

**SECONDARY TRAUMATIC STRESS IN PSYCHOTHERAPISTS
WORKING WITH SURVIVORS OF VIOLENCE**

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Abstract

This study examines the consequences of working with survivors of violence on psychotherapists from Guatemala, Germany and Switzerland. This work reviews relevant literature associated with secondary traumatic stress (STS) and related variables (compassion fatigue, vicarious traumatization, countertransference and burnout). The concept of trauma-focused vs. symptom-relieving working style is introduced and discussed. The results indicate that psychotherapists in Guatemala have greater risk for developing STS than their colleagues in Germany and Switzerland. Guatemalan therapists also showed having less regular supervision than therapists in Germany and Switzerland. Three factors found in the factor analysis explain more than fifty percent of the variance in this sample. Suggestions for further research and preventive measures are identified.

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1. Introduction

This work will try to help understand the relevance of psychological care among psychotherapists. It tries to grasp the “certain something” that psychotherapeutic professionals working with traumatized patients do feel at some point during their career. It is “something” that not every professional is prepared to admit. Probably, because psychotherapists think that they should, of course, know how to deal with it; at least this is what they think people would expect from them. But to expect that a doctor will never need the science of medicine to treat his own illness is naive. In an analogous way, the psychologists and other professionals that care for others will have to utilize the science of psychology for keeping their own psychic health. There naturally are techniques and recommendations for preventing and healing secondary traumatization in psychotherapists. But this will be discussed at the end of this paper. Let us start with the beginning of psychotraumatology.

Findings about psychological trauma emerge from the investigation of the long-term effects of war, torture, rape, family abuse, natural disasters, accidents, hostage taking, and death of loved ones. In other words, research on post-traumatic stress disorder. Special attention was paid to Vietnam veterans and what would be the most effective treatment for the psychological scars inflicted upon them by that war. Yet, this missed something important. What about the people who take care of these traumatized persons, the ones that perform those treatments? If the simple knowledge that a loved one has been exposed to a traumatic event can be traumatizing, and denotes some kind of indirect or secondary exposure; why should the professional be excluded from this group? Judith Herman (1992) suggests that post-traumatic stress disorder could be viewed as contagious, requiring precaution for the protection of the therapist.

Evidently, patient and therapist are not in the same condition. First, psychotherapists were trained to do their job, thereby giving them the aid of specialist means by which to handle or cope with what they hear from their patients. Second, trauma in the context of an institution specialized in helping the traumatized does not put up the professional to live such extreme situations as named above, but to listening to and see the consequences of traumatic events in the traumatized person. Therefore, it should not be as traumatic, given the fact that the professional knows he or she will have to deal with these sorts of topics. A therapist knows what kind of client will enter the office next. So

we are not talking about an *unexpected* event, it is not a direct nor an intense stressor. It is not a first hand traumatization, but one could call it a second hand traumatization. As a result, it is necessary here to draw a line between post-traumatic stress disorder (PTSD) and secondary traumatic stress or secondary victimization. Quoting Figley: “the difference between PTSD and secondary traumatic stress disorder (STSD) is that the latter can be more directly tied to adjustment and recovery of the traumatized person: As the sufferer improves, the supporter experiencing STSD improves” (Figley, 1996, p.571). Just as PTSD is viewed as a normal reaction to an abnormal event, secondary traumatization can be viewed as a normal reaction to the sometimes traumatizing work with victims of violence.

The bulk of research about secondary traumatization points out the following: psychotherapists face an occupational hazard which is not present, in this same manner, in most other occupations. Health professionals process people and they deal with them in situations which have profoundest implications for any human being.

Literature on burnout and countertransference suggests that psychotherapists are vulnerable to experiencing stress as a result of their jobs. “Also included are professionals exposed in the line of duty to traumatized people. These professionals include emergency medical, fire and safety personnel; child protection workers; disaster relief workers; and mental health professionals” (Figley, 1996, p.571). While many individuals who work with trauma survivors experience an enhanced sense of meaning, self-esteem, respect for the strength of others, and connection with humanity, research is beginning to show that, for some individuals, working with trauma survivors, under certain conditions, may have negative effects. Those who work with survivors may begin to show signs of stress disorders ranging from difficulty sleeping to look-alike post-traumatic stress symptoms such as intrusive thoughts, avoidance, and heightened reactivity. I will refer to this phenomenon as secondary traumatization. For me this is the best term to name the psychological reactions a health care worker has as a normal result of stressful and from time to time traumatizing work with victims. It is a somewhat harsh term, but I think this is exactly what is needed. Therapists are not taking this hazard very seriously and this term retains all the risk, distress and attention it urges to emphasize. So in this work secondary traumatization (ST) will be used interchangeable with secondary traumatic stress, secondary traumatic stress disorder and all of the other arisen terms which will be discussed in detail throughout this section.

In the sections following this, namely methods, results and discussion, we will examine secondary traumatization in psychotherapists working with victims of violence. We will differentiate between trauma-focused and symptom-relieving therapists, between the countries where they work and also supervision in regard with ST. But since most participants did work in an institution for victims of organized crime, as torture and internal conflict is; we will now focus our attention to that particular group of therapists who work with these populations.

1.1 Working with torture victims

Due to the fact that two thirds of the psychotherapists who took part of the interviews did work in a research or treatment centre for torture victims, it seems important to illustrate how work in these centres is. Work with torture victims is a topic that does not leave anybody unaffected. Torture and psychotherapy are antipodes: whilst therapy intends to free people from their suffering, torture oppresses human beings and consciously causes them pain. Therapy promotes the autonomy of humans, torture purposes total dependence. Therapy means development and growth, torture spoliation of the radiance of the psyche and mutilation of the body (Lansen, 1996).

Normal therapeutic work helps people that somehow had a bad fate, victims of an illness or that have an unhappy and miserable life history. As terrible as this may be, it is not comparable with what is found in torture victims: women, children, and men that were systematically “mal-treated” as a product of human hands; these are man-made atrocities! “We are from the same human genus than the torturers; they are not the devil and we are not an angel” (Lansen, 1996, p. 253).

‘How can you bear it?’ ‘How can you keep being a spectator to these stories?’ these are often queries done to therapists. There is no answer from professionals to such personal questions. “Of course this work does something to us” (Lansen, 1996, p.254). It can steal the sleep, give burnout, turn you into an onerously person and change the conduct at home and with colleagues. You can get the same symptoms as your patients: stress, tension, depression and peculiar fears. But this work can also elevate you from the small details in everyday life; expedite your spirit and creativity. It can conciliate you with imperfections from others and yourself. It can turn us into supportive and wisely human beings.

When therapists get in contact with torture indirectly, it may be possible that they can not assimilate this experience for a period of time; the identification with the person that could not digest the torture experiences can reveal itself as devastating. But the same as the victim, the therapists can always again gain distance, and anew cautiously come near to the horror. For this process the therapists also need help. Progressively they learn to get hold of the horror, withstand, and become 'containers' for emotions of mourning, pain, humiliation. Together with the patient they can 'digest' the patient's traumatic experiences (Lansen, 1996).

Some aspects that make the treatment of this specific population more difficult are the outlasting symptoms, like depicted by Judith Herman (1992); comorbid diagnosis, for example depression and compulsive behaviours; and disturbed affections (reduced tolerance, regression, lost of capacity to feel and perceive and find words for them). Even the diagnosis of depression seems to stay too short. Colleagues in The Netherlands talk about "existential emotional syndrome" for this population. Because of the high vulnerability of torture victims, there seems to be a predisposition for new traumatizations. The inner, psychic world of the patient can be permanently disrupted by a 'victim attitude', a pattern of aggression and mistrust. These structures may belie underneath the outward appearance. This can impair the intimate sphere in interpersonal relationships (partner, children). Comparably, therapists who work with tortured patients also suffer these impairments and are indirect victims of the traumas. In a long term perspective, the recurring fact of confronting the dark sides of humanity with terrifying forms of oppression and injustice will change fundamentally the person's self, human and world image (Lansen, 1996). As seen with holocaust survivors, not pursued partners and children born after the release can be indirectly affected. In a similar way this also happens in the therapeutic relationship. The client unintentionally engages the psychotherapist into relational aspects that resemble or are a repetition of his or her traumatic story.

Professionals and honorary workers in this humanitarian vocation often are involved in all aspects of their clients' problems, also in problems of their supplying and organization. Especially in this problematic, there is low comprehension and light discernment from the outside world. It is pertinent to mention that the political contexts relevant to this work are different in Europe than in Latin America; therapists interviewed in Guatemala complained about other things than those interviewed in Germany and

Switzerland. Treatment facilities frequently have to carry out extraordinary tasks (in which therapists also happen to participate) with rather limited resources. These centres generally have a status outside the ordinary healthcare and social aid system. Instead of receiving public subvention, as it would be expected in a social state nation, the centres have to gather their own money and therefore also take care of their public relations. At the same time it is requested from them to undertake research and provide public dissemination and social events; to host visitors from other fields of public health services; and to express an opinion to a lot of socio-political and cultural happenings.

In treatment centres for torture victims in Europe, there often emerge problems to the patients that go beyond the torture experience. There are difficulties in adjusting to the foreign country and unfamiliar culture. Troubles occur in regard to residence status and language problems. Moreover, the refugees have incurred gravely losses of friends and relatives, work and reputation. In a lot of families, there are complicated problems of relationship and health. Some centres even indicated to get threats from right wing radicals and very less financial support from their governments. But this hostile posture from governments is also felt in Guatemala. Moreover, and to picture the political circumstances lived, it has been demonstrated that the Guatemalan army carried out a systematic and intentional genocide against the indigenous Maya population (compare Sanford, 2003; Archdiocese of Guatemala, 1999). This should illustrate the working conditions and external stressors under which health workers have to work at these kinds of centres.

Under such conditions, therapists and other high motivated health workers can get much burdened. The concept of burnout is not sufficient to describe the consequences of working with tortured victims. There have been attempts to explain the cause of burnout or STS, for example in the vulnerable personality of each individual therapist (idealists with good heart that take over too much pain). This may be true for just a minority of the cases. Another explanation aims on the feelings of countertransference from the psychotherapists. This is an uncontrolled reaction of the stories, thoughts and conduct from the patients, which rest on the “weak” points of the own therapist. Further, another cause is said to be the over or far reaching identification with the patient added to an absent distance.

I hope to assay with a concept that is relatively new in the field of Psychology. It would be devastating to loose good mental health professionals due to burdensome work, or better said, to the fact that they are just unable to manage the overwhelming conditions of their occupation in a productive way. It is a logic assumption to believe that, as Figley says it, "those who have enormous capacity for feeling and expressing empathy tend to be more at risk of compassion stress" (Figley, 1995, p.1).

As Hudnall Stamm (1997) precisely indicates it, "the great controversy about helping-induced trauma is not 'Can it happen?' but 'What shall we call it?' ". While this area of research is relatively new, researchers in the past have coined a number of terms to describe the effects of working with trauma: copathy (Launglin); identification (Brill, Freud); sympathy (Veith); psychogenic illness (Colligan & Murphy); countertransference (Haley); and more recently burnout (Freudenberger); co-victimization (Hartsough & Meyers); secondary survivor (Remer & Elliot); emotional contagion (Miller, Stiff & Ellis); rape-related family crisis (Erickson); "proximity" effects on female partners of war veterans (Verbosky & Ryan); generational effects of trauma (Danieli); the need for family "detoxification" from war-related traumatic stress (NiCathy, Merriam & Coffman); vicarious traumatization (Pearlman & McCann); secondary catastrophic stress reactions, secondary victimization, secondary traumatic stress disorder, compassion stress and compassion fatigue (Figley); and secondary traumatic stress (Stamm). In 1995 three books were published by each of the latter authors conducting to a "triadic cross-fertilization: each person's work appears in the other two books" (Stamm, 1997). Some of these terms, the most relevant for nowadays, to explain the changes mental health workers may observe in themselves as a result of witnessing the effects of traumatic events on others, will be described below.

1.2 Definitions

Field-specific literature emerged as early as 1980 in relation to emergency service workers. Psychotraumatology is a new emerging field within Clinical Psychology. A recent review of *Psychlit* journal articles found only 17 peer-reviewed articles on secondary traumatization (Stamm, 1997). Of these, only 12 contained data, and the majority of these were descriptive in nature. But papers in this field do not attempt to create a specific diagnostic or nomological term for worker-related stress.

During the 80's Figley called the secondary traumatic stress phenomenon 'secondary victimization'. Although he thinks secondary traumatic stress and secondary traumatic stress disorder are the latest and most exact descriptions of what has been observed amongst trauma therapists, he proposes compassion stress and compassion fatigue as the friendliest terms for this phenomenon. Since some discomfort might arise from a concern that secondary traumatic stress is a derogatory label. Plus, feeling the stress and fatigue of compassion in the line of duty as a health worker better describes the causes and signs of their duty-related experiences (Figley, 1995).

H. Stamm proposed the term 'secondary confiding' at the First World Conference of the International Society for Traumatic Stress in Amsterdam (June, 1992) which did not appeal to a broad audience and had to be retrieved. Another term that showed up was 'indirect-trauma'; in consequence, although there has been a sudden increase in the literature, there is no uniform designator. Even the descriptive definition becomes a matter. Does this apply only to those who are professionals, or also to volunteers and all type of health care providers? To researchers? Are emergency workers exposed directly or secondarily because of another's trauma? These are unanswered questions. Probably, taxonomy will emerge as consensus arises from use (Stamm, 1997).

Most of the constructs and concepts are clearly neither differentiated nor operationalized. The differentiation, while possibly academic, certainly is elusive. In an attempt to get a better overview between these concepts, it may be helpful to recall Figley (1995) where he assigns secondary traumatic stress as compassion stress and stress disorder to compassion fatigue. Stamm (1997) suggests secondary traumatic stress as the broadest term; with other terms, such as compassion fatigue and vicarious traumatization and some forms of countertransference, serving as specific types of secondary traumatic stress. At this point, none of the terms seems truly satisfying for describing helper-encounters with another's traumatic material.

To understand how such work affects providers of mental health it is important to understand burnout and compassion fatigue (Rudolph, Stamm & Stamm, 1997) and all other thoughts that have emerged with the research in this field. At the end of this section I will present the lesser propagated explanation models from Johan Larsen, and Wilson and Lindy. The first model is based on the psychoanalytic object relation theory. The latter emphasizes the particular empathy and identification.

Countertransference

Countertransference (CT) is a term originally used in psychodynamic therapy to describe the emotional reaction to a client by the therapist. It is an over identification with the client or a process of meeting needs through the client. Freud defined it as the distortion on the part of the therapist resulting from the therapist's life experiences and associated with her or his unconscious, neurotic reaction to the client's transference.

Interventions that tend to satisfy the psychotherapist's unconscious needs lead to CT, a situation in which the therapist is incapable of maintaining the limits of the therapy and of working with the projections of the patient's psychic world (Bustos, 1990).

"Johansen suggests that a more contemporary perception of countertransference views it as all the emotional reactions of the therapist toward the patient -regardless of their sources. These sources include, for example, life stressors experienced by the therapist. But they also include the traumata expressed by the patient and absorbed by the therapist" (Figley, 1995).

Yet, McCann and Pearlman assume that countertransference is too narrow because it does not address the lasting and pervasive schema alterations. Moreover, it is a term that describes what every therapist can feel during therapy; it is not specific for therapy with traumatized patients only. However, countertransference and vicarious traumatization affect one another. "Vicarious traumatization changes the self of the therapist, which is the context for all countertransference responses" (Saakvitne & Pearlman, 1996, p. 48). CT affects vicarious traumatization because it influences the therapist's and patient's expectations. "Countertransference is present in all therapies, but is specific to a given client and the particular therapist-client dyad" (Saakvitne & Pearlman, 1996, p. 46). Countertransference is temporarily linked to a peculiar period, event or issue in the therapy or in the therapist's inner or external life as it interacts with therapy.

In contrast to compassion fatigue, CT is a chronic attachment associated with family of origin relationships and has much less to do with empathy toward the client (Figley, 2002a).

Burnout

STS is also frequently cited as 'burnout'. An examination of the etiology of burnout shows increased work load and institutional stress as the precipitating factors, and not trauma (Stamm, 1997). Furthermore, burnout concentrates specifically on (work) stressors rather than behavioural changes and emotional effects.

The construct of burnout is far better developed both in theory and in measure validation than are the trauma-related constructs. Maslach provided the most widely used construct definition plus the best validated measure of burnout (The Maslach Burnout Inventory, MBI). They contain and measure three domains, namely a syndrome of emotional exhaustion; depersonalization; and reduced personal accomplishment. The initial over involvement and emotional exhaustion then leads to withdrawal into depersonalization of clients and poor service delivery which, along with problematic workplace conditions such as work overload and lack of social support, may reduce job satisfaction from personal accomplishment by producing feelings of inadequacy toward the job and clients and a sense of failure that lowers self-esteem (Jenkins & Baird, 2002).

Moreover, "Kahill (1988) identified five categories of symptoms: physical (...), emotional (...), behavioural (...), work-related (...) and interpersonal (...)" (Figley, 1995, p.12). "Burnout is conceptualized as a defensive response to prolonged (...) and demanding interpersonal situations that produce psychological strain and provide inadequate support" (Jenkins & Baird, 2002, p. 424). Other of the many definitions of burnout refer to it as "a syndrome indistinguishable from depressive neurosis (Pines and Aronson, 1981), while others define BO as (...) fatigue or frustration brought by devotion to a cause, way of life or relationship that failed to produce the expected reward (Freudenberger and Richelson, 1980)" (Margison, 1987, p.108). "Burnout is a gradual wearing down of the provider by the feelings of being overwhelmed by one's work and incapable of effecting positive change" (Rudolph, Stamm & Stamm, 1997).

Lansen (1996) enumerates some BO symptoms: apathy, feelings of hopelessness, rapid fatigue, disillusion, melancholy, forgetfulness, irritability and feeling as if work is a heavy weight. These symptoms will be probably combined with physical manifestations such as lack of appetite, sleeping disorders, and persistent colds (Bustos, 1990). In a team where BO is existent, there is neither liveliness nor activeness. The energy is lost

by nagging and whining; the lament about the external world or the management; fight and discussion about the distribution of work. The true tasks impend to be neglected.

As Laurie Anne Pearlman said during a conversation we had at the VIII European Conference on Traumatic Stress in Berlin (May, 2003) burnout can be defined as 'a gap between my expectations and what I am capable to do, and the expectations of my boss'.

Secondary traumatic stress and compassion stress

Secondary traumatic stress (STS) is defined as "the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other –the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995, p. 7).

Charles Figley coined the term compassion stress as a "non-clinical, non-pathological" way to characterize the stress of helping or wanting to help a trauma survivor. Compassion is defined as a feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its cause. Compassion stress is defined as the natural behaviours and emotions that arise from knowing about a traumatizing event experienced by a significant other - a client, friend, or family member. It can be of sudden onset, and the symptoms include: helplessness, confusion, isolation, STS symptoms (Figley, 1995).

Theory predicts that professionals affected by STS are at higher risk to make poor professional judgments than those professionals who are not affected (Pearlman & Saakvitne, 1995). Examples of poor professional judgement could include misdiagnosis, poor treatment planning, or abuse of patients. To the contrary, STS theory predicts that personal, professional and organizational support may provide protective factors to mediate some risks for developing STS (Rudolph, Stamm & Stamm, 1997).

"In contrast to burnout, (...) STS (compassion stress) can emerge suddenly with little warning" (Figley, 1995, p. 12). Additionally, and different to burnout, STS includes a sense of helplessness and confusion, and a sense of isolation from supporters; the symptoms are often disconnected from real causes, and yet there is a faster recovery rate.

Secondary traumatic stress disorder and compassion fatigue

Secondary traumatic stress disorder (STSD) is a syndrome of symptoms nearly identical to PTSD, except that knowledge about a traumatizing event experienced by a significant other is associated with the set of STSD symptoms, and PTSD symptoms are directly connected to the person experiencing primary traumatic stressors (Figley, 1995).

While compassion stress is not a disorder yet, compassion fatigue (CF), also coined by Figley (1995), is considered to be identical to secondary traumatic stress disorder and is the equivalent of post-traumatic stress disorder. Compassion fatigue is a more severe example of cumulative compassion stress. It is defined as “a state of exhaustion and dysfunction, biologically, physiologically, and emotionally, as a result of prolonged exposure to compassion stress” (Figley, 1995, p. 34). “Compassion fatigue, like any other fatigue, reduces our capacity or our interest in bearing the suffering of others” (Figley, 2002a, p. 1434).

“CF develops as a result of the provider’s exposure to their patients’ experiences combined with their empathy for their patients” (Rudolph, Stamm & Stamm, 1997). CF is a sudden and acute state. Burnout may be an important risk factor for compassion fatigue. And with regard to countertransference, STS includes but is not limited to countertransference.

In 1995 Charles Figley proposes four reasons why trauma workers are vulnerable to compassion fatigue: empathy; traumatic events experienced at some point during their lives; unresolved traumas that activate by reports of similar trauma in clients; and trauma work with children. In a newer paper, Figley (2002a) expanded these initial considerations to the point that empathy and emotional energy are the driving force in effective working with the suffering in general; establishing and maintaining an effectively therapeutic alliance; and delivering effective services including an empathic response. This, plus the following eleven variables build a causal model that predicts compassion fatigue: empathic ability, the aptitude of the psychotherapist for noticing the pain; empathic concern, the motivation to respond to people in need; and exposure to the client (direct exposure) are preconditions for the empathic response, meaning the effort to reduce the suffering of the sufferer through empathic understanding. Compassion stress is the residue of emotional energy from the empathic response and

the on-going demand for action to relieve the suffering of a client. Like any stress, with sufficient intensity it can have a negative effect on the human immune system. Together with other factors it can contribute to compassion fatigue unless the psychotherapist acts to control the compassion stress. There appear to be two major sets of coping actions to this: sense of achievement, the extent to which the therapist is satisfied with his or her efforts to help the patient. And disengagement, the degree to which the therapist can distance him or herself from the ongoing misery between sessions. It is the psychotherapist's recognition of the importance of self-care and the responsibility to carry out a deliberate self-care program (see Figure 1).

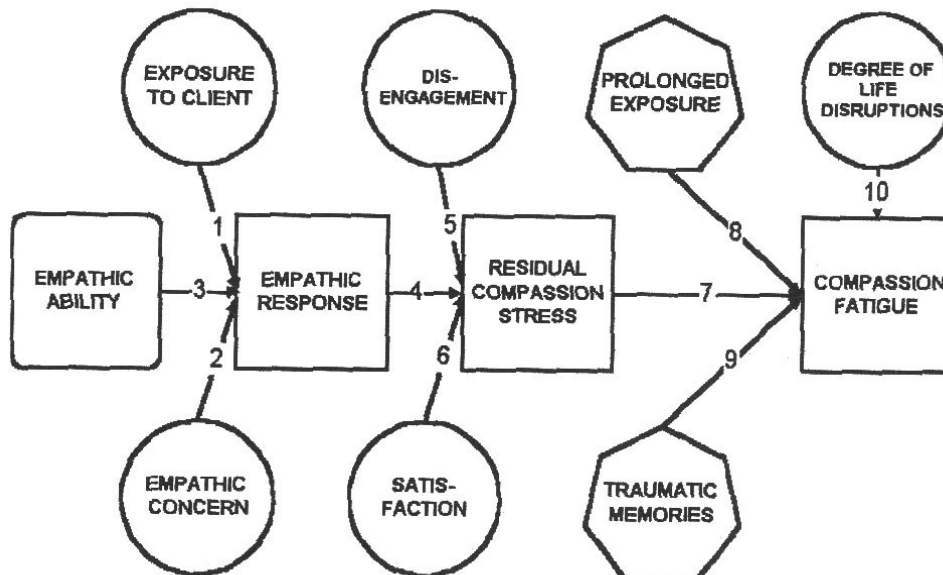


Figure 1: Compassion stress and fatigue model (Figley, 2002, p. 1437)

If compassion stress is permitted to build up, and the subsequent three other variables are present, the therapist is at great risk of compassion fatigue. One of the variables is prolonged exposure, meaning an ongoing sense of responsibility for the care of the suffering, over a protracted period of time. Traumatic recollections are memories that trigger the symptoms of PTSD and associated reactions, such as depression and anxiety. These memories may be from the psychotherapist's experiences with other, rather demanding or threatening clients. And the last variable of the chain that cause CF is life disruption, the unexpected changes in schedule, routine, and meaning life responsibilities that demand attention (e.g. illness, changes in life style, professional or personal obligations). Normally such disruptions create a certain but tolerable level of distress. However, when combined with the other variables, these disruptions can increase the chances of developing compassion fatigue (Figley, 2002a). This model has

also a preventive value, for each variable has an indication of what it requires to prevent it.

STS or STSD (and their counterparts', compassion stress and fatigue) are a natural consequence of caring between two people, one of whom has been initially traumatized and the other of whom is affected by the first's traumatic experience. These effects are not necessarily a problem but a natural by-product of caring for traumatized people.

A harsh critic to the instrument for measuring CF, Compassion Fatigue Self-Test for Psychotherapists (CFST), comes from Jenkins and Baird (2002), when they write that the depathologizing term compassion fatigue invites to misinterpretations from a content validity standpoint because most of the CF scale items query trauma symptoms and experiences, and none evaluate compassion or fatigue. That study also suggests that the CFST-Burnout subscale in particular needs re-examination or conceptual reformulation; its low correlation with the Maslach Burnout Inventory "makes it a questionable measure of burnout" (Jenkins & Baird, 2002, p. 431).

Vicarious Traumatization

"In an effort to describe the effects trauma work can have on psychotherapists, McCann and Pearlman (1990) coined the term vicarious traumatization" (Pearlman & Mac Ian, 1995, p. 558). This concept is an attempt to describe those permanently transformative and inevitable changes that result from doing therapeutic work with trauma survivors. In their research, the authors noted that a number of changes were common among those mental-health workers who had clients that were survivors of traumatic events. "A transformation of the helper's inner experience, resulting from empathic engagement with clients' trauma material" (Saakvitne & Pearlman, 1996, p. 40).

Vicarious traumatization (VT) is conceptualized within constructivist self development theory (McCann & Pearlman, 1990). This theory of personality "blends contemporary psychoanalytic theories (self-psychology and object relations theory) with social cognition theories to provide a developmental framework for understanding the experiences of survivors of traumatic life events" (Pearlman & Mac Ian, 1995, p. 558). "The underlying premise is that human beings construct their own personal realities through the development of complex cognitive structures [Piaget called them schemas] which are used to interpret events" (McCann & Pearlman, 1990, p. 137). Constructivist

self development theory views individuals' adaptations to trauma as interactions between their own personalities and salient aspects of the traumatic events, all in the context of social and cultural variables that shape psychological responses. According to the theory, the aspects of the self that are impacted by psychological trauma are:

- a) frame of reference: believes through which the individual interprets experiences; meaning identity, world view and spirituality (includes also awareness of non-material life aspects).
- b) Self capacities: abilities that enable the individual to maintain a sense of self as consistent and coherent across time and situations (ability to tolerate and integrate strong affect; ability to maintain a sense of self as benign and deserving of love and life; ability of maintaining an inner sense of connection with others).
- c) Ego resources: abilities that facilitate the individual to meet psychological needs and to relate to others (self-awareness skills and interpersonal and self-protective skills).
- d) Psychological needs and cognitive schemas: safety, esteem, trust, control and intimacy in respect to oneself and others. The cognitive manifestations of psychological needs are schemas. To measure disrupted cognitive schemas Pearlman developed a test, the TSI (Traumatic Stress Institute) Believe Scale.
- e) Memory and perception: verbal, imagery, affect, and somatic.

Both papers, McCann & Pearlman (1990) and Pearlman & Mac Ian (1995), indicate that two psychological manifestations of VT might be disrupted: cognitive schemas and intrusive trauma imagery (belonging to the last two aspects enumerated above). Since both areas are particularly relevant for understanding VT, we will stop longer on this matter. The authors' "major hypothesis is that trauma can disrupt these schemas and that the unique way that trauma is experienced depends in part upon which schemas are central or salient for the individual [...]. The therapist's unique reactions will be determined by the centrality or salience of these schemas to himself or herself" (McCann & Pearlman, 1990, p. 137). Changes in the therapists' schemas about the self and the world when working with traumatized victims may be subtle or shocking, depending the degree of discrepancy between the client's traumatic memories and the therapist's existing schemas.

Disruptions and changes in these schemas may be associated with certain emotions or thoughts in the health worker. Clinicians working with victims of random violence may experience a heightened sense of vulnerability and an enhanced awareness of the fragility of life. Any may therefore feel a greater need to take precautions against such violations. "Persons who have been victimized often find themselves in situations of extreme helplessness, vulnerability, or even paralysis. Exposure to these traumatic situations through the client's memories may evoke concerns about the therapist's own sense of power (...). In our experience, helpers with high needs of power are likely to be greatly impacted by the powerlessness reported by their clients" (McCann & Pearlman, 1990, p. 139). It can lead to constructive self-protective action; whether by patient or psychotherapist, it is positive. Yet it can become dysfunctional if it leads to improper attempts to control others or irritation about one's inability to do so. Subsequent to the theory of these authors, the nightmares and images appear especially in those mental areas where the psychotherapist himself is most vulnerable. The imagery that plagues an individual will often reflect the psychological needs and believes that are most important to him or her (Lansen, 1996). "Then the effect of a particular client's troubling story merges with the impact of other stories and interactions with other trauma clients, creating a cumulative effect" (Saakvitne & Pearlman, 1996, p. 41).

With regard to the memory system, psychotherapists may internalize the memories of their clients and may have their own memory systems altered temporarily or permanently. These alterations in memory may become intrusive or disruptive to the helper's psychological and interpersonal functioning. Like the trauma victim, therapists can experience traumatic imagery returning as fragments, in form of flashbacks, dreams or intrusive thoughts. These images may be triggered by previously neural stimuli that have become associated with the patients' traumatic memories. The imagery that is most painful to the therapist often centres on the schemas related to the therapist's salient need areas. That is, a therapist for whom esteem is salient will likely recall those images involving extreme degradation or cruelty at the hands of others. "Likewise, the imagery that is recollected can produce a temporary state of disequilibrium as the schemas accommodate or change" (McCann & Pearlman, 1990, p. 143).

There are a number of possible behavioural changes that might result from vicarious traumatization, including: becoming judgmental of others; no time or energy for oneself; tuning out; having a reduced sense of connection with loved ones and colleagues;

becoming cynical or angry; increased sensitivity to violence; developing rescue fantasies (become overinvolved) and taking on others' problems; developing overly rigid, strict boundaries; feeling protectiveness as a result of a decreased sense of safety of loved ones; generalized despair and hopelessness; avoiding social and work contact. Furthermore, VT can detrimentally affect one's intelligence; memory and imagery; one's ability to get one's psychological needs met; and self-capacities, including: The enduring ability to maintain a steady sense of self; tolerance for a range of emotional reactions in oneself and others; a sense of self as viable and worth loving.

Saakvitne and Pearlman (1996) also identify situational and individual agents that have the function of contributing factors. Belonging to the former are the nature of work and clientele; cumulative exposure to trauma material; organizational, social and cultural contexts. The individual contributing factors are the personal history; personality and defensive style; coping strategies and current life context (stressors and supports).

VT is not an event, but a process. It includes strong feelings and defences against those feelings. Thus, VT is "our strong reactions of grief, rage, and outrage, which grow as we repeatedly hear about and see people's pain and loss (...) and it is our numbing, our preventing shell, and our wish not to know, which follow those reactions. These two alternating states of numbness and overwhelming feelings parallel the experience of PTSD" (Saakvitne & Pearlman, 1996, p. 41).

The changes are not considered pathological, and are seen instead as normal cognitive or emotional changes relating to how the mental health worker felt and thought about him- or herself. These changes tended to occur more often in highly empathic, sensitive individuals, those with a previous history of trauma, and new to the work. The changes are cumulative as, over time, the mental health workers worked with several trauma survivors. "VT implies changes in the therapist's enduring ways of experiencing self, others, and the world" (Pearlman & Mac Ian, 1995, p. 558).

Psychoanalytic object relation theory

This theory does not centre on the horrifying stories; its focus is thrown on the harm to the inner psychic world of the patient. It is about a profound type of self-harm that in an intensive therapeutic relationship deeply touches the therapist's self. In the literature also known as enactment or engagement. Lansen bases his observations specifically on the work with tortured patients.

“During torture, in the torture scene archetype images from the early childhood are relived. It is a repetition of cruel experiences, fears and fantasies that were lived through the pre-oedipal period, in a time where the differentiation between ‘self’ and ‘outside world’ was not possible. This ‘repetition’ is like a regression, a return to an inferior level of cognitive schemata differentiation. In the torture cell castration fears are relived, but also feelings of total powerlessness and worthlessness” (Lansen, 1996, p.265). In the same manner, patterns of persecution conducts and powerlessness can appear during the psychotherapeutic relationship. Even without an exact cognitive depiction or knowledge of the torture experience the therapist can be “sucked into” these patterns. In this way therapists are exposed to experiences from the torture cell. This relationship can generate destructive processes in which the self-harm from one (the victim) finally leads to the self-harm of the other (the therapist).

Model of particular empathy and identification

Wilson and Lindy schematize the special patient-therapist-relationship in the treatment of extreme traumatized clients. The authors present a new approach grounded on a broad psychodynamic basis. The central point is the therapist's capability of empathy. At the beginning the empathy is easily possible and accomplished. The empathic relationship gets under pressure because the patient himself has not integrated the traumatic experiences. The client tends to project his traumatic transferences onto the therapist because he unconsciously behaves in a manner that affects the unresolved, not assimilated and ego-strange aspects of the traumatic event. “The unnatural situation from the torture cell is so repeated” (Lansen, 1996, p.267). The psychotherapist will then identify himself with the horrifying memories and feelings of the patient. But he has to be conscious about these identifications, and he has to perceive this empathy precisely. He has to unfold and enrich his empathy in a process of habit and growth. If he can not do this and is not conscious about this, the circumstance subsists not only

that the treatment will fail but also that the therapist will get harmed. Then the identification of the therapist himself gets disturbed. Wilson and Lindy indicate two main types of derailment: a) type I is the derailment of too much distance, the therapist avoids empathy. b) type II—reactions, in the contrary, concern the over identification; therapists loose the boundaries in their therapy. Both are necessary, a growing empathy with a maintained distance is an optimal condition for the treatment (Lansen, 1996).

To synthesize the concepts discussed up to now, we can say that they do have in common that they all view STS as a natural by-product of caring for traumatized people. “A helper’s vulnerability to vicarious traumatization is unavoidable if her work involves listening empathically to traumatized people with the goal of helping them” (Saakvitne & Pearlman, 1996, p.25). When the psychotherapist understands the unique experience of the patient and the influence this had on his life, a fundamental therapeutic structure emerges that facilitates the growing process of the patient. Moreover, these concepts describe the challenge of the “provider’s ability to render effective services and maintain personal or professional relationships” (Rudolph, Stamm & Stamm, 1997).

Another point in common between the various terms for ST is the alienation feeling. Trauma victims often experience a profound sense of alienation from other people and from the world in general. Therapists who work with victims may experience a similar sense of alienation that results from exposure to horrific imagery and cruel realities. This alienation may be reinforced by other professionals asking “How can you listen to such terrible stories day after day?”. This sense of separateness is compounded by the requirement for confidentiality in psychotherapy. This stands in the way of a sense of connection with others, and may grow into a deep sense of alienation. Additionally, other professionals may assume that the clinician chose this particular field of study because of his or her own unresolved conflicts. This too may contribute to a sense of stigmatization (McCann & Pearlman, 1990).

A further overlap among these concepts is: emotional exhaustion. But different to burnout; CF, STS and VT include much more. VT, for example, has a spiritual component. Recently, theorists of the CF concept suggest that acting with empathy and sorrow are not sufficient ingredients of helping. The helper’s motivation to help is shaped by the satisfaction derived from the work of helping others; this thought is behind the term compassion satisfaction (Stamm, 2002).

As for the differences, countertransference and burnout can occur outside of the context of exposure to traumatic material. CF, STS and VT always arise as a result of exposure to a client's traumatic material, and induce more trait-like changes to values, beliefs, and behaviours. CT applies more to how patients affect our work with them, and CF and VT is about how our patients affect our lives, our relationships with ourselves, and our social networks, as well as our work (Stamm, 1997). CF and CT have a faster onset of symptoms. CF and BO have a faster recovery from symptoms. Burnout may require changing jobs or careers, however, compassion fatigue is highly treatable once workers recognize it and act accordingly (Figley, 2002a).

Like McCann and Pearlman (1990, p. 146) state, "as therapists learn more about their own psychological needs, they will be able to process traumatic material more effectively and limit its impact upon their schemas". "Part of the consultation process with psychotherapists experiencing STSD is to help them with the differentiation in their relationship with their traumatized client" (Figley, 1996, p.571). Therapists may need to recover well before the client does. If we are not empathic or exposed to the traumatized there should be little concern about compassion fatigue.

When taking into account the measurement instruments, further analogous details come up: neither of the developed tests to measure VT, CF or BO has substantial psychometric evidence yet. Results stemming from a study of 99 sexual assault and domestic violence counsellors show concurrent validity between the measures for VT and STS, moderate convergence with BO but useful discrimination, and strong convergence with general distress. The hindmost convergence is larger than what would allow for a good differentiation from general distress. And adequate independent shared variance, meaning that the trauma-related scales had slightly more in common with each other than each had with general distress (Jenkins & Baird, 2002). "STS and VT differ conceptually in their relative emphasis (...), and empirically in these measures' item content and correlates. There is adequate evidence that neither of these measures is reduceable to the other" (Jenkins & Baird, 2002, p. 431).

As can be observed when reading the definitions in this section, even if there may be positive results out of experiencing secondary traumatization, the concept is defined from a rather negative perspective. Even if helpers do feel compassion satisfaction, it is not part of the operationalization of secondary traumatic stress. As well as the

operationalization of secondary traumatic stress, neither did I emphasise much on physiological symptoms like heart diseases, ulcers, etc. In my opinion there is no question that studies have demonstrated that stress carries with physical impairments (compare Valent, 1995 and Margison, 1987), so this matter will not be discussed inhere.

1.3 Justification

This work tries to comply with requests for ongoing investigation with therapists and helpers as done by Pearlman and Mac Ian (1995) and Lansen (1993). This field of investigation caught my attention during an internship experience in Turkey, where I could closely observe psychotherapists and health workers in a treatment centre for victims of human rights violations. What can be done for health workers, for their psychic health, so that they can offer their services as efficiently and as long as possible? I also asked myself, what makes the difference between psychotherapeutic treatments that do success from those that do not. What would make me a good therapist one day? My inquisitiveness found out that most of the studies of the effectiveness of therapy point to the *therapeutic alliance* between client and clinician. This is the precondition for a therapeutic change to take place. "And the most important ingredient in building a therapeutic alliance is the client linking and trusting her or his therapist" (Figley, 2002b, p.2). These feelings are directly related to the degree to which the therapist utilizes and expresses empathy and compassion.

When talking with experts from the psychology field in different countries, some ideas about other variables that may play a role in secondary traumatization came up. For example, what about the working style of the psychotherapist? Could it be possible, that a rather trauma-focused working style (TF) demands more empathy and expression of compassion. In this work the term TF is defined as specifically concentrating on the traumatic event of the target patient. Changes in the therapist's enduring ways of experiencing self, others, and the world; in other words ST or VT, do occur more often in highly empathic, compassionate and sensitive individuals (Pearlman & Mac Ian, 1995). Is it plausible that highly sensitive individuals prefer to use a trauma-focused style and therefore are at higher risk for experiencing secondary traumatization. A symptom-relieving working style (SR) means that the therapist concentrates on daily-life problems, and does not immerse into the cause of these daily problems; he or she works on a supportive basis and does not use therapy time to talk about any traumatic

event the patient may have experienced. The psychotherapists that identify themselves as trauma-focused would be at more exposure during their trauma work than their symptom-relieving counterparts. One would suppose, out of the literature on secondary traumatic stress, that those therapists that are more exposed to the traumatic stories of their patients would have a greater burden and therefore a higher risk to develop STS. In this way, psychotherapists that feel unsatisfied because they may be not sufficiently trained; or be frustrated with their performance; use exposure techniques during therapy; have more workload; or less time to recover from work; may suffer more secondary traumatization.

So trauma-focused and symptom-reliever therapists are seen as two tackles of the same continuum. Both are styles on how to embark the work with traumatized patients. In one extreme of the continuum we have the symptom-relievers, on the other one the trauma focused.

A further theoretic thought is that SR psychotherapists prefer closure, meaning that they are not willing to talk about traumatic events, and for that reason do not encourage their patients to speak about his or her traumatic experience. TF style therapists are believed to want to disclose traumatic experiences themselves; a logic consequence is, that they support the idea that giving testimony brings some appease, and will therefore promote their patients to tell their trauma story in therapy. Because SR get less in touch with the trauma feelings of their patients, they run less risk to develop ST. Is it verisimilar that therapists that possess the characteristics to disclose (TF) will be at more risk to develop secondary traumatization.

I strongly believe that there are cultural differences between the therapists interviewed in Guatemala and the therapists interviewed in Germany and Switzerland. These could reveal themselves by the way the subjects answer to the interview questions. Just by imagining that the social and cultural milieu is unequal (e.g. the frankness in their respective families of origin defer). Thereto comes the professional education, (e.g. the amount of feeling allowed and the way connecting with the patient could be taught differently).

In the rest of this work we will examine if the variables of working style (degree of exposure), disclosure and culture (living in another country) do have an effect on secondary traumatization.

1.4 Hypothesis

First of all, I want to explore if there is any difference in secondary traumatization between psychotherapists working with a trauma-focused style and those working on a supportive, daily-life basis. In short, I am asking whether those psychotherapists working with a symptom-relieving style are in some way “protected” from the effects of compassion fatigue or secondary traumatization. The hypotheses are the following:

- 1a) Therapists identified as working trauma-focused will be at higher risk of experiencing secondary traumatization than psychotherapists having a symptom-relieving working style.
- 1b) Supervision does protect from secondary traumatic stress.
- 2a) Higher secondary traumatization scores and lesser supervision in the group interviewed in Guatemala than in the group interviewed in Switzerland and Germany.
- 2b) Differences in disclosure; family of origin; HSCL-depression; and PTSD-like symptoms; between the group interviewed in Guatemala and the group interviewed in Switzerland and Germany.
- 3) Trauma-focused and symptom-relieving psychotherapists in Germany and Switzerland have a bigger within group discrepancy in variables of secondary traumatization than do the psychotherapists in Guatemala.
- 4a) Disclosure rates; general feeling; family of origin; and PTSD-like symptoms in therapists are different from those measured in students entering university.
- 4b) Psychotherapists that disclose less have less secondary traumatization.
- 4c) Correlation between disclosure, PTSD-like symptoms.
- 5) Therapists that have lived through a traumatic event themselves are more vulnerable or predisposed to suffer from secondary traumatization, than those who have no personal trauma history.

At the end an explorative factor analysis was done to examine the overall variable pool.

2. Method

2.1 Participants

Forty psychotherapists (24 women, 60% and 16 men, 40%) volunteered to participate in the present study. Of these therapists, 26 (65%) were psychologist, 8 (20%) were psychiatrists and the remainder represented various professions. All of the 40 participants were interviewed by the author herself. Twenty-two of the participants were interviewed in Guatemala, of these group, 12 (55%) were women and 10 (45%) were men, 12 participants worked at a treatment centre for victims of organized crime and 10 had their private praxis. Fourteen were (64%) psychologist and 6 (28%) were psychiatrists, one (4%) was a language therapist and one a theologian with studies in psychology. In Germany, 9 (70%) women and 4 (30%) men participated, 9 of these were working in a treatment or research centre for tortured victims. Nine were psychologists (70%), one was psychiatrist (7%), two had an education in psychotherapy (14%) and one was a body psychotherapist. The sample from Switzerland was the smallest, with 3 psychologists (60%), one psychiatrist (20%) and one social worker with an education in psychotherapy. In this group three (60%) were women and two were men (40%), all working in the area of migration.

Mean age, years of psychotherapeutic experience both generally and specific with traumatized patients are presented in Table 1.

Table 1: Age and years of experience of the study group.

Variable	Mean	SD	Range
Age	44	11	26 – 68
Years of professional experience	13	7	1 – 30
Years of experience working with traumatized patients	8	4.5	1 – 18

All participants from Guatemala were working full-time in this area. In Germany and Switzerland, the concept of part-time job is more widespread and most of the participants did not work under full-time contracts.

The purposive sample was recruited from relevant entities working with victims of organized crime; psychology departments of universities; public mental health hospitals; counselling bureau of the public ministry in Guatemala; private psychological practises; and psychiatric offices.

Twenty-six subjects (65% of the study group) were working in an institution for victims of organized crime. The nine identified institutions were: Team for community studies and psychosocial action (Equipo de Estudios Comunitarios y Acción Psicosocial, ECAP); Archbishopric Office for Human Rights in Guatemala (Oficina de Derechos Humanos del Arzobispado de Guatemala, ODHAG); Guatemalan League for Mental Hygiene (Liga Guatemalteca de Higiene Mental). Treatment Centre for Torture Victims, Lindau (Zentrum zur Behandlung von Folteropfern eV Lindau); Treatment Centre for Torture Victims, Berlin (Behandlungszentrum für Folteropfer); Psychological Research and Model Ambulatory from the University of Konstanz, Germany (Psychologische Forschungs- und Modellambulanz der Universität Konstanz); Ambulatory for Torture and War Victims, Swiss Red Cross - Bern (Ambulatorium für Folter und Kriegsoffer, SRK); Medicine Unit for Travel and Migration from the University Hospital of Geneva (Unité de Médecine des Voyages et Migrations Hôpital Cantonal Universitaire de Genève); and Psychosocial Counselling Center, German Red Cross - Freiburg (Psychosoziale Beratungsstelle für Migranten, Deutsches Rotes Kreuz).

For the rest of the participants in Guatemala, one participant was working at the Master Program in Social Psychology and Political Violence of the Metropolitan University Center in Guatemala (Master en Psicología Social y Violencia Política del Centro Universitario Metropolitano, CUM); two were working at a public mental health hospital; two at the counselling lawyer's office representation of the public ministry (Oficina de Atención a la víctima, Ministerio Público and Procuraduría de la Niñez); and five participants were interviewed from three different private mental health centres. As for the other participants in Germany, which did not work in an institution for victims of torture, four were working in their own private praxis in the city of Konstanz.

There were no physically invasive aspects to the study; there was some risk of emotional distress. Participants were allowed to discontinue participation whenever they would feel to do so. These and other warnings and rights of the participant were outlined in the informed consent which had to be undersigned before the interview began. Then a copy with general information about the study topic was handed out. It included a short reference of mental health resources.

2.2 Measures and procedures

Willingness to participate was asked by phone or e-mail. Appointments were then made by phone, participation was voluntary. First the author contacted all organisations she knew worked with victims of organized violence. Later participants named institutions and professionals that might be interested in the research study. The data was collected by the structured interview and a self-test administered after fulfilling the interview. This procedure lasted approximately 50 minutes. Not all the participants in Guatemala did make the self-test because it was incorporated later in the study. The interviews in Guatemala were done in English language and a translation into German was done for the participants in Germany. In Switzerland the interview was conducted in English or German depending on the preference of the participant.

For the independent measure an interview was developed. The interview is a comprehensive instrument compound of different standardised questionnaires, which were adapted to be used as an interview; as well as additional qualitative and explorative questions. The latter of course is leaded by hypothesis that can be found in the literature, as we will see explained in the following paragraphs (for a detailed gaze of the complete interview please go to the appendix). To measure the dependent variable the subscales from the Professional Quality of Life Self-Test were used.

General information

This part was particularly developed for this study and included questions about the psychotherapists' age; work experience and therapy style; number of therapy sessions and theoretical approach used in therapy; number of patients treated in the last year and current amount of patients; topics of their patients' stories; social network and coping style.

General state

This second part consisted of questions to how the therapist generally feels; aiming to obtain an approximate picture of the psychotherapist's usual state of worry and restlessness. Six items like "do you feel nervous and restless"; "do you worry too much over something that really does not matter" and "do you have disturbing thoughts" have to be rated from 0 (almost never) to 3 (almost always) in a 4-point Likert-scale. A sum is formed by adding the scores (the highest achievable sum is 18 points).

Hopkins Symptom Check List (HSCL)- Depression scale

The Hopkins Symptom Check List (HSCL) depression scale was adapted and used to assess the risk of depression amongst psychotherapists. It is an instrument with 15 statements that have to be rated in a 4-point Likert-scale ranging from 0 (not at all) to 3 (extremely). Some examples of the rated items are “feel hopeless about the future”; “have poor appetite”; “feel lonely”; “feel worthless”; “feel no interest in things”; “cry easily”; “have feelings of being trapped or caught”.

Family of origin score

This score is obtained by adding the answers given by the participants. Five statements must be rated from 0 (strongly disagree that it describes my family of origin) to 4 (strongly agree that it describes my family of origin) in a 5-point Likert-scale. Two examples for these statements are “in your family, you felt that you could talk things out and settle conflicts” and “found it easy in your family to express what you thought and how you felt”. The higher the score obtained, the more open the family is and higher the degree of family disclosure for that participant.

The questions about the family of origin were taken from a previous questionnaire for human rights workers who returned from a field job, developed by the Department of Clinical Psychology and Neuropsychology of the University of Konstanz in collaboration with the Center for the Research on Emotion, Gainesville, Florida (human rights workers questionnaire, unpublished document, University of Konstanz).

PTSD-symptom appraisal

Questions followed on whether the subject has lived through a traumatic experience of her own; this included indicating from a list of traumatic events, which one has happened to her. This part ended with a PTSD-symptom check-up questionnaire from the PDS (Posttraumatic Stress Diagnostic Scale, Foa). This questionnaire includes 17 items that ask for PTSD-symptoms (5 items relate to intrusions, 7 items to avoidance and 5 items to hyperarousal). All 17 items were rated with a 4-point Likert-scale from 0 (not at all or only once) to 3 (almost always, e.g. 5 or more times in a week). A subject was diagnosed with PTSD if he or she indicated at least one intrusion, three avoidance and two arousal symptoms; plus these symptoms having caused serious problems in any area of his or her life during the past month.

Short Version of Mueller/Maercker Questionnaire

This questionnaire about disclosure was adapted to fit into the nature of this study, a structured interview. This version uses 12 items to measure three constructs of disclosure: want disclosure (talk), amount of closure (silence), and negative affects after disclosing (emotional responding). The items had to be rated in a 5-point Likert-scale from 0 (strongly disagree) to 5 (strongly agree). Some examples of the disclosure items are: “You like to talk about the event as often as possible”, “you often feel the urge to talk about your experience“, and “the more often you talk about the event, the clearer the picture gets that you have of the event”. “You never find the right time to talk about the experiences that you had during the event”, “you often think about the event, but never talk about it”, and “you haven’t told anybody about the experience”, for instance, are samples of items that measure closure. An illustration of the items to measure negative affect are “talking about the event is distressing”, and “you are extremely tense when you report the event”.

Position to work-related statements

This part consisted of 11 questions about the posture to work-related statements. These 11 items were adapted from the questionnaire for human right workers developed by the Department of Clinical Psychology and Neuropsychology of the University of Konstanz in collaboration with the Center for the Research on Emotion, Gainesville, Florida (unpublished document, University of Konstanz). Statements like “The therapist must be empathic with the person”, “at some point during the interview the patient often gets stuck or their reports begin to be incomplete/fragmented” were asked to be rated in a 5-point Likert-scale ranging from 0 (strongly disagree) to 5 (strongly agree).

The thought behind this was, that trauma-focused therapists would highly agree with items like “the therapist must be empathic with the person” and “giving testimony brings always at least some relief to the eyewitness”, while symptom-relievers would preferably answer to these with ‘disagree’. Symptom-relievers would rather agree with items such as “the primary goal of diagnostic interviewing is to gain useful information from the eyewitness”, “the interviewer should have a neutral position”, “sometimes during an interview, you are not sure how to help the person to get through it without disturbing him or her even more” and “interviewing eyewitnesses often tends to upset them emotionally”. TF therapists would, if ever, agree with them to a lesser degree.

Secondary traumatization

The last part of the interview was developed for this study exclusively; it contains 10 questions to symptoms of secondary traumatization, as viewed by the author. Questions include inquiries about how vividly and intense the psychotherapist experiences the narrations or stories of his or her patient; intrusions therapists may have developed in response to the stories of their patients; also physical reactions towards identification with the patient; and avoidance of patients with trauma history. Meant are items such as “how hard do you try not to think about your patients’ stories”, “do you try to avoid patients with history of trauma” and “do some of your own emotions become related or connected to what the patient told you in therapy”. Most of the questions in this part can be answered with yes, sometimes or no. Three items are dichotomised, “have you experienced intense feelings about these stories” can only be answered with yes or no, and “how do you experience what your patient tells you” is divided into two categories: one category can be answered with “in images” and/or “in emotions” and the other one with “in 1st person” and/or “in 3rd person experience”.

Professional Quality of Life – Revision III (ProQOL - R III) (Stamm, 1995-2002)

Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales-III is a self-test with 30 items. It comprises three sub-scales: Compassion Satisfaction (10 items), Burnout (10 items) and Compassion Fatigue (10 items). The psychometric properties of this revised, shorter version of the original version called Compassion Satisfaction /Fatigue Self-Test for Helpers, are Compassion Satisfaction alpha = .82; Burnout alpha = .71 and Compassion Fatigue alpha = .78. The authors warn that research is still going on, this scale and the scores should be used as a guide, not confirmatory information. Subscales and cut points are theoretically derived, when possible, data should be used in a continuous fashion. Participants are asked to rate, on a 6-point Likert-scale ranging from 0 (never) to 5 (very often), how often a statement like “I feel connected to others”, “I am an unduly sensitive person” and “I feel trapped by my work as a helper” has been true in the last 30 days.

Computer instruments

All analysis was conducted using the SPSS Statistical Software Package (German and English version 11.5.1; SPSS, Inc. 2002). The data from the unpublished study of the Department of Clinical Psychology and Neuropsychology of the University of Konstanz (Elbert et al.) was imported from a Microsoft Excel sheet (Microsoft Office 2002).