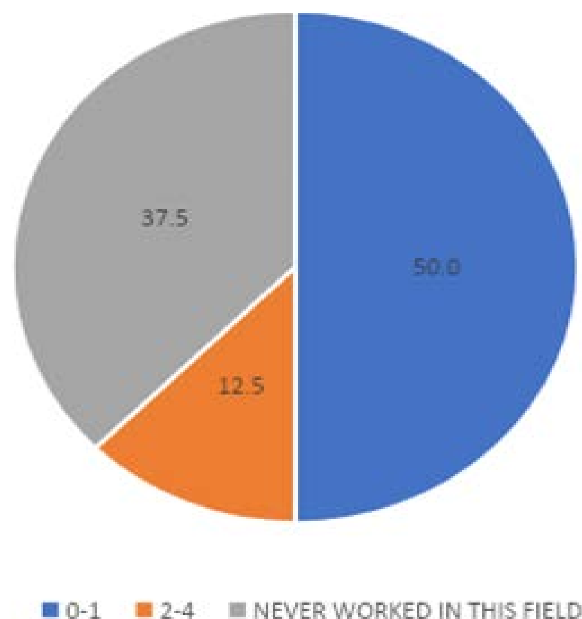
3.3.3.5 Conclusion

These data seem to suggest the relevance of offering to health professionals' free online courses like the Care Path Mooch.

3.3.4 Volunteers

Examining the work experience of the Volunteers sample that responded, it emerges that half of them (50%) have an experience between 0 and 1 year of work in the field, while 37.5% have never worked in this field; in fact, only 12.5% of the respondents have an experience between 2 and 4 years, while no one has an experience greater than 4 years of work with traumatized minors (Figure 74).

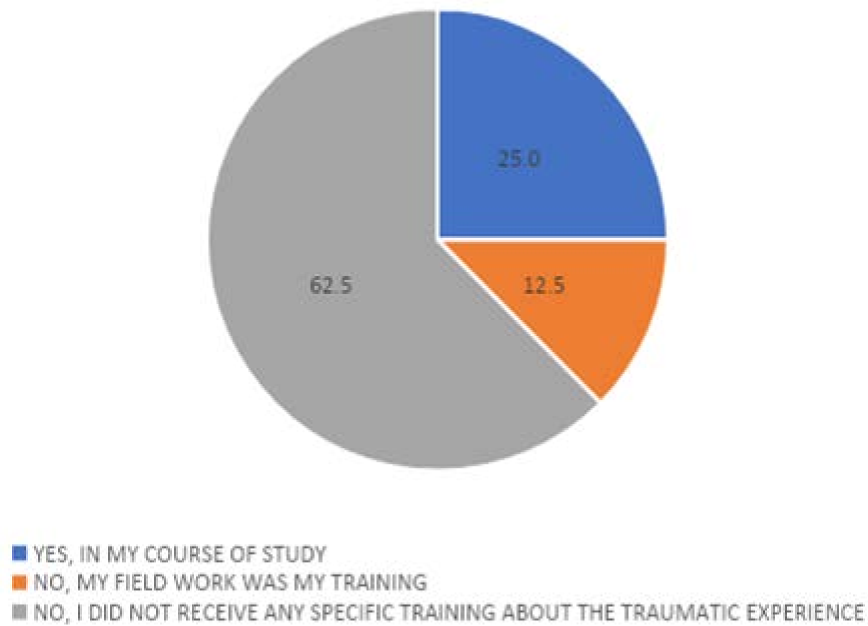
FIGURE 74. YEARS OF WORK WITH MINORS AFFECTED BY TRAUMA



3.3.4.1 Specific training and working experience

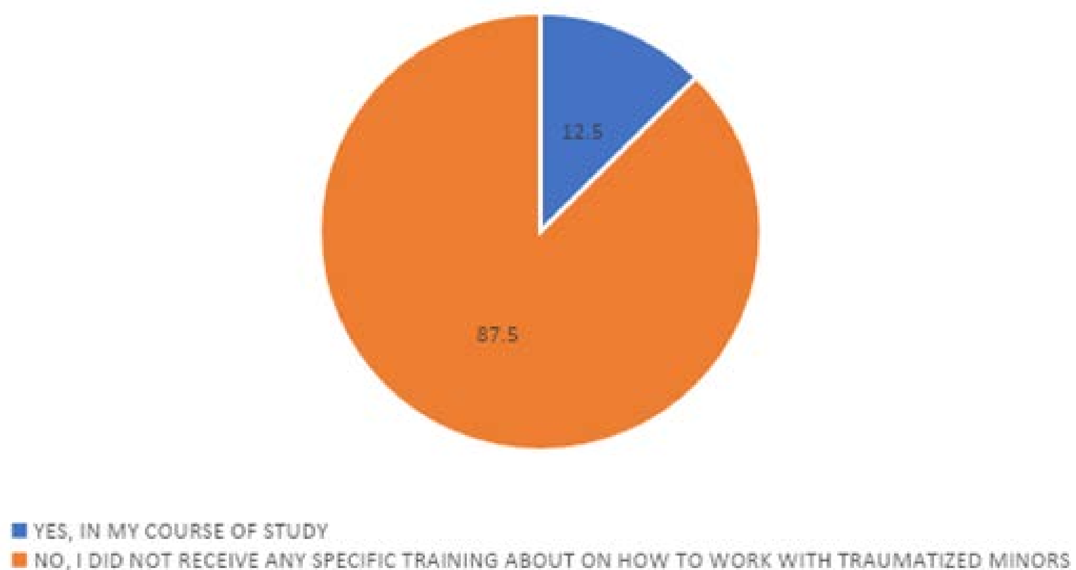
Examining the percentage of the volunteers' respondents that received specific training on traumatic experiences, it emerges that 62.5% did not receive any training in this topic, (Figure 75).

FIGURE 75. SPECIFIC TRAINING ABOUT TRAUMATIC EXPERIENCE



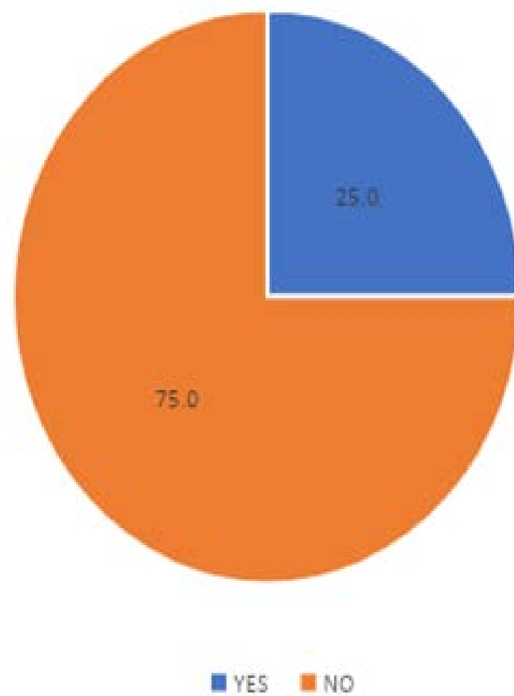
Examining the presence of specific training on how to work with traumatized minors, it emerges that 87.5% have not received any specific training in this topic (Figure 76).

FIGURE 76. TRAINING ON HOW TO WORK WITH TRAUMATIZED MINORS



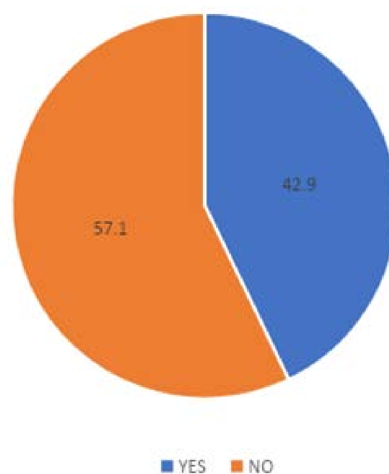
As can be expected, even regarding skills on how to recognize signs from trauma, it appears that 75% of respondents did not learn to recognize these specific indicators (Figure 77).

FIGURE 77. TRAINING ON HOW TO RECOGNIZE SIGNS OF TRAUMATIC EXPERIENCES



57.1% of the respondents report to not have any knowledge about trauma linked to the migratory experience (Figure 78).

FIGURE 78. KNOWLEDGE ON TRAUMA LINKED TO THE MIGRATORY EXPERIENCE



3.3.4.2 Age of clients

Examining the age of the client population, it emerges that also in this volunteers' sample, as in the previous groups, the prevalent is with preadolescents and adolescents while there is less experience with preschool age.
Specifically, 12.5% reported to work with preschool age (Figure 79), 37.5% with preadolescents (Figure 80) and 25% reported to work with adolescents (Figure 81).

FIGURE 79. EXPERIENCE IN WORKING WITH TRAUMATIZED YOUNG PEOPLE: 0-5 YEARS OLD

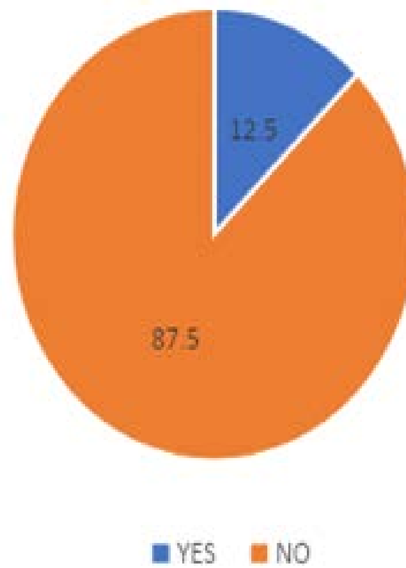


FIGURE 80. EXPERIENCE IN WORKING WITH TRAUMATIZED YOUNG PEOPLE: 6-12 YEARS OLD

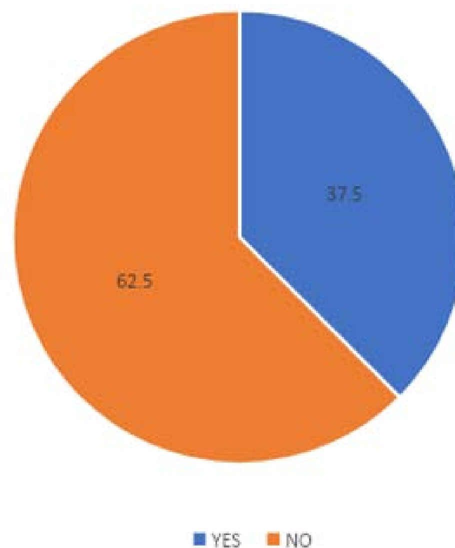
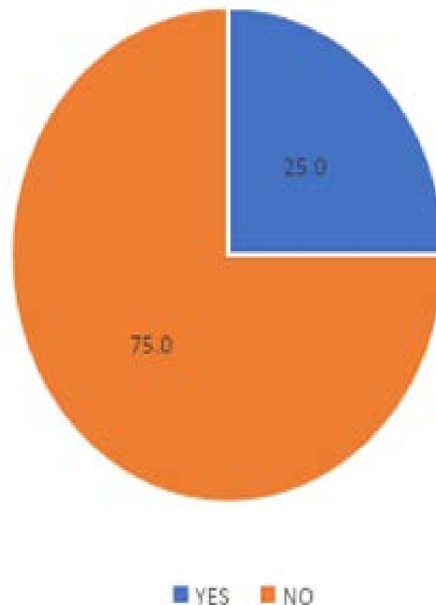


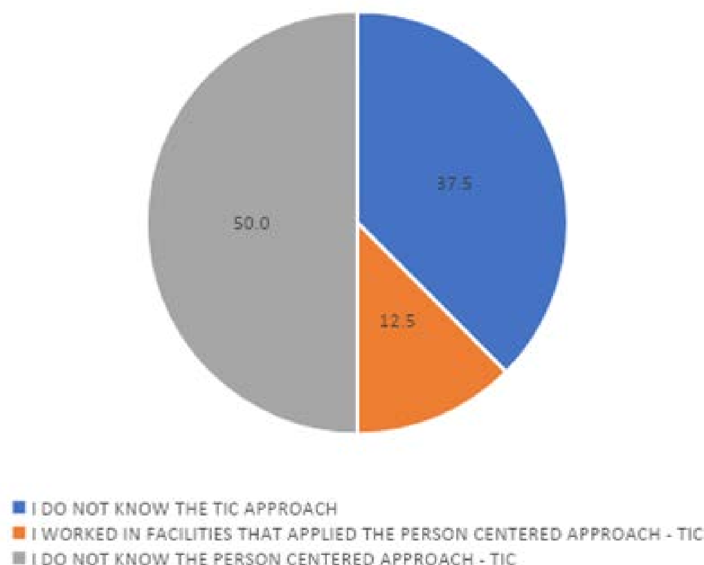
FIGURE 81. EXPERIENCE IN WORKING WITH TRAUMATIZED YOUNG PEOPLE: 13-18 YEARS OLD



3.3.4.3 PCA and TIC knowledge

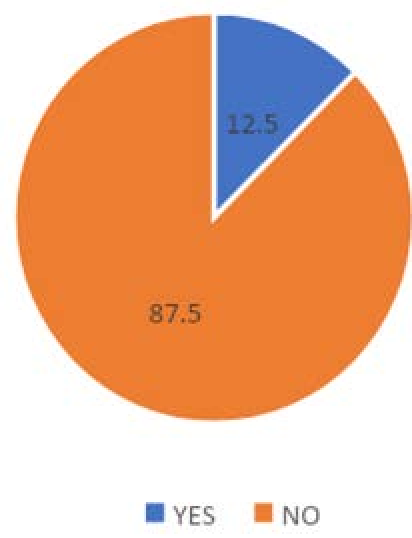
Turning now to the specific knowledge and skills with PCA/TIC it emerges that half of the respondents of the volunteers sample are not aware of either the Trauma Informed Care approach (TIC) or the Person Centered Trauma Informed Care approach only 12.5% know the PCA/TIC approach since they did have a work experience in facilities that applied the approach (Figure 82).

FIGURE 82. STUDY AND PROFESSIONAL EXPERIENCE OF PCA OR TIC



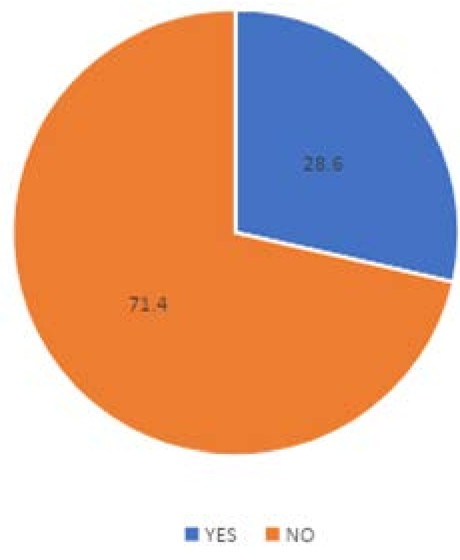
Congruently the total sample of volunteers does not have any specific knowledge even of good practices and malpractices in TIC and PCA (Figure 83).

FIGURE 83. KNOWLEDGE OF TIC GOOD PRACTICES IN THE TREATMENT OF TRAUMATIZED MINORS



Participants reported to not have knowledge of TIC bad practices as well (Figure 84).

FIGURE 84. KNOWLEDGE OF TIC BAD PRACTICES IN THE TREATMENT OF TRAUMATIZED MINORS

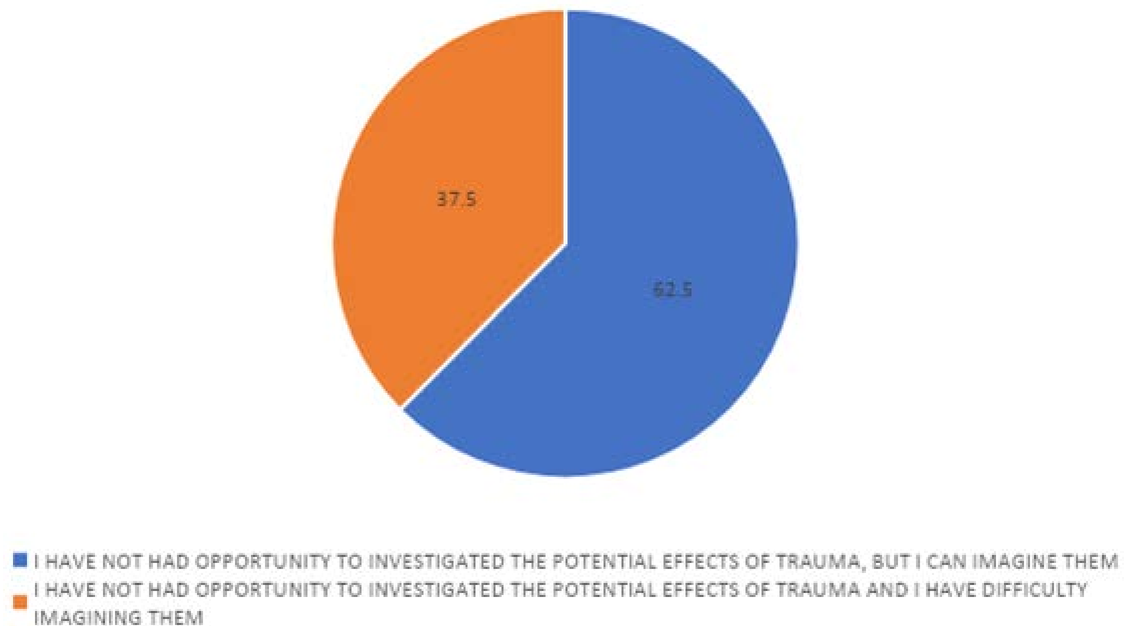


3.3.4.4 Study and professional experience

Examining the studies and professional experiences on the effects of traumatic experiences, it emerges that nobody of the respondents is aware of the effects of

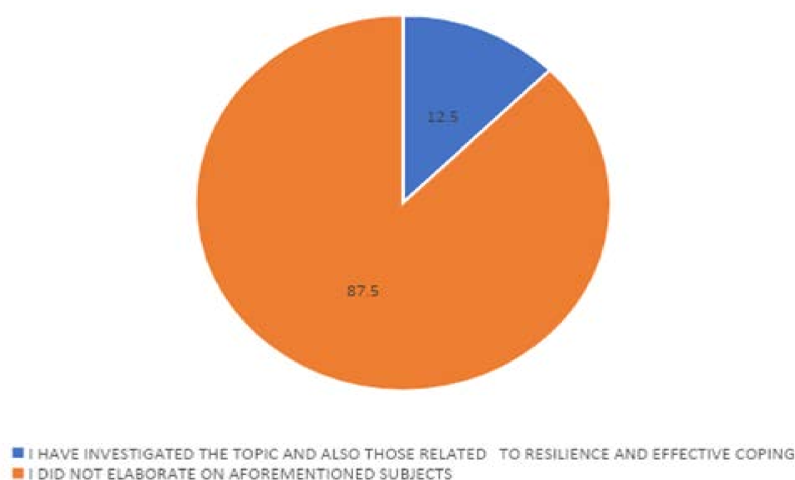
trauma in a specific way, a part of the sample (62.5%) claims, however, to be able to imagine them (Figure 85).

FIGURE 85. STUDY AND PROFESSIONAL EXPERIENCE ON THE EFFECT OF TRAUMATIC EXPERIENCES



Likewise, respondents declare that they are not aware that there is the phenomenon of growth after trauma, resilience and coping (Figure 86).

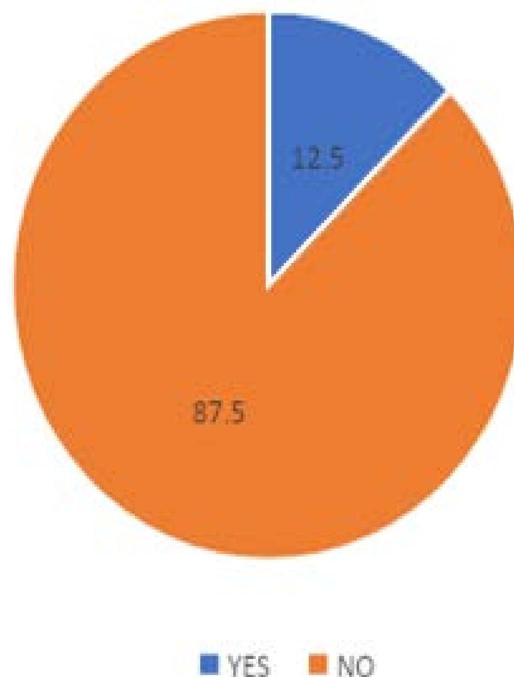
FIGURE 86. STUDY AND PROFESSIONAL EXPERIENCE OF GROWTH FROM TRAUMA



Looking at the item on the potential impact of trauma on children and young adults, it emerges that 87.5% of the volunteers that responded do not have specific

knowledge about it, in line with previous findings on specific knowledge about trauma (Figure 87).

FIGURE 87. STUDY AND PROFESSIONAL EXPERIENCE ABOUT THE POTENTIAL IMPACT OF TRAUMA ON CHILDREN AND YOUNG PEOPLE



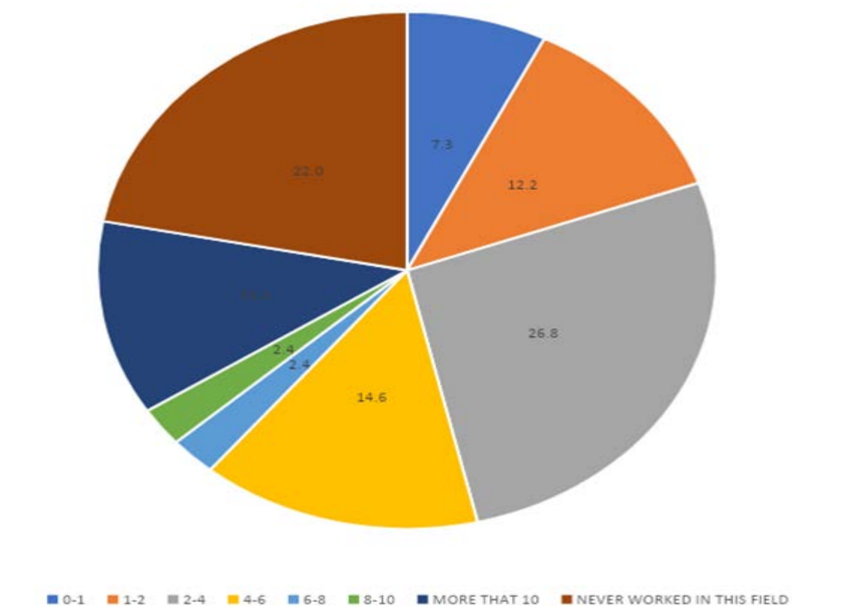
3.3.4.5 Conclusion

Comparing these answers to the questionnaire with the results of many years of research on effectiveness of helping lay professions and/volunteers in the helping professions, and more specifically the research and the guidelines on Trauma Informed Care (TIC), This data seems to point out to the need to offer courses to Educators similar to the Care Path Mooc, evidently not to have volunteers to invade or practice beyond their we defined roles and responsibilities, spelled out by laws, regulations, professional guilds, and ONG , and institutional regulations, but to respect them and avoid the risk of doing things that may provoke re-traumatization and to fulfill an effective role of volunteer, that by the way in the field of trauma care in many European countries has the larger number of people among the professional profiles that offer help to the minors affected by trauma.

3.3.5 Psychologists

41 participants reported to be psychologist. Looking now at the responses from the sample of psychologists, it emerges that there are years of different experience on minors who have been victims of trauma, 26,8% had work experience with his client population; 14. 6% had experience of 4-6 years of work and 12.2% of the respondents have more than ten years of experience in this area. 22% of responding psychologists have never worked with this client population (Figure 88).

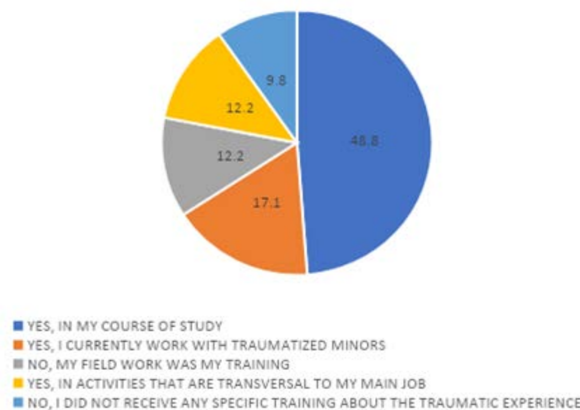
FIGURE 88. YEARS OF WORK WITH MINORS AFFECTED BY TRAUMA



3.3.5.1 Specific training and working experience

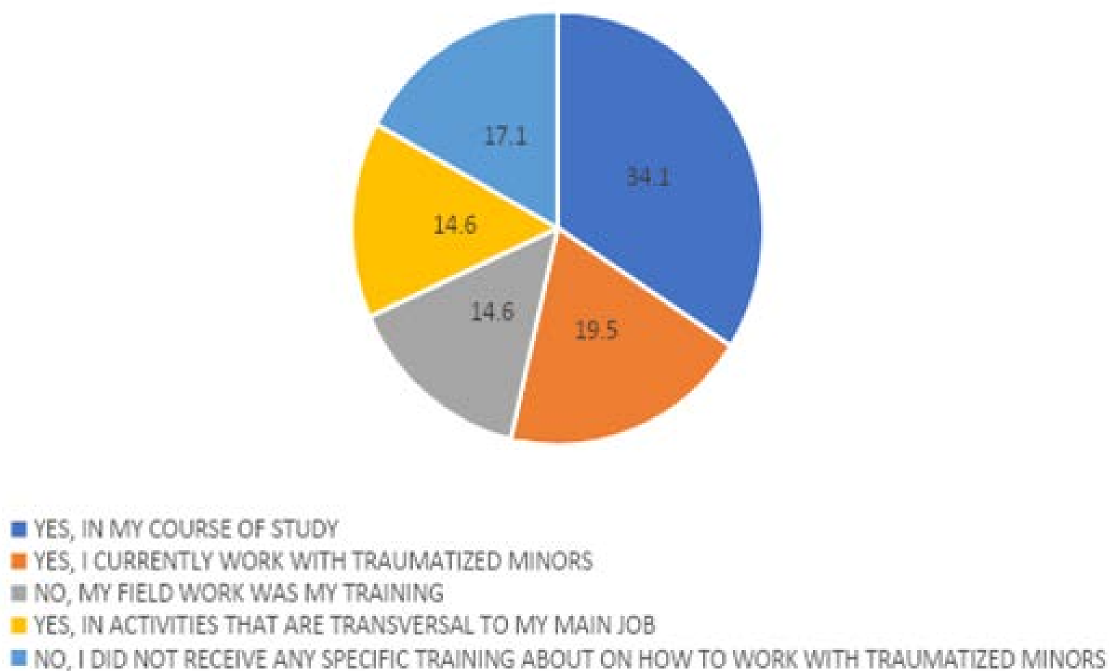
Looking at the specific training related to traumatic experiences, it emerges that almost half of the psychologists' sample (48.8%) addressed these aspects during their course of study. Others did get their training in their field work but 9.8% of the respondents clearly did not receive any training about this topic. This last data having 9.8 of the psychologists responding to this item that are without any training and competence on trauma underlines the relevance of the offering of free courses like the Care Path Mooc addressing this topic and offering ample bibliography and websites where to access free training and materials (Figure 89).

FIGURE 89. SPECIFIC TRAINING ABOUT TRAUMATIC EXPERIENCE



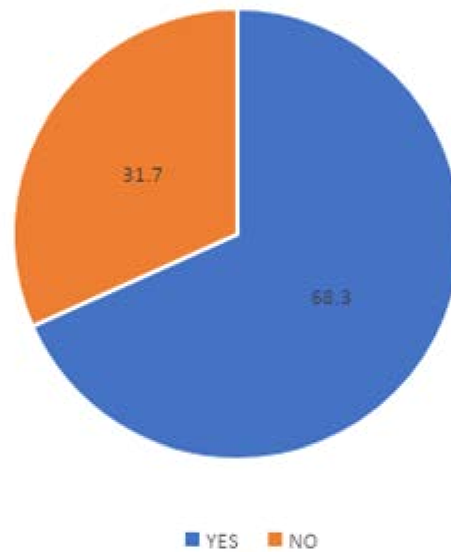
Regarding how to work with traumatized minors, 34.1% of the respondents highlighted that they have addressed this aspect in their studies (Figure 90).

FIGURE 90. TRAINING ON HOW TO WORK WITH TRAUMATIZED MINORS



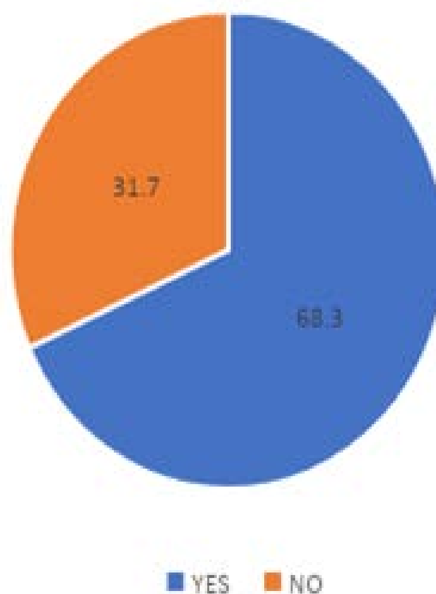
Examining now the skills on how to recognize the signs of trauma, it emerges that 68.3% have not developed skills in this regard while 31.7% say stated that they have the tools to do so (Figure 91).

FIGURE 91. TRAINING ON HOW TO RECOGNIZE SIGNS OF TRAUMATIC EXPERIENCES



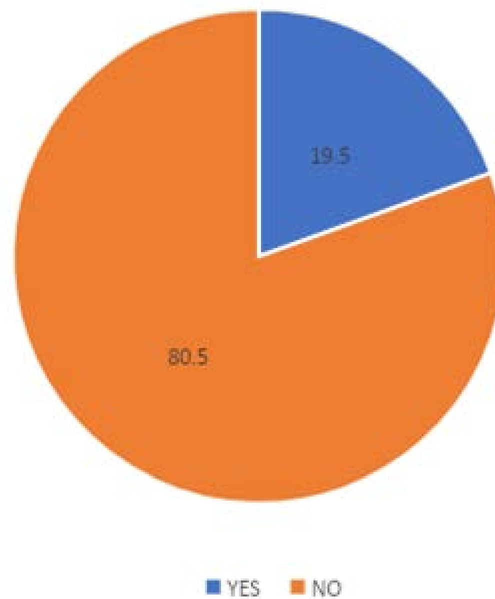
The 75.6%, in the psychologists sample however, points out that they do not know specifically the correlation between trauma and migratory phenomena (Figure 92).

FIGURE 92. KNOWLEDGE ON TRAUMA LINKED TO THE MIGRATORY EXPERIENCE



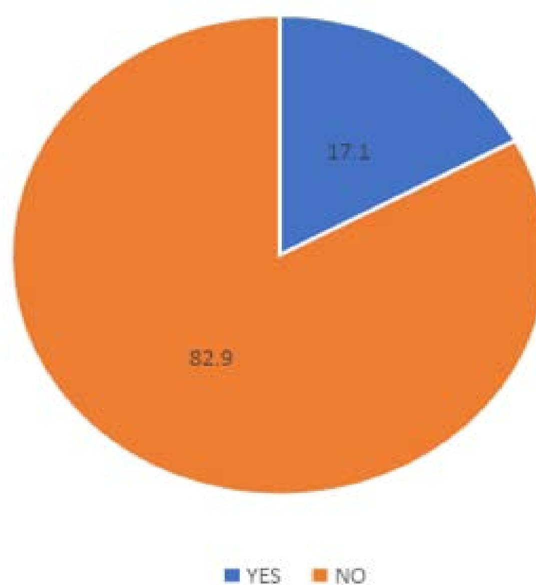
Similarly, there is a lack of knowledge about most of the sample (80,5%) regarding screening and evaluation techniques to identify the presence of trauma (Figure 93).

FIGURE 93. KNOWLEDGE ON SCREENING AND EVALUATION TECHNIQUES TO IDENTIFY TRAUMA



As can be expected, considering that there seems to be a lack of specific expertise on trauma assessment and screening, similarly, 82.9% in the sample of psychologists, stated that they lack specific expertise on treatment of trauma. These data seem to underline a severe need of further training in order to have those professionals to operate in science and conscience, offering the best services possible of their clients (Figure 94).

FIGURE 94. KNOWLEDGE ON SPECIFIC INTERVENTIONS FOR THE TREATMENT OF TRAUMA



3.3.5.2 Age of clients

Considering the age at which the psychologists sample work, an inverse trend emerges compared to the rest of the other groups of helpers, as many psychologists of the sample work with pre-school age but also with pre-teen and adolescent age clients. Specifically, 29.5 % of the respondents reported to work with pre-school children (Figure 95), 39% to work with preadolescents (Figure 96) and 48.8% with adolescents (Figure 97).

FIGURE 95. EXPERIENCE IN WORKING WITH TRAUMATIZED YOUNG PEOPLE: 0-5 YEARS OLD

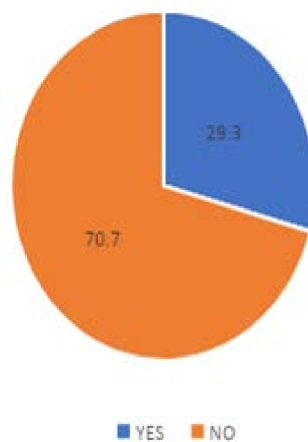


FIGURE 96. EXPERIENCE IN WORKING WITH TRAUMATIZED YOUNG PEOPLE: 6-12 YEARS OLD

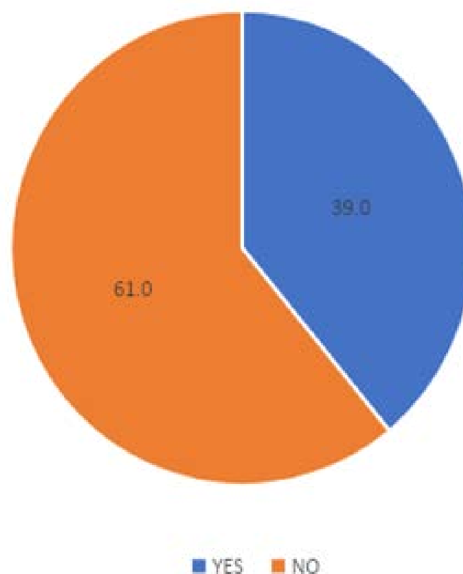
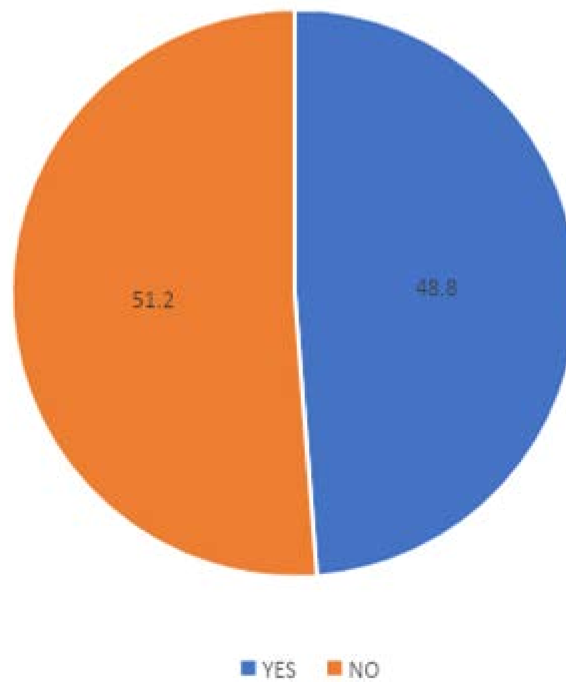


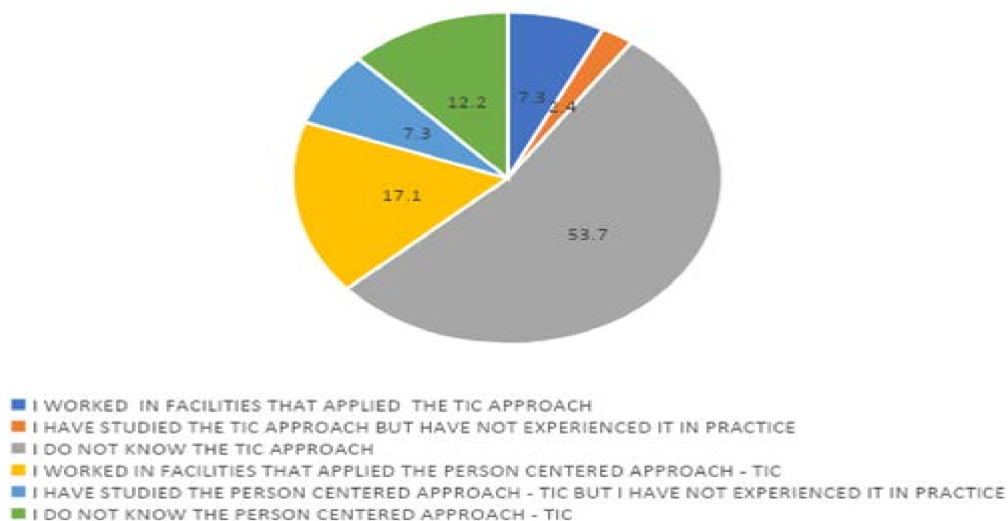
FIGURE 97. EXPERIENCE IN WORKING WITH TRAUMATIZED YOUNG PEOPLE: 13-18 YEARS OLD



3.3.5.3 PCA and TIC knowledge

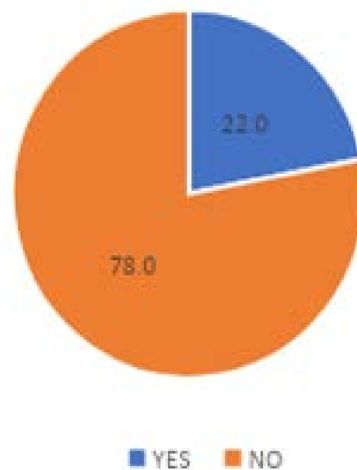
A review of professional experience and studies on PCA and TIC shows that 53.7% are not familiar with the PCA/TIC approach (Figure 98).

FIGURE 98. STUDY AND PROFESSIONAL EXPERIENCE OF PCA OR TIC



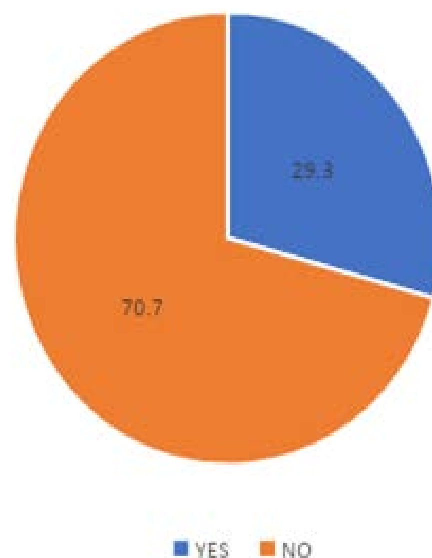
78% of the psychologists' sample respondents have no knowledge of good practices in Trauma Informed Care (Figure 99).

FIGURE 99. KNOWLEDGE OF TIC GOOD PRACTICES IN THE TREATMENT OF TRAUMATIZED MINORS



70% of the psychologists' sample, on the other hand, are not aware of Trauma Informed Care (TIC) bad practices (Figure 100).

FIGURE 100. KNOWLEDGE OF TIC BAD PRACTICES IN THE TREATMENT OF TRAUMATIZED MINORS

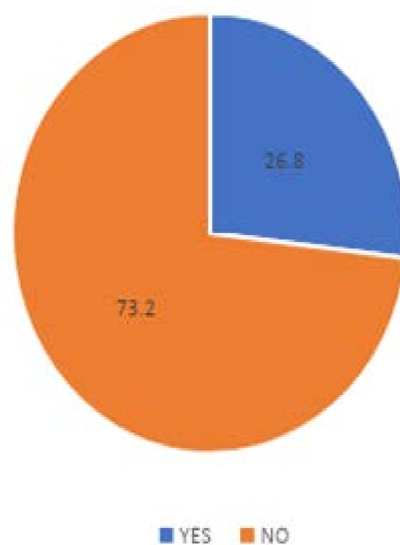


73.2% of the sample do not know about **t**he PCA –TIC approach good practices while 26,8% has knowledge about such topic (Figure 101).

Likewise, 73.2% of the sample does not know what are considered Bad practices in the PCA-Trauma Informed Care of minors while 26,8% declare to have such knowledge (Figure 102).

FIGURE 101. KNOWLEDGE OF PCA - TIC GOOD PRACTICES IN THE TREATMENT OF TRAUMATIZED MINORS

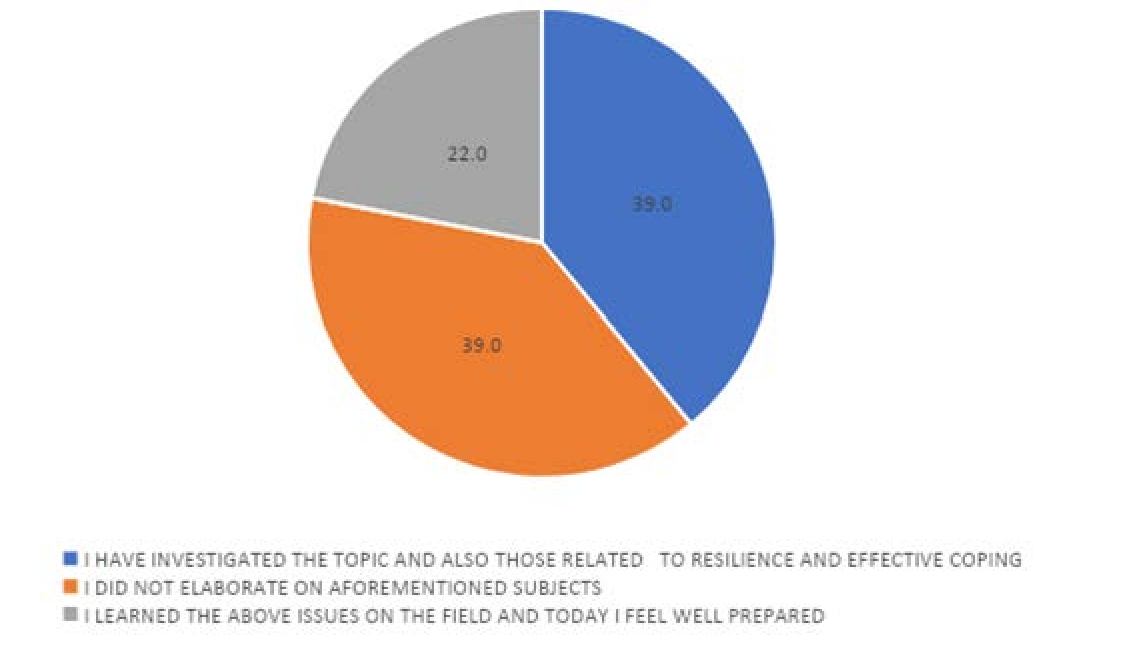
FIGURE 102. KNOWLEDGE OF PCA - TIC BAD PRACTICES IN THE TREATMENT OF TRAUMATIZED MINORS



3.3.5.4 Study and professional experience

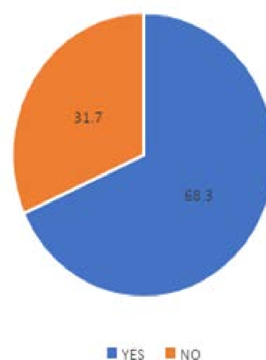
With regard to the growth after trauma 22% of the psychologist's respondents stated that they feel well prepared, another 39% of respondents stated that they have knowledge about growth after trauma, while there is also a 39% who have no particular knowledge about this topic (Figure 103).

FIGURE 103. STUDY AND PROFESSIONAL EXPERIENCE OF GROWTH FROM TRAUMA



Finally, on the item on knowing how to recognize the potential impact of trauma on children, it emerges that 68.3% of the psychologists' sample have not developed skills in this regard while 31.7% stated that they have the tools to do so (Figure 104).

FIGURE 104. STUDY AND PROFESSIONAL EXPERIENCE ABOUT THE POTENTIAL IMPACT OF TRAUMA ON CHILDREN AND YOUNG PEOPLE



3.3.5.5 Conclusion

Comparing these answers from psychologist that responded to the questionnaire with the results of many years of research on psychologists effectiveness and more specifically the research and the guidelines about Trauma Informed Care (TIC), This data seems to point out to the need to offer psychologists similar to the Care Path Mooch and hopefully have the Training curricula at the universities that graduate psychologist to be updated.

3.4 Differences between countries

The analyses were made on the Italian (n = 207) and Greek (n = 45) samples as the Hungarian (n = 3) one had too few participants.

3.4.1 Years of experience in working with minors

In table 1a there is a significant difference between Italian and Greek participants. Specifically, it seems that more Greek participants have less experiences than Italian ones.
However, if we dichotomize the variable (table 1b - have work experience with minor, do not have work experience with minor) the significance is lost.
This may be explained because there are many categories in the previous variable (8) but not many participants for each category in each group (i.e. no Greek participant reported working with children age 4-6): it is possible that if the groups were more balanced (i.e. more Greek participants) the difference may fade also in the original variable.

TABLE 1A. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN REPORTED AMOUNT OF YEARS OF EXPERIENCES IN WORKING WITH MINORS EFFECTED BY TRAUMA.

	Italy		Greece			
Years	n	%	n	%	χ^2(*df*)	*p*
0-1	21	10.14	15	33.33	22.84 (7)	002*
1-2	13	6.26	4	8.89		
2-4	25	12.08	7	15.56		
4-6	24	11.59	0	0		
6-8	10	4.83	3	6.67		
8-10	15	7.25	2	4.44		

11+	51	24.64	7	15.56		
Never worked in this field	48	23.19	7	15.56		

* significant with $p < .005$

TABLE 1B. χ^2 TEST WITH DICHOTOMIZED VALUES (NO = NEVER WORKED IN THIS FIELD, YES = ALL THE OTHER ITEMS).

	Italy			Greece				
Worked in this field	n	*%r*	%c	n	*%r*	%c	$\chi^2(df)$	*p*
No	48	19.05	23.19	7	2.78	15.56	1.26(1)	.261
Yes	159	63.10	76.81	38	15.08	84.44		

3.4.2 Specific training received about traumatic experience

There is a significant difference between the Italian and Greek samples. Greeks reported to have received less formal training than Italian (Table 2).

TABLE 2. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN REPORTED SPECIFIC TRAINING RECEIVED ABOUT TRAUMATIC EXPERIENCE.

	Italy		Greece			
Item	n	%	n	%	$\chi^2(df)$	*p*
Yes, in my course of study	70	33.82	10	22.22	13.85 (4)	.008*
Yes, I currently work with traumatized minors	48	23.19	4	8.89		
Yes, in activities that are transversal to my main job	22	10.63	10	22.22		
No, my field work is my training	31	14.98	6	13.33		
No, I did not receive any specific training about the traumatic experience	36	17.39	15	33.33		

* significant with $p < .01$

3.4.3 Training on how to work with traumatized minors

There are no significant differences between the Greek and Italian sample (Table 3).

TABLE 3. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN REPORTED TRAINING ON HOW TO WORK WITH TRAUMATIZED MINORS.

	Italy		Greece			
Item	n	%	n	%	χ^2(*df*)	*p*
Yes, in my course of study	57	27.54	11	24.44	3.91 (4)	.419
Yes, I currently work with traumatized minors	36	17.39	6	13.33		
Yes, in activities that are transversal to my main job	31	14.98	10	22.22		
No, my field work is my training	39	18.84	5	11.11		
No, I did not receive any specific training on how to work with traumatized minors	44	21.26	13	28.89		

3.4.4 Specific training received in working with traumatized minors

There are no significant differences between the Greek and Italian sample (Table 4).

TABLE 4. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN REPORTED SPECIFIC TRAINING RECEIVED IN WORKING WITH TRAUMATIZED MINORS.

		Italy		Greece			
Item		n	%	n	%	χ^2(*df*)	*p*
To recognize the signs of traumatic experiences	no	87	42.03	16	35.56	.64 (1)	.423
	yes	120	57.97	29	64.44		
The potential impact of trauma on children and young respondents	no	113	54.59	22	48.89	.48 (1)	.487
	yes	94	45.41	23	51.11		
The screening and evaluation techniques to identify the trauma	no	183	88.41	38	84.44	.54 (1)	.463
	yes	20	11.59	7	15.56		
Specific interventions for the treatment of trauma	no	187	90.34	38	84.44	1.34 (1)	.286
	yes	20	9.66	7	15.56		
Trauma linked to the migratory experience	no	139	67.15	35	77.78	1.95 (1)	.286
	yes	68	32.85	10	22.22		
Other	no	187	90.34	36	88.49	3.88 (1)	.068
	yes	20	9.66	9	11.51		

3.4.5 Specific experiences in working with traumatized minors of different age ranges

There are no significant differences between the Greek and Italian sample (Table 5).

TABLE 5. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN REPORTED SPECIFIC EXPERIENCES IN WORKING WITH TRAUMATIZED MINORS OF DIFFERENT AGE RANGES.

		Italy		Greece		$\chi^2(df)$	*p*
Age range		n	%	n	%		
0-5 years	no	166	80.19	37	82.22	.10 (3)	.755
	yes	12041	19.81	8	17.78		
6-12 years	no	123	59.71	22	51.11	1.12 (3)	.290
	yes	83	40.29	23	48.89		
13-18 years	no	81	39.13	24	53.33	3.07 (3)	.080
	yes	126	60.87	21	46.67		
Other	no	175	84.54	35	77.78	1.22 (3)	.270
	yes	32	15.46	10	22.22		

3.4.6 Study and professional experience of PCA and TIC

There is a significant difference between Greek and Italian participants. Greeks reported more hand on experience in working with the PCA-TIC approach while a large part of Italians reported to not know the TIC approach (Table 6).

TABLE 6. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN REPORTED STUDY OR PROFESSIONAL EXPERIENCE THE PERSON CENTERED APPROACH (PCA) AND/OR THE TRAUMA-INFORMED CARE (TIC).

	Italy		Greece			
Item	n	%	n	%	$\chi^2(df)$	*p*
I worked in facilities that applied the TIC approach	9	4.35	2	4.44	23.95 (5)	.000*
I have studied the TIC approach but have not experienced it in practice	10	4.83	1	2.22		
I do not know the TIC approach	106	51.21	13	28.89		

I worked in facilities that applied the PCA - TIC	11	5.31	12	26.67		
I have studied the PCA - TIC but I have not experienced it in practice	7	3.38	3	6.67		
I do not know the PCA - TIC	64	30.92	14	31.11		

* significant with p < .001

3.4.7 Knowledge of TIC and PCA good and bad practises

There are significant differences in all the items between the Italian and Greek samples. Specifically, Italian reported less knowledge of good and bad practices in both TIC and PCA-TIC approaches (Table 7).

TABLE 7. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN REPORTED KNOWLEDGE OF GOOD/BAD PRACTICES OF TIC/PCA.

		Italy		Greece			
Item		n	%	n	%	$\chi^2(df)$	*p*
Knowledge of TIC good practices in treatment of traumatized minors	no	183	88.41	32	71.11	8.83 (1)	.003*
	yes	24	11.59	13	28.89		
Knowledge of what TIC considers as bad practices in treatment of traumatized minors	no	176	85.02	31	68.89	6.56 (1)	.010**
	yes	31	14.98	14	31.11		
Knowledge of PCA-TIC good practices in treatment of traumatized minors	no	176	85.02	28	62.22	12.46 (1)	.000***
	yes	31	14.98	17	37.78		
knowledge of what PCA-TIC considers as bad practices in treatment of traumatized minors	no	180	86.96	27	60.00	18.31 (1)	.000***
	yes	27	13.04	18	40.00		

* significant with p < .005
** significant with p < .05
*** significant with p < .001

3.4.8 Study and professional experience about effects of traumatic experiences

There are no significant differences between the Greek and Italian sample (Table 8).

TABLE 8. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN REPORTED STUDY AND/OR PROFESSIONAL EXPERIENCE ABOUT EFFECTS OF TRAUMATIC EXPERIENCES.

	Italy		Greece			
Option	n	%	n	%	χ^2 (df)	p
I have investigated the potential effects of the trauma on behavior and on the way, respondents relate to each other	81	39.13	26	57.78	5.59 (2)	.061
I have not had opportunity to investigate the potential effects of trauma, but I can imagine them	101	48.79	14	31.11		
I have not had opportunity to investigate the potential effects of trauma and I have difficulty imagining them	25	12.08	5	11.11		

3.4.9 Study and professional experience of using neutral and supportive language

There are no significant differences between the Greek and Italian sample (Table 9).

TABLE 9. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN REPORTED STUDY AND/OR PROFESSIONAL EXPERIENCE OF USING NEUTRAL AND SUPPORTIVE LANGUAGE.

	Italy		Greece			
Option	n	%	n	%	χ^2 (df)	p
I elaborated on topics of effective communication with traumatized minors only on theoretical level	49	23.67	7	15.56	3.37 (2)	.186
I have explored topics on theoretical level and i have been able to put them into practice	64	30.92	20	44.44		
I have not had the opportunity to elaborate on topics of effective communication with traumatized minors	94	45.41	18	40.00		

3.4.10 Study and professional experience of how to ask useful questions/managing interview without being judgmental or invasive

There are no significant differences between the Greek and Italian sample (Table 10).

TABLE 10. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN REPORTED STUDY AND/OR PROFESSIONAL EXPERIENCE OF HOW TO ASK USEFUL QUESTIONS/MANAGING INTERVIEW WITHOUT BEING JUDGMENTAL OR INVASIVE.

	Italy		Greece			
Option	n	%	n	%	χ^2 *(df)*	*p*
I elaborated on topics on how to effectively manage an interview and I was able to put them into practice	62	29.95	14	31.11	.63 (2)	.731
I went into more detailed on the techniques and I was able to put them into practice	73	35.27	18	40.00		
I went into more detailed on the techniques and I was able to put them into practice	72	34.78	13	28.89		

3.4.11 Study and professional experience of how to create individualized project respecting the characteristic of the person

There are no significant differences between the Greek and Italian sample (Table 11).

TABLE 11. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN REPORTED STUDY AND/OR PROFESSIONAL EXPERIENCE OF HOW TO CREATE INDIVIDUALIZED PROJECT RESPECTING THE CHARACTERISTIC OF THE PERSON.

	Italy		Greece			
Option	n	%	n	%	χ^2 *(df)*	*p*
I elaborated on topics only on theoretical level	42	20.29	14	31.11	2.64 (2)	.268
I elaborated on topics and I was able to put them into practice	79	38.16	16	35.56		
I have not been able to deepen on subjects and design techniques useful for the development of individualized projects	86	41.55	15	33.33		

3.4.12 Study and professional experience of "post-traumatic growth"

There is a significant difference between the Italian and Greek samples. Greeks reported a better knowledge about the post-traumatic growth topic, both at an experience level and at a theoretical one. A large percentage of the Italian sample (70%) reported to not have elaborated on the topic (Table 12).

TABLE 12. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN STUDY AND/OR PROFESSIONAL EXPERIENCE OF "POST-TRAUMATIC GROWTH".

	Italy		Greece			
Option	n	%	n	%	χ^2 *(df)*	*p*
I have investigated the topic "Growth from Trauma" and also those related to resilience and effective coping	32	15.46	15	33.33	14.78 (3)	.002 *
I did not elaborate on aforementioned subjects	145	70.05	18	40.00		
I learned the above issues on the field and today I feel well prepared	25	12.08	10	22.22		
I do not feel the need to develop further my knowledge on growth from trauma, resilience and effective coping	5	2.42	2	4.44		

* significant with $p < .005$

3.4.13 Study and professional experience to receive feedback on their ability to empathize with others

There are no significant differences between the Greek and Italian sample (Table 13).

TABLE 13. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN REPORTED STUDY AND/OR PROFESSIONAL EXPERIENCE TO RECEIVE FEEDBACK ON THEIR ABILITY TO EMPATHIZE WITH OTHERS.

	Italy		Greece			
Option	n	%	n	%	χ^2 *(df)*	*p*
Yes	153	73.91	30	66.67	.98 (1)	.323
No	54	26.09	15	33.33		

3.4.14 Study and professional experience to receive feedback on ability to deeply respect others

There are no significant differences between the Greek and Italian sample (Table 14).

TABLE 14. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN REPORTED STUDY AND/OR PROFESSIONAL EXPERIENCE TO RECEIVE FEEDBACK ON ABILITY TO DEEPLY RESPECT OTHERS WHEN THEY HOLD BELIEFS, VALUES, CULTURES AND BEHAVIORS DIFFERENT FROM THEIRS.

	Italy		Greece			
Option	n	%	n	%	*χ^2(df)*	*p*
Yes	152	73.43	30	66.67	.84 (1)	.359
No	55	26.57	15	33.33		

3.4.15 Study and professional experience of active listening

There are no significant differences between the Greek and Italian sample (Table 15).

TABLE 15. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN REPORTED STUDY AND/OR PROFESSIONAL EXPERIENCE OF ACTIVE LISTENING, THE ABILITY TO KNOW HOW TO LISTEN WITH A HIGH DEGREE OF ATTENTION AND COMMUNICATIVE PARTICIPATION WITH THE OTHER PERSON, PAYING ATTENTION NOT ONLY TO THE VERBAL MESSAGE BUT ALSO TO WHAT IS ALSO EXPRESSED NONVERBALLY.

	Italy		Greece			
Option	n	%	n	%	*χ^2 (df)*	*p*
I have experienced active listening techniques only on a theoretical level	34	16.43	6	13.33	.83 (2)	.660
I have explored the techniques of active listening on a theoretical level and i have been able to put them into practice	142	68.60	30	66.67		
I have not had the opportunity to explore in any way the techniques of active listening	31	14.98	9	20.00		

3.4.16 Perceived ability of establishing a good relationship with clients

There is a significant difference between the Italian and Greek samples. Italians reported more facility in establishing good relationships with almost all their clients. The Greeks reported more facility in establishing good relationships with a good portion on their clients. However, dichotomizing the categories (good capacities: the first two option; bad capacities, the other two) the significance is lost (Table 16).

TABLE 16. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN PERCEIVED ABILITY OF ESTABLISHING A GOOD RELATIONSHIP WITH CLIENTS.

	Italy		Greece			
Option	n	%	n	%	$\chi^2(df)$	*p*
Yes with almost all my clients	88	42.51	8	17.78	20.09 (3)	000*
With a good portion of my clients	101	48.79	29	64.66		
With some clients	6	2.90	7	15.56		
I don't know	12	5.80	1	2.22		

* significant with $p < .001$

3.4.17 perceived quality of relationships between colleagues

There are no significant differences between the Greek and Italian sample (Table 17).

TABLE 17. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN PERCEIVED QUALITY OF RELATIONSHIPS BETWEEN COLLEAGUES IN THE THEIR WORK TEAMS.

	Italy		Greece			
Option	n	%	n	%	$\chi^2(df)$	*p*
Supportive, we do an excellent team work	59	28.50	10	22.22	5.58 (4)	.232
Good enough, but we could improve	100	48.31	29	64.44		
There are various difficulties between us that prevent us from doing good team work	22	10.63	1	2.22		
I do not know	3	1.45	1	2.22		
I do not work in a team	23	11.11	4	8.59		

3.4.18 Perceived ability to manage levels of work stress

There are no significant differences between the Greek and Italian sample (Table 18).

TABLE 18. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN PERCEIVED ABILITY TO MANAGE LEVELS OF WORK STRESS.

	Italy		Greece			
Option	n	%	n	%	$\chi^2(df)$	*p*

Very high but I can manage altogether effectively	46	22.22	11	24.44	5.80 (4)	.214
Too high and this has a negative effect on me and the quality of my work	4	1.93	1	2.22		
Too high for everyone and this affects the members of the team and the quality of the work of our group	5	2.42	4	8.89		
Moderate and manageable	58	28.02	14	31.11		
There are stressors in periods of very intense work but after that there are less frenetic times in which we can recover	94	45.41	15	33.33		

3.4.19 Study and professional experience about young refugees

There are no significant differences between the Greek and Italian sample (Table 19).

TABLE19. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN REPORTED STUDY AND/OR PROFESSIONAL EXPERIENCE ABOUT YOUNG REFUGEES.

	Italy		Greece			
Option	n	%	n	%	χ^2 *(df)*	*p*
I further explored only at theoretical level	43	20.77	5	11.11	3.56 (1)	.169
I further explored at theoretical level and I also have professional experience	69	33.33	13	28.89		
I have not had the opportunity to further explore	95	45.89	27	60.00		

3.4.20 difference in empathy, deep respect and congruence

There is a significant difference between the Italian and Greek samples in the self-reported level of empathy. Greeks reported a lower level of empathy compared to Italians (Table 20)

TABLE 20. T-TEST TO CHECK FOR DIFFERENCES BETWEEN THE SELF-REPORTED LEVEL OF EMPATHY, (MIN 1 MAX 5) LEVEL OF DEEP RESPECT (MIN 1 MAX 5) AND, STUDY/PROFESSIONAL EXPERIENCE OF CONGRUENCE (MIN 1, MAX 3) IN GREEK AND ITALIAN PARTICIPANTS.

	Italy (n = 207)		Greece (n = 45)			
Item	m	*sd*	m	*sd*	t *(df)*	*p*
Level of Empathy	4.06	.76	3.67	.88	3.04 (250)	.003*

Level of deep respect	4.23	.69	4.02	.72	1.79 (250)	.075
Study/professional experience of congruence	1.27	.52	1.27	.50	.05 (250)	.963

* significant with $p < .005$

3.4.21 Reported difficulty in managing emotions

There is a significant difference between the Italian and Greek samples in the self-reported difficulty in managing impotence. Italian reported more difficulty in managing this emotion (Table 21).

TABLE 21. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN SELF-REPORTED DIFFICULTY IN MANAGING EMOTIONS.

		Italy		Greece			
Emotion		n	%	n	%	$\chi^2(df)$	p
Anger	yes	75	36.23	16	35.56	.01 (1)	.932
	no	132	63.77	29	64.44		
Hurt	yes	38	18.36	5	11.11	1.37 (1)	.242
	no	169	81.64	40	88.89		
Fear	yes	44	21.26	15	33.33	3.01 (1)	.083
	no	163	78.74	30	66.67		
Impotence	yes	118	57	11	24.44	15.68 (1)	000*
	no	89	43	34	75.56		
Envy	yes	13	6.28	6	13.33	2.64 (1)	.104
	no	194	93.72	39	86.67		
Other	yes	7	3.38	1	2.22	.16 (1)	.688
	no	200	96.62	44	97.78		

* significant with $p < .001$

3.4.22 self-reported interests to further explore some trauma-related areas

There are multiple significant differences between the Italian and Greek samples in self-reported interests to further explore some trauma-related areas of knowledge (Table 22), specifically:

- More Greeks reported interest in the Human Trafficking knowledge area.
- More Italians reported interest in the Geo-political context knowledge area.
- More Greeks reported interest in the Refugee rights knowledge area (this is peculiar: 0 Italian reported interest in this topic).
- More Greeks reported interest in the Working Alliance knowledge area.
- More Greeks reported interest in the Emergency Management knowledge area.
- More Italian reported interest in the TIC and PC-TIC knowledge areas.

TABLE 22. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN SELF-REPORTED INTERESTS TO FURTHER EXPLORE SOME TRAUMA-RELATED AREAS OF KNOWLEDGE.

		Italy		Greece			
Area of knowledge		n	%	n	%	$\chi^2(df)$	*p*
Cross Cultural Mediation	yes	55	26.57	15	33.33	.84 (1)	.359
	no	152	73.43	30	66.67		
Human Trafficking	yes	40	19.32	18	40.00	8.39 (1)	.003*
	no	167	80.68	27	60.00		
Geo-political context	yes	68	32.85	5	11.11	8.49 (1)	.004**
	no	139	67.15	40	88.89		
Communication and active listening	yes	73	35.27	19	42.22	.77 (1)	.380
	no	134	64.73	26	57.78		
Protection of fundamental human rights	yes	37	17.87	10	22.22	.46 (1)	.497
	no	170	82.13	35	77.78		
Refugee Policies	yes	35	16.91	13	28.89	3.44 (1)	.064
	no	172	83.09	32	71.11		
Refugee rights	yes	0	0	9	20	42.93 (1)	.000**
	no	207	100	36	80		

The rights of minors, rights of vulnerable respondents	yes	71	34.40	9	20	3.49 (1)	.062
	no	136	65.70	36	80		
Working Alliance	yes	28	13.53	13	28.89	6.40 (1)	.011***
	no	179	86.47	32	71.11		
Effective welcoming techniques	yes	50	24.15	15	33.33	1.63 (1)	.202
	no	157	75.85	30	66.67		

* significant with $p < .005$; ** significant with $p < .001$; *** significant with $p < .05$

TABLE 22 CONTINUED. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN SELF-REPORTED INTERESTS TO FURTHER EXPLORE SOME TRAUMA-RELATED AREAS OF KNOWLEDGE.

		Italy		Greece			
Area of knowledge		n	%	n	%	$\chi^2(df)$	p
Emergency Management	yes	57	27.54	30	66.67	25.04	000**
	no	150	72.46	15	33.33		
Conflict Management	yes	80	38.65	22	48.89	1.61 (1)	.205
	no	127	61.35	23	51.11		
Stress Prevention and Management	yes	66	31.88	12	26.67	.47 (1)	.493
	no	141	68.12	32	73.33		
Evaluation of PTSD	yes	81	39.13	12	26.67	2.47 (1)	.116
	no	126	60.87	33	73.33		
Treatment of PTSD	yes	95	45.89	15	33.33	2.37 (1)	.124
	no	112	54.11	30	66.67		
TIC	yes	90	43.48	10	22.22	6.98	.008***
	no	117	56.52	35	77.78		
PC-TIC	yes	108	52.17	16	35.56	4.08 (1)	.043****
	no	99	47.83	29	64.44		
Other	yes	5	2.42	0	0	1.11	.292

	no	202	97.58	45	100		

* significant with $p < .005$; ** significant with $p < .001$; *** significant with $p < .01$; **** significant with $p < .05$

3.4.23 Perceived efficacy of different training methods

There are multiple significant differences between the Italian and Greek samples in perceived efficacy of different training methods (Table 23), specifically:

- More Greeks reported interactive sessions to be an effective training method
- More Italian reported discussion debates to be an effective training method
- More Italian reported technical demonstrations to be an effective training method

TABLE 23. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN PERCEIVED EFFICACY OF DIFFERENT TRAINING METHODS.

		Italy		Greece			
Training methods		n	%	n	%	χ^2 *(df)*	*p*
Analysis and discussion of cases	yes	161	77.78	33	73.33	.41 (1)	.521
	no	46	22.22	23	26.67		
Frontal lessons	yes	50	24.15	6	13.33	2.50 (1)	.114
	no	157	75.85	39	86.67		
Interactive sessions	yes	86	41.55	30	66.67	9.39 (1)	.002*
	no	121	58.45	15	33.33		
Discussion debate	yes	66	31.88	7	15.56	4.79 (1)	.029**
	no	141	68.12	38	84.44		
Work in small groups	yes	81	39.13	24	53.33	3.07 (1)	.080
	no	126	60.87	21	46.67		
Technical demonstrations	yes	80	38.65	7	15.56	8.72 (1)	.003*
	no	127	61.35	38	84.44		
Supervision	yes	99	47.83	16	35.56	2.24 (1)	.134
	no	108	52.17	29	64.44		
Peer supervision	yes	44	21.26	12	26.67	.63 (1)	.429

	no	163	78.74	33	73.33		
Other	yes	1	.48	0	0	.22 (1)	.640
	no	206	99.52	45	100		

* significant with $p < .005$; ** significant with $p < .05$

3.4.24 willingness to study more in-depth topics related to traumatized young children

There are two significant differences between the Italian and Greek samples in self-reported willingness to study more in-depth topics related to traumatized young children (Table 24), specifically:

- More Greeks are interest to study in deep Physical trauma linked to war or accidents.
- More Italian are interest to study in deep Psychological trauma of various kinds.

TABLE 24. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE ITALIAN AND GREEK SAMPLES IN SELF-REPORTED WILLINGNESS TO STUDY MORE IN DEPTH TOPICS RELATED TO TRAUMATIZED YOUNG CHILDREN.

		Italy		Greece			
Topic		n	%	n	%	$\chi^2(df)$	*p*
Physical trauma linked to war or accidents	yes	77	37.20	25	55.56	5.17 (1)	.023*
	no	130	62.80	20	44.44		
Psychological trauma of various kinds	yes	170	82.13	30	66.67	5.39 (1)	.020*
	no	37	17.87	15	33.33		
Trauma resulting from genital mutilation	yes	54	26.09	13	28.89	.15 (1)	.700
	no	153	73.91	32	71.11		
Sexual abuse during war	yes	67	32.37	19	42.22	1.60 (1)	.227
	no	140	67.63	26	57.78		
Sexual abuse during the war	yes	82	39.61	17	37.78	.05 (1)	.819
	no	125	60.39	28	62.22		
Sexual abuse during trip	yes	86	41.55	19	42.22	.01 (1)	.934
	no	121	58.45	26	57.78		

Torture	yes	78	37.68	24	53.33	3.76 (1)	.053
	no	129	62.32	21	46.67		
Living long periods of time without caregivers	yes	94	45.41	24	53.33	.93 (1)	.334
	no	113	54.59	21	46.67		
Other	yes	3	1.45	0	0	.66 (1)	.417
	no	204	98.55	45	100		

* significant with $p < .05$

3.4.25 additional analyses

There is a significant difference between the mean of total number of self-report emotions difficult to manage in the Italian and Greek samples. Italians report to have problems in managing more emotions than Greeks (Table 25).

TABLE 25. χ^2 TEST TO CHECK FOR DIFFERENCES BETWEEN THE SUM OF THE TOTAL NUMBER OF REPORTED EMOTIONS PROBLEMATIC TO MANAGE, OF AREAS OF KNOWLEDGE OF INTEREST AND OF TOPICS TO STUDY IN DEEP IN GREEK AND ITALIAN PARTICIPANTS.

	Italy (n = 207)		Greece (n = 45)			
Item	m	*sd*	m	*sd*	t (*df*)	*p*
Total number of emotions which participants have difficulties in managing	1.43	.66	1.20	.46	2.17 (250)	.031*
Total number of areas of knowledge of interest	5.02	2,91	5.40	2.83	-.80 (250)	.425
Total number of topics to study in deep	3.43	2.12	3.80	2.44	- 1.02 (250)	.309

4. Conclusions

In general, the respondents have different levels of experience with trauma and minor affected by trauma.
Main elements regarding training needs appear to be:

- Elaborate on "topics of effective communication with traumatized minor"; many respondents (43,9%), in fact, didn't have the opportunity to elaborate on this topic.
- TIC and Person Centered Approach. More respondents don't know TIC (46,7%) and the Person Centered Approach - PCA-TIC (30,6%). This tendency is confirmed in the next items focused on good and bad practices regarding TIC and PCA-TIC. In particular, 84,7% don't have "knowledge of tic good practices in treatment of traumatized minors"; 81,2% don't have "knowledge of what tic considers as bad practices in treatment of traumatized minors"; 81,6% don't have "knowledge of what PCA-TIC considers as bad practices in treatment of traumatized minors.
- Communication: regarding "study/professional experience of using neutral and supportive language", 43,9% of respondents, "have not had the opportunity to elaborate on topics of effective communication with traumatized minors"
- Regarding "study/professional experience of growth for trauma", 64,7% of sample "did not elaborate on Growth from trauma".
- Training: 52,9% did not study "the potential impact of trauma on children and young respondents"; 87,8% didn't study "the screening and evaluation techniques to identify the trauma"; 89,4 didn't study "specific interventions for the treatment of trauma"; 69% didn't study "trauma linked to the migratory experience".

  Methodology: 76,9% of the respondents indicated that they prefer "analysis and discussion of cases" as training methodology.

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