How therapists cope with clients' traumatic experiences

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Abstract

An initial finding of high emotional stress in trauma therapists working in a specialized trauma institute led to three empirical studies on trauma-related therapist reactions. The purpose of these studies was to investigate the relation between high emotional burden and burnout, and the trauma-specific processes described by the concepts "secondary traumatic stress", "vicarious traumatization" and "traumatic countertransference".

The initial qualitative/quantitative study examined how a group of specialized trauma therapists (N=63) coped with clients' traumatic experiences. The results on trauma-related reactions were inconclusive.

This motivated a qualitative study of expert psychotherapists (N=11). Interviews with expert trauma therapists and other expert therapists were focused on reactions to the confrontation with traumatic experiences and differences between both groups of experts. Results indicated a specific reaction pattern to traumatic situations, but revealed no other differences between trauma specialists and other experts.

To further examine trauma-specificity of this reaction pattern, a third study was conducted with psychology students (N=100) using an experimental design. The results suggest the existence of a trauma-specific reaction pattern, characterized by shock, anxiety and the experience of being carried away by strong emotions. The relation of trauma reactions with traumatic situations is endorsed by results on differential reactions to traumatic and interactionally difficult situations, although results suggest that other kinds of situations with high emotional impact may also evoke trauma-reactions.

In the discussion the results are considered in relation to the limitations of the studies are followed recommendations for further research. Our results thus far support the high emotional impact of confrontation with traumatic material, but nuances psychopathological or other long-term negative changes that are suggested by the terms secondary or vicarious traumatization.

Key words: traumatic countertransference, secondary traumatic stress, vicarious traumatization, trauma therapy, psychotherapist

Introduction

Traumatic experiences are the ultimate confrontation with human vulnerability, ugliness and perversion. This is especially so in situations of interpersonal violence, war and persecution. They evoke great stress, anxiety, threat and helplessness, and disturb the foundation of someone's personal and interpersonal existence.[1, 2]

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In therapy with traumatized clients, the therapist becomes witness and in transference-countertransference enactments sometimes even part of the past dramas of the client. This cannot leave a therapist untouched, and since the nineties of the past century trauma therapists have sought to conceptualize the impact of trauma therapy on the therapist in his/her empathic connection with the client.

The sudden confrontation with clients' traumatic experiences may cause symptomatic reactions in the therapist that resemble the symptoms of the post-traumatic stress disorder – "secondary traumatic stress". In the long run these reactions may cause emotional exhaustion (as in burnout) of the therapist, described as "compassion fatigue".[3] The accumulated violation of existing (benign) basic assumptions by the trauma narratives of clients could cause "vicarious traumatization" – distortions of trauma-relevant cognitive schemas regarding safety, trust, esteem, intimacy and control.[4, 5] The high emotional and "forbidden" traumatic themes that emerge in the therapeutic relationship evoke strong emotional reactions and countertransference reactions, which gain a specific colour when they reflect the roles of the traumatic situation or dissociative reactions of the client.[5, 6] Whereas secondary traumatic stress reactions are described as relatively independent of therapist factors, cognitive distortions and countertransference reactions are viewed as the result of an interaction between clients' material and the personal make-up of the therapist. However, the distinctions between the different aspects of the therapist's process in reaction to clients' traumatic experiences is less clear than it seems in this description, and authors use the concepts often as (almost) synonymous.[7]

At the time we started our research, studies were scarce and valid instruments non-existent. Although this situation has changed during the last decade, trauma-specificity of these therapist reactions is still unclear, especially for cognitive distortions and countertransference.[8] The interest in the sources and dynamics of the high emotional burden reported by trauma therapists continues and this was the motivation of our first and subsequent studies. In short, the purpose of these studies was to investigate whether the high emotional burden reported by Centrum '45 therapists[9] was related to the confrontation with clients' traumatic experiences and how it related to burnout and to the trauma-specific processes described by the concepts "secondary traumatic stress", "vicarious traumatization" and "traumatic countertransference". Further, we aimed to clarify the short-term and long-term changes and coping strategies described by these concepts.

Study 1 – Emotional burden and burnout

The common factor in the concepts "traumatic countertransference", "secondary traumatic stress", and "vicarious traumatization" is that they are seen as effects of the stressful encounters with traumatized clients. Contextual and temporal elements in the descriptions of these concepts point to the possibility that they may be part and parcel of the therapist's coping process, of which emotional burden and burnout could be negative outcomes. Therefore, the framework we adopted for this study was an interactional coping model, as it relates to the normality of the stress-coping process as well as to the sequence and mediating factors of coping with traumatic stress.[2, 10] This model enabled us to temporarily step back from the known concepts, which still could be related to this coping process. It offered a structure for studying the actual coping process of

therapists and its influencing factors. Our research questions for the first study were:

1. What kind of difficulties do trauma center therapists experience in their clinical work?
2. Is emotional burden related to burnout?
3. Are there indications of traumatic countertransference, secondary traumatic stress or vicarious traumatization in trauma center therapists?

Method

Design

The study had an explorative, descriptive design, using qualitative and quantitative methods. It was conducted in Centrum'45, the Dutch national institute for treatment of victims of violence, war and persecution. Participants worked either in the department for survivors and veterans of the Second World War and their children (WW II department) or the department for traumatized refugees and asylum seekers (Refugee department).

Participants & procedure

Fifteen therapists participated in a semi-structured interview. They had different backgrounds (psychiatrist, psychotherapist, art or psychomotor therapist and milieu therapist) and different lengths of work experience in Centrum '45. The interviews started with the description by the therapists of two self-experienced difficult situations with clients, the therapist's own emotional reactions and coping behaviour, and reflections on helping and hindering factors in dealing with the situations. In addition, they filled in a questionnaire (see instruments). To ensure privacy of the participants, the interviews were conducted by an interviewer who was contracted for the study. Interviews were only available to the researchers after removal of all possible identifying elements in the transcribed text, which was analyzed according to the principles of grounded theory analysis.[11]

After this pilot phase the questionnaire was distributed amongst all employees of Centrum '45, including administrative and housekeeping staff. Ninety-two questionnaires were returned, a response rate of 72%. Forty percent of the respondents were male, 62% were over 40 years of age, 35% worked less than 3 years in Centrum '45 and 45% longer than 5 years. The therapist group consisted of 20 milieu therapists and 43 other therapists, including psychiatrists, psychotherapists, art or psychomotor therapists and social workers. Thirty-seven therapists worked in the WW II department and 25 worked in the Refugee department.

Instruments

The questionnaire contained instruments for burnout, work experience, situational strain, coping, resources, countertransference, sleep disturbances and nightmares, and cognitive schemas. Emotional burden was measured by a single item. Impact of a self-experienced difficult situation and the intensity of emotional reactions was measured by the STRess Appraisal INventory (STRAIN).[12] Work experience was measured by 4 item scales, including scales for role-clarity, loyalty to the organization, and the intention to change jobs.[12] For burnout we used the Dutch version of the Maslach Burnout Inventory.[13] Countertransference was measured with the Emotions Questionnaire (EMO), which was constructed for this study on the basis of existing literature on traumatic countertransference. It contained 5 items on awareness of countertransference reactions and 13 items in 3 subscales relating to role reactions, negative emotions and distancing.[14] We assumed that sleeping difficulties would first signal

secondary traumatic stress. Items relating to nightmares and restless sleep were taken from the Nightly Intrusions after Traumatic Experiences questionnaire (NITE)[15] as measures for secondary traumatic stress. Three subscales of the World Assumptions Scale (WAS),[16] Good World, Good People and Just World, were translated into Dutch and used in this study to evaluate cognitive schemas that are relevant to coping with traumatic experiences.[a]

Statistical Analysis

Analyses was mostly correlational, with t-tests or cross-tabulation used for comparisons between groups, Pearson correlations for relations between variables, and hierarchical regression analyses for the exploration of contributing factors in emotional burden and burnout.

Results

Difficult situations

The 15 therapists described a total of 44 difficult clinical situations. In 55% the difficulty was attributed to the psychopathology of the client: aggression, post-traumatic symptoms or other psychopathology. Therapeutic relationship difficulties accounted for 34% of the difficult situations and had to do with failing to establish a working alliance, anxiety of the client to start talking about past experiences and insufficient progress in the therapy. The last category of difficulties (11%) consisted of dilemmas for the therapist because of ongoing violence, double agenda of the client (for instance related to getting a refugee status in The Netherlands), or severe and unsolvable psychosocial problems.

In the quantitative study, therapists in the WW II department mentioned more often difficulties with colleagues or the organization, whereas therapists of the Refugee department more often reported client-related difficulties (Chi-square (3, 63)=8.44, $p<.05$).

Emotional burden and burnout

Emotional burden was higher in therapists than in administrative and housekeeping staff (45% and 11% respectively reporting high emotional burden) and higher in therapists working with refugees ($M=2.64$, $SD=.70$) than in therapists of WW II survivors ($M=2.22$, $SD=.67$), $t(60)=2.40$, $p<.05$). The level of emotional exhaustion of therapists of Centrum '45 was somewhat higher than in a general mental health (GMH) reference group:[17] Centrum '45 therapists $M=20.0$ ($SD=7.7$), GMH $M=17.5$, $t(58)=2.47$, $p<.05$. In contrast to the findings on emotional burden, burnout level was similar for both Centrum '45 therapist groups.

Two hierarchical regression analyses were conducted with emotional burden and burnout as dependent variables. Situation related factors (impact and total emotional strain) and work related factors (teamwork, role-clarity and loyalty) were entered as independent variables (see Table 1). Burnout was related to organizational stress (the wish to change jobs), whereas experienced emotional burden was primarily linked to work with clients (impact and role-clarity).

Traumatic countertransference, secondary traumatic stress and vicarious traumatization

Comparison of means did not reveal significant differences between the two Centrum '45 therapist groups with regard to total countertransference, countertransference subscales, on sleep disturbances or on basic

a) A more comprehensive description of the study and the instruments can be found in Smith et al.[12, 14]

Table 1. *Client related and work related contributing factors in experienced emotional burden and emotional exhaustion (burnout). Hierarchical regression (N=63).*

	Emotional burden			Emotional exhaustion		
variable	**B**	**SE B**	**ß**	**B**	**SE B**	**ß**
Step 1						
Impact	0.28	0.07	0.59***	0.60	1.03	0.11
Total Strain	0.00	0.01	0.08	0.23	0.10	0.41*
Step2						
Impact	0.24	0.07	0.50***	0.17	0.92	0.03
Total Strain	0.00	0.01	0.04	0.19	0.09	0.35*
Role-clarity	–0.07	0.03	–0.33**	–0.11	0.34	–0.04
Loyalty	0.03	0.03	0.14	–0.41	0.38	–0.14
Job change	0.01	0.03	0.03	1.06	0.34	0.42**

Emotional burden R2=0.42; Δ R2=0.10* for Step 2; Emotional exhaustion R2=0.24; Δ R2=0.25*** for Step 2; * p<0.05, ** p<0.01, *** p<=0.001

assumptions. However, Centrum '45 therapists' reported fewer negative feelings than client-centered therapists: trauma therapists M=14.2 (SD=3.5), client-centered therapists M=17.8 (SD=4.0), t(82)=4.4, p<.001. Client-centered therapists scored higher on disgust (p<.01), anxiety (p<.001), sorrow (p<.001), anger (p<.01) and feeling estranged (p<.05). A comparison of basic assumptions between trauma therapists and client-centered therapists showed a significant difference on the scale "goodness of people" (trauma therapists M=14.2 (SD=4.0), client-centered therapists M=16.1 (SD=2.6), t(82)=2.50, p<.05). Trauma therapists were more cynical about the goodness of people than client-centered therapists.

Discussion study 1

Although burnout levels were hardly higher than in other mental health professionals, the results on experienced emotional burden support the relevance of research on trauma-specific effects on therapists.

Since all of our participants worked primarily with traumatized clients, the situation categories represent different aspects of trauma-related difficulties. About 50% was related to post-traumatic psychopathology, and the differences between therapists working in the two departments suggest that severity of symptoms and a high level of psychosocial problems of the clients may contribute to emotional stress in therapists. However, the difference in emotional burden could also have been related to the pioneering situation in the new Refugee department. The higher level of problems with colleagues in the WW II department could signal parallel processes of the deeply engraved (dysfunctional) post-traumatic coping strategies of the clients. The difficulties in the therapeutic relationship and the dilemmas of the therapist suggest that the dynamics of the traumatic situation extend into the therapy. Most clients had the experience that talking was dangerous and even life-threatening and existential threat was not over for most of the asylum seekers who were waiting for the decision about their permit to stay.

Our results on specificity of the effects of trauma-related therapeutic difficulties were ambiguous. Although we found some differences in countertransference profile and basic assumptions, these results should be considered with caution because of differences in study designs between the Centrum

'45 and the client-centered studies (the latter were convenience samples for validation of the EMO and WAS).

These results, the lack of reliable instruments for measurement of therapist reactions to clients' material,[18] and serious doubts about trauma-specificity in the literature[8] motivated another explorative study. In this study, we set out to interview trauma therapists and other therapists (not specialized in trauma treatment) on their reactions to traumatic and other difficult clinical situations.

Study 2 – Trauma confrontations and other therapeutic difficulties

The previous study only explored reactions to their clinical work of a group of specialized trauma therapists working in the same institution. Despite precautions to ensure privacy, participants' narratives may have been influenced by the in-company character of the study. Symptomatic reactions and long-term negative changes were not prevalent in our qualitative material. However, these kind of semi-acute and long-term changes are the core of trauma-specific effects as described in the literature, with potentially strong negative impact on in-session therapist coping behaviour. So, we decided to pay more attention to semi-acute and long-term changes in relation to psychotherapeutic practice in the second study. Our investigation into trauma-specificity was two-fold: therapist reactions to traumatic situations and differences between specialized trauma therapists and other (non-specialized) psychotherapists.

Our research questions for this study were:

1. How do therapists react to traumatic material compared to other difficult situations?
2. Do trauma therapists and other psychotherapists differ with regard to their coping with difficulties in clinical practice?

Method

Design

The study had an explorative qualitative design, using in-depth interviews about therapists' own experiences of difficult clinical situations.

Participants & procedure

A convenience sample of five expert trauma therapists and six expert therapists working in regular psychotherapeutic practice participated in a 90 minute interview (conducted by the first author). The open structure of the interview (similar to that of study 1) allowed for personal accounts about the participants' reactions in emotionally taxing situations with clients and on long-term personal changes and coping with the stress of the profession. The experts had backgrounds as psychiatrists or psychologists and most of them were either psychoanalytic or client-centered psychotherapists.

Analysis

The audiotapes of the interviews were transcribed and subsequently analyzed according to principles of grounded theory analysis. The emerging categories of therapist reactions were used in a checklist to quantify the original interview material. This enabled frequency analyses and Multiple Correspondence Analysis (SPSS) of the data to explore patterns and clusters of therapist reactions.[19]

Results

Difficult situations

The grounded theory analysis resulted in three kinds of difficult situations: traumatic situations,[20] existentially difficult situations[7] and interactional difficulties.[9] In traumatic

situations the material of the client reflected traumatic experiences according to the DSM-IV A criterion for post-traumatic stress disorder.[1] Existentially difficult situations were those situations in which the therapist deeply felt the hopelessness of the situation of the client, whereas in interactional difficulties the main difficulty was in the strong emotional demands of the client on the therapist.

Therapist reactions

Therapist reactions were initially analyzed separately from the situational content, which resulted in 20 categories of reaction types. Almost all therapists mentioned that they experienced shock, anxiety, helplessness and intrusions, and that they ruminated about sessions, felt provoked, or were carried away by strong feelings of the client. They used talking with colleagues or others about their in-session experiences to unburden. In the Multiple Correspondence Analysis, most of these reactions clustered around traumatic situations. This result points to a trauma-specific therapist reaction pattern: shock, anxiety, feeling overwhelmed and carried away by strong feelings of the client, somatic reactions and talking. In existential situations therapists reported a strong sense of responsibility for the client or the therapeutic process. Intrusive experiences were not discriminating among therapists or different types of difficult situations. The other therapist reaction categories clustered as a function of the therapist's personal style in therapy.

Differences between expert trauma therapists and other expert therapists

Although we did find differences between therapists in relation to their work setting (therapists in private practice felt more responsible), no differences emerged between trauma therapists and other therapists within the expert group. A Multiple Correspondence Analysis of the combined quantified data of the interview material of the first and second studies revealed, however, differences between the group Centrum'45 trauma therapists and the experts. Therapists working in Centrum '45 reported more active interventions, whereas the expert therapists tended to more reflection and an experiencing position in therapy.[19]

Discussion of study 2

The results of the analyses of the quantified interview material showed a reaction pattern that was specifically related to the described traumatic situations. This pattern included anxiety, shock, somatic reactions and the feeling of being carried away, and being overwhelmed by the strong feelings of the client. This pattern was replicated in the combined analysis of the qualitative data of study 1 and study 2. Intrusive experiences were reported by all experts, but only in relatively few situations. They seemed not exclusively related to traumatic situations, as they were also reported in other situations with high emotional impact. Traumatic situations can be overwhelming, even for very experienced therapists, and work setting and other therapist characteristics seem to exert little influence on this reaction pattern.

Although this trauma pattern is highly arousing, our data do not suggest that therapists are traumatized by the confrontation with difficult traumatic situations. On the contrary, the expert therapists were all well-functioning and enjoying their profession. This reaction pattern may have contributed to the high emotional burden of Centrum '45 therapists, who are more frequently confronted with clients' traumatic experiences than the experts who had a lot of other tasks besides their psychotherapeutic work. How-

ever, the high emotional burden of Centrum '45 therapists did not lead to symptomatic reactions, indicative of secondary traumatization of the therapists.

Furthermore, the results of this study do not give clear support of long-term changes that colour in-session reactions of therapists to clients as conceptualized in the countertransference-vicarious traumatization cycle.[5] We found no differences in reaction patterns related to trauma specialization of the expert therapists. The difference between Centrum '45 therapists and expert therapists in therapeutic attitude (active versus reflexive/experiencing) may reflect a coping strategy with high emotional burden or with feelings of helplessness in face of the severe post-traumatic and existential problems of the clients. Other explanations are possible but cannot be decided on these analyses: reflections of an organizational culture, an interview artifact, or an effect of the different levels of experience of Centrum '45 and expert therapists.

Trauma-specificity thus seems probable for reactions to traumatic situations. Experience with particularly severely traumatized clients, combined with frequent confrontations may influence therapists' in-session reactions. However, our results oppose the view that long-term trauma therapy experience as such negatively influences therapist's well-being or in-therapy behaviour. Given the exploratory nature of our studies thus far, these results need to be tested in a controlled quantitative design.

Study 3 – Specificity of trauma-reactions

Specificity of reactions to different kinds of high impact clinical situations was the topic of the third study, the more active in-session behaviour by Centrum'45 therapists could reflect a coping strategy to alleviate the impact of trauma confrontations. Our research question for this study was:

1. Are trauma-reactions specifically related to the confrontation with traumatic experiences of clients?

Method

Design

The study had an experimental design, using four clinical vignettes as stimulus material. It was approved by the Ethics Committee of the Department of Psychology in the Faculty of Social and Behavioural Sciences at the University of Amsterdam.

Participants & procedure

Participants were psychology students (N=100, mean age 21.4 (SD 1.7), range 18-34 years), who received credits or a small financial compensation for their participation. After giving informed consent and completing a short demographic questionnaire, they viewed videotaped vignettes of enacted clients telling their therapist about a recent event. Two vignettes were Dutch translations of vignettes used in the Psychological Mindedness Assessment Procedure (PMAP),[20] showing clients with relational problems. Two vignettes were constructed for this study[a]. In one vignette, a refugee, doing fairly well, suddenly confronted her therapist with the traumatic story of the loss of her child during her flight. The second vignette showed a borderline client who first idealizes the therapist and then suddenly turns into a fierce rage, threatening suicide. The procedure followed the PMAP manual,[20] to which was added that participants reported their emotional reactions on a checklist after each

a) Both vignettes were constructed by Ton Haans, with cooperation of the first author.

viewing. Only the results of the emotional reactions on the two newly constructed vignettes are reported here.

Instruments

The Therapist Reactions and Emotions questionnaire (TREq) is a 20 item questionnaire developed to measure therapist emotions and behavioural tendencies in clinical situations. Intensity is scored on a 5 point Likert scale ranging from "hardly or not at all" to "very strongly". Items reflect the 20 reaction categories found in study 2; the five subscales reflect the clusters of therapist reactions. The subscale Responsible includes items about feeling more responsible than usual, engaged, fascinated or carried away by strong feelings of the client. The subscale Active Coping comprises ruminating as an attempt to find a solution, talking, asking advice, and attempts to change the situation of the client. The Trauma subscale includes shock, anxiety, intrusive images, and somatic reactions. Anger, sorrow, helplessness, and feeling provoked or manipulated are combined in a subscale Negative Feelings, and the subscale Distancing includes disconnecting from the client, limit setting, feeling a great distance, and emotional withdrawal of the therapist. The subscales are comparable with categories of countertransference found in other studies,[21] except for the trauma subscale which is specific for the TREq. Internal consistency of the total scale ranged from Cronbach's alpha .84-.87 over different vignettes, subscales alpha's from .53-.72. The TREq-total score differentiated neurotic vignettes and both vignettes with high emotional impact ($p>.001$). The Refugee and Borderline vignettes evoked significantly different scores on the TREq-subscales "trauma-reactions" ($p=.001$) and "distancing" ($p<.001$), which supports construct validity of the TREq.[22]

Analysis

We used multivariate analysis of variance (MANOVA) to study the effects of vignette-type on therapist reactions, with subsequent univariate analysis of variance (ANOVA) to study interaction effects.

Results

To investigate specificity of therapist reactions to different clinical situations, we conducted a MANOVA with the five subscales of the TREq as dependent variables and "vignette" (Refugee or Borderline) and gender as independent variables; age was entered as co-variate. We found a main effect for vignette on trauma-reactions ($F(1,192)= 8.15$, $p<.01$) and on distancing ($F(1,192)= 23.62$, $p<.001$). Trauma-reaction scores were significantly higher for the refugee vignette, whereas more distancing was related to the borderline vignette.

To study the relation between trauma-reactions and distancing, we created two groups of participants with respectively low and high scores on distancing reactions by using a median split on TREq-distancing. Gender, vignette and low versus high distancing were entered as independent variables; age was entered as co-variate. Again, a main effect for vignette emerged. The refugee evoked significantly more trauma-reactions than the Borderline ($F(1,192)=7.30$, $p<.01$). An interaction effect was found for gender and low/high distancing on trauma-reactions ($F(1,192)=4.46$, $p<.05$): male participants with high distancing also scored high on trauma-reactions, which was not the case for female participants whose scores were not related to high vs. low distancing. In addition, we found an interaction between vignette and low/high distancing on trauma-reactions ($F(1,192)=5.78$, $p<.05$).

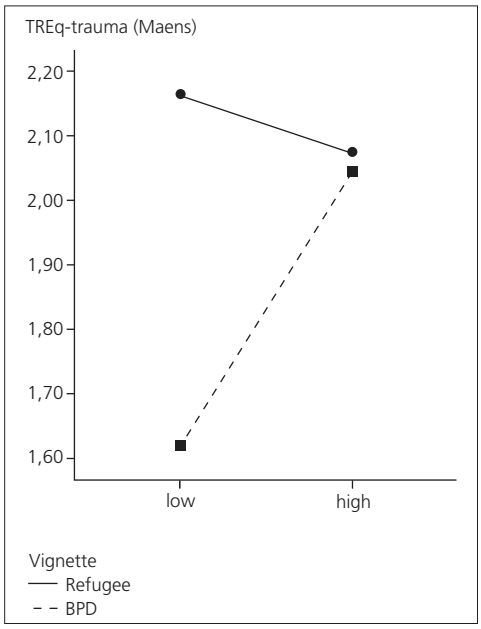

Figure 1 *Effects of vignette and low/high distancing reactions on trauma-reactions.*

Figure 1 shows the plot of this analysis. For the refugee, scores on trauma-reactions are high whether distancing is low or high. Although high distancing seems to alleviate trauma-reactions somewhat, the difference is not significant (no main effect for low/high distancing). In reaction to the borderline client, low distancing goes with low scores on trauma-reactions. However, participants with high distancing report significantly more trauma-reactions. Low scores on both trauma-reactions and distancing suggest low impact, whereas the combination of high distancing with trauma-reactions probably reflects a high impact of the borderline vignette on these respondents.

Discussion of study 3

In this study, of all possible therapist reactions, trauma-reactions and distancing emerged as specifically related to the refugee and the borderline vignette, respectively. The refugee client, whose narrative suited the criteria of a "traumatic situation", evoked mainly trauma-reactions, whereas participants reacted to the borderline client with distancing. Because we supposed that distancing could also be a coping strategy against high impact, we compared groups of participants with low or high distancing on trauma-reactions. Distancing was hardly functioning as a coping strategy with the traumatic situation. Instead, it seemed to be a sign of strong countertransference reactions to the borderline client. It is not to be decided on these data whether these strong countertransference reactions or the situation itself acted as "traumatic stimuli". These results suggest that trauma-reactions are related to a high impact of clinical situations on the therapist. However, although trauma-reactions are not exclusive for traumatic situations, it was not only the dominant reaction pattern in the traumatic situation of the experimental condition, but it was also not influenced by the level of distancing or by other reaction patterns. The summary conclusion of this study could then be that trauma-reactions are specific for, but not exclusively related to, traumatic situations.

Apart from the inherent limitations of an experimental analogue for generalizability of the results to therapeutic situations, our participants were psychology students and not therapists. This could influence the psychometric properties of the TREq, as well as the countertransference patterns evoked by the experimental vignettes. The study should be replicated with a therapist group, to account for this. Further, the TREq measures behaviour tendencies and emotional reactions to a clinical situation, but not cognitive countertransference reactions. These should

be included in a more comprehensive study on therapist reactions and coping with difficult clinical situations.

General discussion

The purpose of our studies was to investigate whether a high emotional burden of trauma therapists was specifically related to the confrontation with clients' traumatic experiences. Further, we aimed to clarify the trauma-specific effects on therapists: "secondary traumatic stress", "vicarious traumatization" and "traumatic countertransference".

The sequence of these three studies points to the relevance of further research on therapists' own experiences during psychotherapeutic practice, especially with traumatized clients. The first study differentiated burnout and emotional stress; the former was mainly related to organizational factors, the latter to clinical situations. Our findings lend empirical support for trauma therapists' reports of the high emotional impact of their work, and role clarity was identified as an important supportive work related factor.

The second and third studies identified a trauma-reaction pattern that was clearly related to the encounter with traumatized clients, although it was also evoked in other high impact situations. Trauma-reactions were related to traumatic situations rather than to therapist factors, which supports trauma-specificity of these reactions, and distinguishes them from countertransference (in the classical sense), in which the therapist's own conflicts play a decisive role. However, this does not mean that such a trauma-specific reaction pattern necessarily points to secondary traumatization of the therapist. The link with traumatic situations and post-traumatic reactions is emphasized in the term "secondary traumatic stress". An alternative naming as "confrontation anxiety"[23] symbolizes the sudden emotional impact and intensity of reactions to traumatic and other high impact situations, without pointing to a pathological process in the therapist.

The second study revealed no differences between expert trauma therapists or other expert psychotherapists, which suggests that at least these experienced trauma therapists had no signs of trauma-specific long-term negative effects of their work, described as "vicarious traumatization", showing in their reactions towards clients. This result could have been influenced by the experts' long-time and outstanding experience. They seemed to have found a balance in coping with the impact of clients' traumatic experiences. This may however be different for younger therapists. The difference between the expert group and the therapists of Centrum '45 suggests that therapeutic style may change with growing experience. Alternatively, the active therapeutic style could represent a coping strategy with the high exposure to traumatic material of Centrum '45 therapists. However, it is also possible that these results reflect the influence of underlying trauma-specific cognitive distortions signifying vicarious traumatization, or of organizational factors.

Further research should thus include trauma specialists as well as psychotherapists in regular psychotherapeutic practice of different levels of experience, and should investigate their reactions to emotionally neutral, traumatic and other high impact situations. This research focused on therapist reactions to difficult clinical situations, and specifically on behavioural tendencies and emotional reactions. Further research should also investigate the interaction between cognitive functioning and behavioural and emotional reactions, and the influence of the underlying emotional state of the therapist.

More research is also needed on the reaction patterns as operationalized in the TREq. A factor-analysis of the TREq-items could possibly refine the differential reactions to high impact situations in general and traumatic situations.

Departing from the concepts "traumatic countertransference", "secondary traumatization" and "vicarious traumatization", our research has covered a broader field. Our studies underscore how an empathic connection with severely traumatized clients naturally gets to the therapist. Although stressful, this inescapable part of the psychotherapeutic profession can possibly turn into a personally enriching experience for the therapist, as most of the therapists told us. But a therapist cannot do it on his/her own. A supportive professional environment may make the difference between growth and burnout, which is a message for both therapists themselves as well as for the organizations in which they work.

Acknowledgements

Primarily, we thank the therapists who were willing to invest their time participating in these studies. Moreover, we are grateful for, and were often moved by, the very personal way they shared their personal experiences and their vulnerabilities in their clinical work.

Centrum '45 generously supported the studies, for which we are thankful.

The third study was conducted with enthusiasm and efficiency by Greta Groen, Willie Burgman and Eva van Steenbergen. They gathered the data and did the first analyses, for which we want to acknowledge them.

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