Predictors and Moderators of Difficulties and Coping for Trauma Therapists

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A Dissertation Submitted to

The Faculty of
The Columbian College of Arts and Sciences and
The Graduate School of Education and Human Development
of The George Washington University
in partial fulfillment of the requirements
for the degree of Doctor of Philosophy

January 31, 2012

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Dedication

In Loving Memory of My Father

Dr. Robert L. Jones

Because you said I could, I would, and I did.

Acknowledgments

This journey would not have been possible without the steadfast love and support of my husband, and hope, joy and inspiration of my children. Thank you to my mother for her love and encouragement throughout this long and arduous process.

I was honored to be encouraged and mentored by Dr. Sylvia Marotta both in this dissertation process and in my training as a therapist and supervisor. I am also grateful for Dr. Christine Courtois, who was a great support to me and fostered my growth as a trauma therapist. I am thankful for Dr. Monica Megivern who guided my development as a supervisor, leader, and educator through her words and lead by example. These women have greatly influenced my professional and personal life and helped teach me the art of balancing theory, principle, science, compassion, empathy, kindness, and strength.

I am thankful for many other mentors and teachers who have contributed to my development as a therapist and as a person. I especially want to acknowledge Dr. Richard Lanthier, Dr. Huynh-Nhu Le, Dr. Jennifer Kahler, Dr. Randy Parker, Dr. Steve Liter, Dr. Barbara Clark, Dr. Peggy B. Smith, and Dr. David Mumford, for their mentorship, care and support. Also, I would like to say thank you to Tara Filmyer, Dr. Guyla Davis, and Dr. Tine Jensen et al. at NKVTS for their guidance and help throughout various stages of this process. A special thanks to Dr. David Orlinsky for our communication and his guidance for the use of the DPCCQ.

Finally, I would like to say thank you to the trauma therapists who participated in this study who gave their time and thoughtfulness with the hope of understanding how we manage and cope with our intensive, yet important work. This work is for trauma survivors and is a testament to their courage, strength, and capacity to hope and heal.

Abstract of Dissertation

Predictors and Moderators of Difficulties and Coping for Trauma Therapists

This study is designed to determine to what extent therapist work experience with complex trauma and trauma training moderates anxious and avoidant attachment styles and self-differentiation in effecting therapist difficulties and therapist coping with complex trauma patients. A random sample of trauma therapists was surveyed from a large, international trauma association. Approximately 126 trauma therapists participated in the study where the majority identified as female (62%), white (93%), with a doctoral-level degree (64%), and where a majority described themselves as experienced, expert-level trauma therapists with complex trauma patients. Self-differentiation and attachment avoidance were found to predict difficulties. Self differentiation was a predictor of avoidant coping where the lower the level of self differentiation, the more avoidant coping employed. Experience with repeated trauma patients/clients was found to moderate the relationship between attachment anxiety and difficulties experienced with complex trauma patients. More difficulties were reported by trauma therapists with higher attachment anxiety and less experience with repeated trauma patients. Experience with patients with single-incident trauma moderated the relationship between attachment anxiety and avoidant coping. More avoidant coping was reported by trauma therapists with higher attachment anxiety and more experience with single-incident trauma patients. Experience with patients with single-incident trauma also moderated the relationship between attachment avoidance and avoidant coping. More avoidant coping was reported by trauma therapists with higher attachment avoidance and more experience with single-incident trauma patients. The findings of this study suggest that experienced, expert-level trauma therapists experience few difficulties when working with complex trauma patients,

and employ little avoidant coping strategies. These findings are contrary to some previous research findings. Further investigation is needed to determine potentially unique ways in which experienced, expert-level trauma therapists experience difficulties and cope differently than other non-trauma or less experienced therapists. Future studies may also focus on other potential moderators of trauma therapist attachment anxiety, attachment avoidance, and self-differentiation in addition to work experience and training.

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CHAPTER 1

The therapeutic process is a dynamic one in which personal change may occur and manifest in many ways (Orlinsky & Rønnestad, 2005; Smith, Kleijn & Hutschemaekers, 2007; Teyber, 1997). This involves the therapist, the facilitator of change, and the patient who discovers, creates, and integrates change to acquire a coherent sense of self, increased life functioning, and an ability to cope with and manage psychological and emotional problems. Strupp (1978) describes psychotherapy, itself as, "an interpersonal process designed to bring about modifications of feelings, cognitions, attitudes, and behaviors which have proved troublesome to the person seeking help from a trained professional" (p. 3). Teyber (1997) underscores the importance of the therapist in the process, "in order to utilize the therapeutic relationship systematically as a vehicle for change…therapists must understand very specifically the meaning of their dynamic interactions with their clients" (p.16). Therapeutic interactions are reciprocal and continuously shape and change the therapist and patient, as well as the process (Rasmussen, 2005).

Therapists who work with trauma survivors (victims of childhood abuse, rape, domestic violence, war, torture, etc.) confront severe relational deficits, comorbid diagnoses, cognitive impairments, attachment problems, and other psychological, emotional and often medical issues when working with these patients (Courtois, 2004; Herman, 1992; Linehan, 1993; van der Kolk, McFarlane & Weiseith, 1996). Individuals who have experienced multiple traumatic experiences, across developmental time periods, over the lifespan have uniquely challenging psychological, emotional, and relational dysfunction (Courtois, 2004; Herman, 1992; Linehan, 1993; van der Kolk, McFarlane & Weiseith, 1996). Working with these problems in therapy threaten the therapeutic process over and beyond the type of

intervention that may be employed (Briere & Scott, 2006). The trauma therapist is also exposed to the possibility of psychological and emotional effects (Herman, 1992; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Wilson & Thomas, 2004), as well as personal transformation including personal growth and awareness (Marmaras, Lee, Siegle, & Reich, 2003).

Trauma therapist reactions include the difficulties they experience and the coping they employ in their work with trauma survivors (Smith, Kleijin, & Hutschemaekers, 2007). In response to the complexity of trauma survivor impairments, the therapist may experience more difficulties with these patients and employ negative coping strategies to deal with these difficulties as they occur (Smith, Kleijin, & Hutschemaekers, 2007; Smith, Kleijn, Trijsburg, and Hutschemaekers, 2007). Negative coping is not only harmful to the therapist but detrimental to the patient, as well (Pearlman & Saakvitne, 1995). Boundary and ethical violations are more likely if a therapist becomes vulnerable to difficulties they encounter and cope in an unhealthy or negative manner (Gutheil, 1989).

The therapist brings a unique set of inherent qualities and learned traits that will ultimately affect the therapeutic process (Beutler et al., 2004). The interaction of therapist characteristics and exposure to the patient's trauma material can have negative effects (Marmaras et al., 2003; Pearlman & Saakvitne, 1995). In addition to hearing the content of the traumatic material, the severity of the relational deficits, self-care problems, (Bennett, Parry, & Ryle, 2006) and attachment disturbances (Fossati et al., 2005) creates an intense therapeutic process.

Attachment style and self-differentiation are relational constructs that can be used to explore how an individual connects within human relationships (Wei, Russell, Malinckrodt, & Vogel, 2008). Attachment theory accounts for how and in what

manner an individual may bond in a relationship (Bowlby, 1973). Trauma therapist attachment style is a relational characteristic which can either enhance or detract from the therapist's ability to cope with the traumatic material (Marmaras et al., 2003) and the relational aspect of the therapy. Securely attached therapists are more responsive and attentive to the needs of insecurely attached patients while insecure therapists experience more distress and intervened more intensely to their patients (Dozier, Cue, & Barnett, 1994). The therapist's anxious or avoidant attachment style will influence the therapeutic process (Marmaras et al., 2003). Bernier and Dozier (2002) discuss a consensus in the literature underscoring the importance of therapist-patient matching (secure attachment with insecure attachment, respectively) in the therapeutic process.

Self-differentiation describes how an individual distinguishes between feeling processes and intellectual processes (Peleg-Popko, 2002) and separate him/herself from others, and to what extent distress is experienced due to a life stressor (Bowen, 1978). Based upon an interpersonal construct, self-differentiation accounts for how an individual reacts under distress in a relationship (Skowron & Friedlander, 1998). Trauma therapist self-differentiation is another relational characteristic describing the tendency to distance or enmesh themselves within relationships. A trauma therapist with a low-level of self-differentiation will, by definition, be hyperfocused and involved in intense emotional experience, unable to remain autonomous, either rigidly or consistently seeking acceptance and approval, and emotionally cutting-off when strong feelings are too difficult to manage (Bowen, 1978; Kerr & Bowen, 1988; Peleg-Popko, 2002; Skowron & Friedlander, 1998; Wei, Russell, Mallinkrodt, & Vogel, 2008). When the therapeutic process then becomes strained and it puts both the therapist and patient at-risk for ethical problems and boundary crossing. For the complex trauma patient, this could be another relationally traumatic experience that

adds to the cumulative trauma experienced previously. So the effect of therapist attachment and self-differentiation on the therapeutic process may be exacerbated if both therapist and patient struggle with relationally-based problems, and possibly share insecure attachment styles and poor boundary control.

In this study, it is proposed that therapist work experience and specialized trauma training may help to moderate the extent to which therapist attachment style and self-differentiation affects therapist difficulties and coping with complex trauma patients. Therapist work experience and training, in general, is discussed in the literature regarding patient outcomes (Beutler et al., 2004; Roth & Fonagy, 2005) and not in terms of their effects on the therapeutic process. Therapist work experience and training is usually defined as one unit, or more generally quantified as the therapist's education level (Roth & Fonagy, 2005; Stein & Lambert, 1995). Problems occur when trying to pinpoint the exact type and amount of education, experience, and training, since it tends to be cumulative (Beutler et al., 2004). Defining specialized training clearly is more helpful in measuring training (Beutler, et al., 2004). The therapist's years of experience devoted to the treatment of a specific group of patients seems to be more important than overall experience in general (Crits-Christoph, 1991; Fernandez-Alvarez, Clarkin, Salgueiro, & Critchfield, 2006); and specialized training and experience with personality disorders (diagnostically appropriate for many complex trauma patients (Courtois, 2004; Herman, 1992; Linehan, 1993) are generally accepted to enhance patient outcomes (Critchfield & Benjamin, 2006).

Chrestman (1995) and Smith, Kleijn, Trijsburg & Hutchsemaekers (2007) found that work experience and training have a positive effect on therapeutic work with trauma survivors. Chrestman (1995) found that professional experience and

additional training, as well as a lower number of trauma cases and increased time spent in research activities was associated with lower distress in therapists. Smith, Kleijn, Trijsburg, and Hutchemaekers (2007) found that trauma therapists employed more active interventions in comparison to other expert therapists when faced with difficulties. Trauma training and work experience may moderate the overall effect of therapist attachment and self-differentiation on therapist difficulties and coping during practice.

By investigating the relationship between therapists and experience with complex trauma patients, this study may shed light onto the importance of therapist relational and interpersonal deficits, or otherwise, on therapeutic interactions and reactions (difficulties and coping) experienced in practice. Moreover, the study may underscore the need for specialized training and experience with this group of patients to lessen therapist difficulties, increase their constructive coping strategies to ultimately maximize healthy, therapeutic interactions and promote therapeutic change.

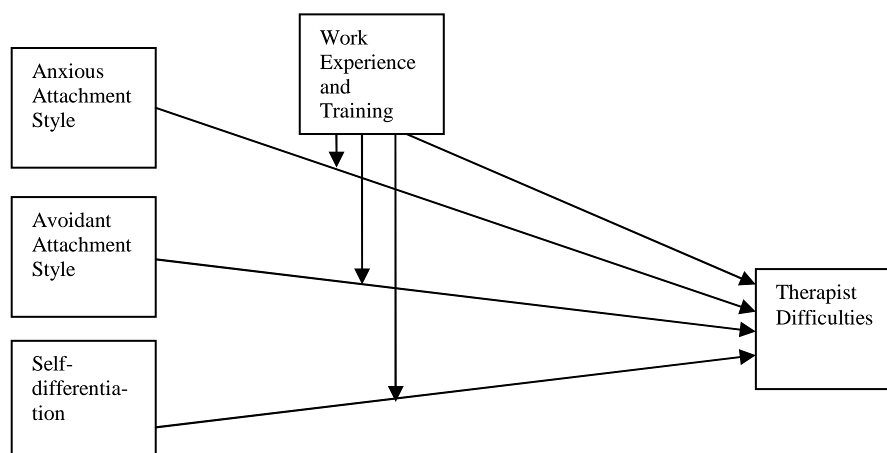

Figure 1a. Path diagram for moderator model: Difficulties.

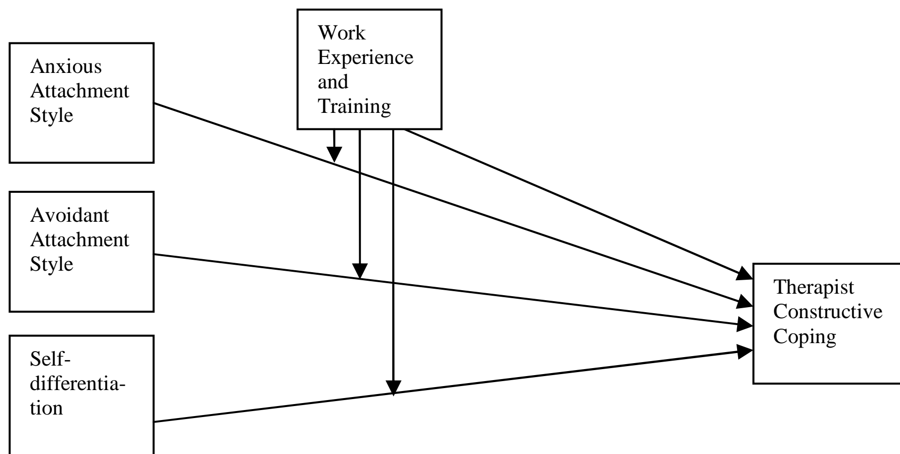

Figure 1b. Path diagram for moderator model: Constructive coping.

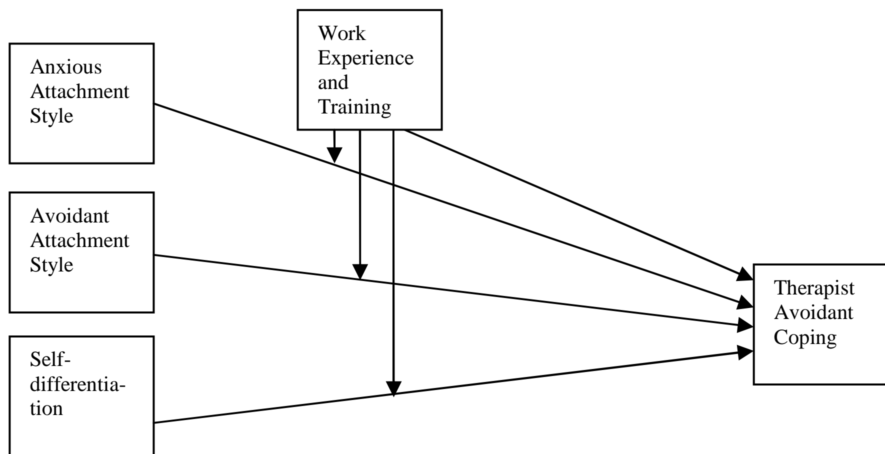

Figure 1c. Path diagram for moderator model: Avoidant coping.

Problem Statement

The problem investigated in this study is to determine to what extent therapist work experience with complex trauma and trauma training moderates anxious and avoidant attachment styles and self-differentiation in effecting therapist difficulties and therapist coping with complex trauma patients.

Purpose

The purpose of this study is to examine how therapist attachment style, self-differentiation, work experience, trauma training, therapist difficulties and coping are

uniquely related in the therapeutic process with complex trauma patients. Specifically, one aim of the study is to understand how attachment style and self-differentiation are associated with therapist difficulties and coping in practice with complex trauma patients. Secondly, the aim is to understand how work experience and trauma training moderates the overall effect of therapist attachment style and self-differentiation on therapist difficulties and coping in practice with complex trauma patients. In a broader context, the study seeks to investigate the therapeutic process with a specific group, complex trauma patients. This study contributes to the scant literature available exploring the therapeutic process with these patients, and provide insight into ways in which trauma therapists may improve their work with these patients regardless of their personal variables they bring to the process.

Research Questions and Hypotheses

Research Questions

The research questions addressed in this study are:

- To what extent are trauma therapist difficulties and coping explained by anxious and avoidant attachment styles and self-differentiation?
- To what extent do work experience and trauma training moderate the relationship between anxious and avoidant attachment styles and self-differentiation on therapist difficulties with complex trauma patients?
- To what extent do work experience and trauma training moderate the relationship between anxious and avoidant attachment styles and self-differentiation on therapist coping with complex trauma patients?

Research Hypotheses

The research hypotheses addressed in this study include:

1. Hypothesis 1, model A. Trauma therapists who identify as anxiously or avoidantly attached and who have a low level of self-differentiation will experience increased difficulties in their work with complex trauma patients.

   Hypothesis 1, model B. Trauma therapists who identify as anxiously or avoidantly attached and who have a low level of self-differentiation will experience less constructive coping in their work with complex trauma patients.

   Hypothesis 1, model C. Trauma therapists who identify as anxiously or avoidantly attached and who have a low level of self-differentiation will experience more avoidant coping in their work with complex trauma patients.

2. Increased work experience and trauma training will moderate trauma therapist attachment and self-differentiation in relationship to trauma therapist difficulties; in turn, this will result in decreased difficulties when working with complex trauma patients for those trauma therapists who are more versus less anxiously or avoidantly attached and those who have lower levels of self-differentiation.

3. Increased work experience and trauma training will moderate trauma therapist attachment and self-differentiation in relationship to trauma therapist coping; in turn, this will result in increased positive coping reactions (constructive coping) and decreased negative coping (avoidant coping) when working with complex trauma patients for those trauma therapists who are more versus less anxiously or avoidantly attached, and those who have lower levels of self-differentiation.

Need for Study

Therapists often encounter patients who have been victims of repeated and extreme trauma over several developmental time periods (Courtois & Ford, 2009). These patients are in great need of psychological help and present with a vast number of debilitating symptoms as a result of their experiences. The repeated and cumulative experience of interpersonal violence across the lifespan, including sexual/physical/emotional abuse, domestic violence, torture, and/or incest, within intimate relationships where the victim is entrapped and conditioned precludes the development of complex posttraumatic stress reactions (Courtois, 2004; Courtois & Ford, 2009).

As many as 1 in 3 girls, and 1 in 6 boys are sexually abused by the age of 18 (Illinois Coalition Against Sexual Assault, 2005), while a lifetime history of sexual abuse is estimated to occur somewhere between 15-25% of the general female population (Leserman, 2005). Most (almost three-quarters) of sexual abuse perpetrators were one or both parents or parental figure (US Department of Health and Human Services, 2005), where repeat offence is common in the case of incest (Courtois, 2010; Greenfield, 1997). London, Bruck, Ceci, and Shuman (2005), reviewed retrospective studies of childhood sexual abuse disclosure rates of women and men and found that only 1/3 of adults disclosed abuse during childhood. In one British study, the average age of disclosure of such abuse is 26, taking an average of 12 years for the individual to disclose a history of sexual abuse (Ussher & Dewbery, 1995). Due to their complex posttraumatic reactions, reduced life functioning, and often times, psychiatric hospitalizations, these individuals are in great need of psychological help and are repeated users of mental health services due to the potency

of their traumatic reactions as a result of a trauma history (Courtois, 2004; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, J., 2005).

The long-term consequences of such devastating interpersonal trauma include psychiatric disorders (Briere, 2002; Briere & Spinazzola, 2005; Brady, 1997; Herman, 1992; Read, van Os, Morrison, & Ross, 2005; van der Hart, Nijenhuis & Steele, 2005), relationship maladaptations (Courtois, 2004; Briere, 2002; Wallis, 2002; Brady, 1997; Barach, 1991), substance abuse (Cohen & Hien, 2006; Najavits, 2002; Najavits,Weiss, Shaw, & Muenz, 1998; Wadsworth, Spampneto, & Halbrook, 1995), suicidality (Linehan, 1993, 1991), sleep disturbance (Davis & Wright, 2007), self-harm (Briere, 1992; Royal Australian and New Zealand College of Psychiatrists Team for Deliberate Self-harm, 2004; van der Kolk, McFarlane, & Weisaeth, 1996), prostitution (Medrano, Hatch, Zule, & Desmond, 2003; Potter, Martin, & Romans, 1999), promiscuity (Orcutt, Cooper, & Garcia, 2005), and crime (ChildHelp, 2005). Several health problems are also associated for both men and women with a past history of sexual abuse including headaches, gastrointestinal, (for women) gynecologic, and panic symptoms (Leserman, 2005), and eating disorders (van der Kolk, McFarlane, & Weisaeth, 1996), to name a few. Dissociative disorders, depression, anxiety, substance abuse, personality disorders, and psychosis have all been found to be related to a history of trauma (Gold, 2004). Read, van Os, Morrison and Ross (2005) went a step further and revealed that, according to a review of several large-scale general population studies, childhood trauma causes the onset of psychosis and schizophrenia with a ‘dose-effect.’

The psychological, biological, and social consequences of interpersonal trauma puts survivors at a greater risk of revictimization leading to repeated traumatic experiences (Duckworth & Follette, 2011; Gladstone et al., 2004; Maker,

Kemmelmeier, & Peterson, 2001; Risser, Hetzel-Riggen, Thomsen, & McCanne, 2006), or complex trauma (Courtois, 2004, 1999). Individuals develop symptomatology as a result of adaptations to the trauma involving the attachment system, memory processing, and psychobiological reactions (Alexander & Anderson, 1994; Briere, 2002; Briere & Spinazzola, 2005; Courtois, 2010, 1999, 1988; Pearlman & Courtois, 2005; van der Kolk, McFarlane, & Weissaeth, 1996; Wilson, Friedman, & Lindy, 2001). Complex posttraumatic stress describes the overall symptom constellation, described in the 7 problem areas, where the individual was/is exposed to trauma over a variety of time spans and developmental periods where the victim is in a state of entrapment under subordination and coercive control by a perpetrator (Courtois, 2004; Herman, 1992). These problem areas include: 1) alterations in the regulation of affective impulses, 2) alterations in attention and consciousness, 3) alterations in self perception, 4) alterations in perception of the perpetrator, 5) alterations in relationship to others, 6) somatization and/or medical problems, and 7) alterations in systems of meanings (Herman, 1992). These symptoms are comprehensive and include developmental and attachment-related issues, dissociative mechanisms, high-risk behavior, and distorted self-perception and relationships with others (Courtois, 2010, 2004, 1997).

Therapists who work with complex traumatic stress survivors face challenges helping these patients due to the content of the trauma material, patient presentation and comorbid diagnoses, and relational deficits that often hinder the therapeutic process (Bennett, Parry, & Ryle, 2006; Herman, 1992; Linehan, 1993; Marmaras et al., 2003; Smith, Kleijn, & Hutschemaekers, 2007). Trauma therapists experience difficulties treating these patients (Smith, Kleijn, & Hutschemaekers, 2007) and may experience negative effects from their work (Courtois, 2010; Marmaras, 2003;

Pearlman & Saakvitne, 1995; Wilson & Thomas, 2005). Trauma therapists employ coping strategies to manage their difficulties (Smith, Kleijn, Trijsburg, & Hutschemaekers, 2007). Potential problems arise when therapists experience difficulties and cope ineffectively in ways that harm both therapist and patient. The need to study how trauma therapist reactions are managed and moderated to protect both therapist and patient and to discover if additional experience and trauma training may alleviate problems arising from therapist reactions. Complex trauma patients are a traditionally difficult population with which to work (Courtois, 2010; Pearlman & Saakvitne, 1995; Wilson & Thomas, 2004). By understanding how to help the helper, this population may be served more ethically and with greater efficacy.

Delimitations

This study has parameters that define the framework of the research. First, the sample is limited to only those therapists (counselors, marriage and family therapists, social workers, psychologists, psychiatrists) who are members of the International Society for Traumatic Stress Studies (ISTSS). Membership in ISTSS makes it likely these individuals are trauma therapists due to their academic interest and practice in trauma. The rationale behind this delimitation is to narrow the focus of the study to work with complex trauma patients, and therapists who work with this group, who are more likely to belong to this well-known professional organization dedicated to the study and treatment of trauma. Inclusion criteria require that participants 1) hold membership in ISTSS, 2) work within the United States because of language, educational norms, and professional licensure and title norms, 3) currently (or in the past 6 months) see at least two patients for therapy, at least one of whom has criteria for a complex trauma background and has met most of the seven problem areas for complex traumatic reactions, as outlined by Herman (1992) and described by Courtois

(2004). The primary purpose for this is to ensure, to the best of this researcher's capability, that the right target group of patients is being considered. Also, the therapists seeing these patients must have recently experienced the therapeutic process with these patients so they may more accurately reflect upon their experiences.

Limitations

Regardless of the precautions taken conceptually, practically, and methodologically, there are still several limitations to this study. They fall into three main categories: problems with definitions and communication with the participant, problems with instruments, and some statistical implications. First of all, although great care has been taken to strategically define all terms within the study as well as for the purposes of communication with participants, the constructs and concepts carry wide variation in how they are defined and conceptualized in general, and by participants. For example, the definition of trauma, complex trauma, and complex traumatic reactions carry practical definitional differences in by participants. Definitions will be included in the demographic questionnaire for clarification. These definitions are not used in the *DSM-IV-TR* (American Psychiatric Association, 2000), and are instead the definitions used within the academic research on trauma. As a result, there may be some confusion among participants in trying to identify complex trauma and complex reactions. If criteria were based upon diagnoses, according to the *DSM-IV-TR* definition of trauma, the most severely dysfunctional patients would be left out of consideration.

Because the criterion variables, therapist difficulties and coping in practice are rarely studied, there are few choices in terms of instruments. Regarding therapist difficulties, as conceptualized in this study, only one scale by Orlinsky et al. (1999) derived from the Davis et al. (1987) taxonomy, measures a range of therapist

difficulties on a continuous scale. As a result, the only reliability and validity data available for the instrument is found in the large-scale study by Orlinsky et al. (1999). Similarly, the reliability and validity data available for the Orlinsky et al. (1999) coping scale is also limited to their research findings. However, this scale captures a range of coping strategies as opposed to trauma therapist coping usually measured in terms of self-care, leisure activities, or traumatic reactions.

An obvious overall limitation of the study is the survey length and the personal nature of the items. Participants may be reluctant to take the survey because it is too long and/or they are asked personal questions and questions about their professional work. As a result, a smaller sample size may ensue which would diminish the statistical power of the study, and limit the generalizability of the results. Interaction effects may be difficult to detect when testing for moderation (Holmbeck, 1997), however, because the predictor variables and the moderator variable are unlikely to be highly correlated, there is a better chance that the moderator effects will be more evident. Work experience and training are combined to a compound moderator variable, which may somewhat convolute the meaning of the results.

Method

This study uses multiple regression analysis to test the moderation effects of work experience and trauma training on the impact of attachment and self-differentiation (predictor variables) on therapist difficulties and coping (criterion variables) in practice with complex trauma patients.

Participants will be randomly selected from a pool of members from the on-line directory of the International Society for Traumatic Stress Studies (ISTSS) under the inclusion criteria previously discussed. An email will be sent to potential participants which includes an informed consent, a description of the importance of

their participation and the approximate amount of time needed to complete the survey, contact information for this researcher and a research assistant (to provide another level of anonymity for participants), and a web link to the survey, and an endorsement from Dr. Christine Courtois. Dr. Courtois is an internationally recognized expert in trauma, and her endorsement may help to increase the response rate. For incentive, the participants will have the opportunity to submit their name to a drawing to win one of four $50 on-line gift certificates for a popular on-line bookstore. A demographic questionnaire, along with three surveys will be used to measure the constructs. The difficulties and coping scales of the Development of Psychotherapists Common Core Questionnaire (DPCCQ) (Orlinsky et al., 1999), the Differentiation of Self Inventory (DSI) (Skowron & Friedlander, 1998), and the Experiences in Close Relationship-Short Form (ECR-S) (Wei, Russell, Mallinkrodt, & Vogel, 2007; see also Brennan, Clark, & Shaver, 1998), will be used. The data will be extracted from the surveys and translated directly into Statistical Package for the Social Sciences (SPSS) for data analysis.

Definitions

Several terms must be defined within the context of this investigation since many of the terms are generally known among the participants but they may carry slightly different meanings. *Complex trauma* is trauma that occurs repeatedly and cumulatively over developmental time periods and within specific relationships and contexts (Courtois, 2004). This includes child abuse, domestic violence, attachment trauma occurring within intimate relationships where the victim is entrapped and conditioned (Courtois, 2004). Participants are asked to review a definition of complex trauma for clarification. *Complex trauma patients* are those patients who have experienced complex trauma and who experience problems in the following

seven symptom areas: 1) alterations in the regulation of affective impulses, 2) alterations in attention and consciousness, 3) alterations in self-perception, 4) alterations in perception of perpetrator, 5) alterations in relationship to others, 6) somatization/medical problems, 7) alterations in systems of meaning. Specific diagnoses are not used to describe these posttraumatic patients because of the variability in diagnoses to capture all the symptoms (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Participants are asked to self-identify as a therapist who works with a patient(s) with this description. *Trauma therapists*, are defined in this study as those therapists who work primarily with patients who have experienced trauma. This identification is accounted for as part of the inclusion criteria where participants are members of ISTSS and must see at least two trauma patients (including one complex trauma patient) in their practice.

In terms of criterion variables, the following definitions are used. *Therapist difficulties* in practice are defined as those difficulties encountered by therapists when skills fail during therapy or when therapists do not know how to use skills (Orlinsky & Rønnestad, 2005; Orlinsky et al., 1999). *Therapist coping* in practice is defined as those coping strategies employed, whether intentional or not, in order to navigate the therapeutic process regardless if those strategies actually benefit the therapist and/or patient (Orlinsky & Rønnestad, 2005; Orlinsky et al., 1999). Constructive coping refers to the positive coping strategies employed while avoidant coping refers to the negative strategies employed (Orlinsky & Rønnestad, 2005; Orlinsky et al., 1999). Therapist difficulties and therapist coping will be measured by the therapist difficulties and therapist coping subscales of the Development of Psychotherapists Common Core Questionnaire (DPCCQ) (Orlinsky & Rønnestad, 2005; Orlinsky et al., 1999).

Definitions of predictor variables include the following. *Attachment* is the adult attachment style of the therapist whereby human beings have the propensity "to make strong and affectional bonds to particular others." (Bowlby, 1977, p. 201). Anxious and avoidant attachment will be measured by the Experiences in Close Relationship-Short Form (ECR-S) (Wei, Russell, Mallinkrodt, & Vogel, 2007; see also Brennan, Clark, & Shaver, 1998). *Self-differentiation* is the ability to distinguish between feeling processes and intellectual processes (Peleg-Popko, 2002), and when under distress, determines if the individual will become emotionally reactive, emotionally cut-off, fused with others, or unable to remain autonomous (Bowen, 1978; Kerr & Bowen, 1988; Peleg-Popko, 2002; Skowron & Friedlander, 1998). Self-differentiation will be measured by the Differentiation of Self Inventory (DSI) (Skowron & Friedlander, 1998).

Trauma training is defined as training either within the context of graduate school which specifically focused on trauma, and/or trauma training post graduate school which may include continuing education, seminars, etc. *Work experience* is defined as general experience in the field of therapy post graduate school. Trauma training and work experience are added and combined into a compound variable using the demographic questionnaire responses regarding their experience and training.

CHAPTER 2

This study targets a specific group of therapists who treat a specific group of clients to determine how some specific therapist characteristics influence their reactions during the therapeutic process, and how the therapists' work experience and training may moderate their reactions. The problem investigated in this study is to determine to what extent work experience and trauma training with complex trauma moderates the relationship between therapist attachment style and self-differentiation in effecting therapist difficulties and therapist coping in practice with complex trauma patients. First, the purposes of the research and research questions are described. Then there is a description of trauma therapists who work with complex trauma patients and an explanation of the importance of studying the therapeutic process. Specific trauma therapist characteristics that influence the therapeutic process are examined, beginning with the proposed criterion variables, therapist difficulties and therapist coping in practice. Then, the predictor variables, therapist attachment style, and therapist self-differentiation are explored. The proposed moderators, therapist work-experience and trauma training, are reviewed. Finally, the lack of literature regarding these variables is discussed as substantiation of the need for this research study.

There are significant gaps in the literature that are addressed regarding trauma therapists and the characteristics they bring to the therapeutic process with complex trauma patients. There is little research looking at how training and experience may help to moderate those characteristics which may negatively influence the therapeutic process and ultimately, the patient. Specific therapist characteristics that may influence the therapeutic process are discussed broadly, and therapist-patient

dynamics that occur with patients who have experienced complex trauma are highlighted throughout.

Unlike most other studies looking at therapist characteristics, this study does not address specific client outcomes that are a result of these characteristics. The underlying question here is how trauma therapist work experience and trauma training influence the relationship between personological therapist characteristics (attachment and self-differentiation) quality of the and the actual therapeutic process they deliver. This study investigates how work experience and trauma training may moderate therapist attachment style and self-differentiation and in what way that may enhance or detract from the therapists' internal (difficulties) and external (coping) reactions during the therapeutic process.

Purpose

Overall, this study seeks to explore the difficulties and coping reactions of the trauma therapist during therapy with complex trauma patients in order to better understand how work experience and trauma training impact trauma therapist coping and difficulties by potentially interacting with the more personal variables, therapist attachment style and self-differentiation. In terms of the moderator research model presented, the purposes of the present study are:

- To understand how anxious and avoidant attachment styles and self-differentiation are associated with therapist difficulties and coping in practice with complex trauma patients.
- To understand how work experience and trauma training moderates the overall effect of therapist anxious and avoidant attachment styles and self-differentiation on therapist difficulties and coping in practice with complex trauma patients.

Trauma Therapists

When therapists work with traumatized patients, they are affected by the traumatic content and the way in which the patient relates to the therapist as a function the patients' relational deficits, difficulties, and emotional dysregulation resulting from their traumatic experiences. Therapists who work with traumatized populations experience a high level of emotional burden (Smith, Kleijn, & Hutschemaekers, 2007; Smith, Kleijn, Trijsburg & Hutschemaekers, 2007). Trauma therapists confront a complex clinical presentation including post-traumatic psychopathology, severe symptoms (acute posttraumatic symptoms, dissociation, etc.), and psychosocial troubles which may promote trauma therapist emotional stress (Smith, Kleijn, & Hutschemaekers, 2007; Smith, Kleijn, Trijsburg & Hutschemaekers, 2007). Considering these trauma therapists work with a population that is in need of careful psychological care (Courtois, 2004), there is a need for them to know the ramifications of their work which may include personal psychological symptoms and stress reactions that relate to trauma therapists' emotional, physical, and social well-being (Trippany, Kress, & Wilcoxen, 2004). The rationale for knowing these ramifications is help trauma therapists recognize what characteristics they bring to the therapeutic process, how these help or hinder their work, and how they can ultimately cope more effectively to improve their work with trauma patients.

Information on the identity, characteristics, contributions and the perspectives and experiences of therapists who work primarily with trauma patients is hard to come by (Lonegran, O'Halloran, & Crane, 2004). The literature that is available focuses on trauma therapist reactions, but not on their personal characteristics. Personal characteristics are mentioned within the context of experiencing vicarious trauma or compassion fatigue. In general, there is not much recent information

regarding the identity of psychotherapists (trauma-focused or otherwise), their professional and personal characteristics, and their contributions (Orlinsky & Rønnestad, 2005). Nor is there much empirical research regarding psychotherapists' representations of patients and how that may ultimately evolve, influence and change behavior (Geller, Lehman, & Farber, 2002).

There is a wealth of older literature addressing the psychotherapist as a person with a set of inherent and acquired characteristics that are brought to the therapeutic process (Castonguay & Beutler, 2006; Okiishi, Lambert, Nielsen, & Ogles, 2003). Hill, Nutt, and Jackson (1994), did an extensive review of psychotherapy process research published in two prominent counseling and clinical psychology journals and found that reported individual therapist characteristics only included experience level, gender, and to a lesser extent therapist race/ethnicity. Most research has focused on therapist techniques, followed by therapist manner, some combination of the two, and only one study focused on the relationship. Research on therapist characteristics has dissipated in the last twenty years probably due to a focus on empirically supported treatments and evidence-based practice (Beutler et al., 2004; Okiishi, Lambert, Nielsen, & Ogles, 2003). Orlinsky et al. (1999) makes a strong statement regarding the direction of psychotherapy research with respect to therapist characteristics, underscoring the trend in recent literature to focus solely on treatment and outcome:

> There is a strong presumption in psychotherapy research that treatment procedures are ultimately the main determinants of psychotherapeutic benefit, and that the nature and characteristics of the psychotherapists who provide those treatments should matter only with regard to their competence to perform the treatments in question and their ability to engage patients in

> cooperative relationships. The study of psychotherapists seems to slip from view again and again… (p. 128)

A brief snapshot of findings on therapist variables is necessary in order to understand how therapist characteristics are presented in the current literature, including definitions and how variables may influence patient outcomes. Very little is discussed in terms of looking at therapist variables and their influence on a specific patient population. Moreover, there is even less attention on therapist variables and therapist outcomes when working with a specific population, as addressed in the current study.

Therapist characteristics include sex, gender, ethnicity, training, experience, theoretical orientation (Beutler, 2004; Beutler, Machado, & Neufeldt, 1994; Okiishi et al., 2006), competence (Barber & Meuenz., 1996; Frank et al., 1991), empathy, directiveness, relationship skills, emotional adjustment, personality variables (Lafferty, Beutler , & Cargo, 1989) relational behaviors (Beutler, Machado, & Neufeldt, 1994), attachment style (Cassidy & Shaver, 1999) and countertransference reactions (McIntyre & Schwartz, 1998), to name a few. Beutler, Machado, and Neufeldt (1994) separated therapist variables into four quadrants including observable traits (gender, age, ethnicity), observable states (training, skill, experience, etc.), inferred traits (personality, coping styles, therapist emotional well-being, values, attitudes, beliefs), and inferred states (therapeutic relationship) in order to differentiate between inherent versus acquired characteristics, and the way in which the therapist interacts with the patient.

Using Beutler et al.'s (1994) classification system the constructs chosen for this study include work experience and trauma training (observable states) as potential moderators of the impact of therapist attachment style and self-differentiation

(inferred traits) on therapist difficulties and coping in practice (inferred traits). It is suggested that trauma therapist attachment and self-differentiation encompass the therapist's inherent ability to remain comfortable with longer-term, emotionally intense situations which require patience and flexibility in the relationship. It is important to understand if and how learned and acquired skills and experience and controllable variables, may influence inferred traits (attachment, self-differentiation, coping and difficulties) that the therapist brings to the therapeutic process. If this observable state, in fact, influences the inferred traits in a positive way, there is a clear case for enhancing trauma training and promoting work experience with traumatized individuals as a means of tempering any negative attachment or self-differentiation influence on therapist difficulties and coping.

Orlinsky and Rønnestad (2005), organize therapist variables similarly to Beutler, Muchado, and Neufeldt (1994), however, they categorize them into a comprehensive framework labeled 'facets of therapeutic work' addressing the therapist's influence over the therapeutic process. Their categorization involves the therapeutic process as a whole rather than individual therapist characteristics. Therapist characteristics are separated into seven categories including: 1) the goals that guide the therapist's work; 2) the clinical skills that therapists use to attain goals; 3) the difficulties therapists encounter when working with the patients; 4) the coping strategies the therapists employ to address their difficulties; 5) the general experience of relational agency while working; 6) the relational manner of the therapists as the therapist and patient interact in the therapeutic process; and 7) the therapist's personal feelings during sessions.

All seven of the aforementioned therapist characteristics are of interest in the therapeutic process and are explored in this study to some degree. For the purposes of

this study, the two characteristics under investigation are: the difficulties therapists encounter when working with patients and the coping strategies they employ to address these difficulties. The primary rationale behind this is to investigate the unique way in which this specific group of patients may evoke or activate therapist reactions within the therapeutic process. Difficulties encountered by the therapist may be due to a sense of decreased self-efficacy, frustration with the case, or negative personal reaction which may cause the therapist to feel powerless, overwhelmed, or unable to effectively help the patient (Orlinsky & Rønnestad, 2005; Orlinsky et al., 1999). Coping employed by the therapist as a reaction to the difficulties experienced may involve a range of problem-solving attempts from acknowledgement of their distress to avoidance of therapeutic engagement (Orlinsky & Rønnestad, 2005; Orlinsky et.al., 1999), some of which may ultimately harm both the patient and therapist. The therapeutic process may also be affected since an important part of treatment for this group of patients is based upon relational navigation and repair, and emotional and affect regulation (Briere & Scott, 2006). The therapist's personal feelings during sessions may be conceptualized as therapist difficulties, and the relational components organized by Orlinsky and Rønnestad (2005) as therapist attachment style and self-differentiation variables within the context of this study.

Much of the research concentrates on the impact of specific therapist characteristics, especially dysfunctional therapist behaviors (Skovolt & Rønnestad, 1992), on treatment outcomes (Roth & Fonagy, 2005) while leaving the impact of specific therapist characteristics on the therapeutic process and therapist outcomes neglected. Attachment and self-differentiation are important therapist variables to examine because these factors speak to how the therapist relates to the patient and the process of relating. For complex trauma patients, the process of relating and

connecting within the therapeutic relationship is often difficult, and sometimes chaotic due to their severe posttraumatic symptoms, emotional dysregulation and inherent mistrust of the therapist by the patient as a function of past traumatic experiences. Therapist difficulties and coping are important therapist variables to explore because they are the therapist's internal and behavioral reactions to the patient including the content they are divulging, the way in which the material is relayed, and the therapeutic relationship.

Instead of focusing on the therapist and the therapeutic process, most of the available research focuses on the effects of therapist variables on treatment outcomes. Crits-Christolph's (1991) meta-analytic review found a great deal of variation in findings regarding the contributions of the individual therapist, ranging from slight in some studies to accounting for a great deal of variance in others. There is very little relationship of therapist age, gender, or ethnicity on treatment outcome explored in the literature (Beutler et al., 2004; Beutler, Machado, & Neufeldt, 1994; Okiishi, 2006; Roth & Fonagy, 2005). Therapist characteristics shown to have a relationship to positive patient outcomes include the therapist's level of empathy, emotional adjustment, and personality variables (Lafferty et al., 1989).

Another gap in the literature has to do with defining a specific group of patients, and how therapist variables may impact the treatment process and treatment outcomes with specific groups of patients. Rosenheck, Fontana, and Cottrol (1995), studied patients with PTSD and found no significant effect of therapist-patient ethnic match on symptom reduction or psychiatric severity. Beutler, Machado, and Neufeldt (1994) report that therapist relational behaviors and interventions that stretch across orientation, such as directiveness and self-disclosure, are significant therapist variables especially when applied to patients with specific personality traits or

interpersonal styles. Trauma therapist attachment and self-differentiation may be conceptualized as relational and therapist difficulties and coping as relational behaviors. Complex trauma patients are a population that can be considered to have 'specific personality traits and interpersonal styles,' as described by Beutler, Machado, and Neufeldt (1994).

Beutler et al. (2004) present a comprehensive overview of available research regarding the impact of specific therapist variables on client outcomes, however, only seven studies reviewed specifically had posttraumatic stress disorder as the leading diagnosis, and no studies had borderline personality disorder, though there were several others labeled "mixed diagnoses." In these seven studies, no information was included regarding the nature of the trauma (i.e. type of trauma, and/or number of traumatic experiences), or the PTSD. So there is no way of knowing if the patients studied experienced a single traumatic event or repeated trauma conducive to complex traumatic reactions. This underscores the lack of literature available for diagnosis-specific research regarding therapist characteristics on client outcomes, and even less research available regarding the therapeutic process involving a specific type of therapist (i.e. trauma therapist) with patients possessing specific diagnoses or set of symptoms (i.e. complex trauma).

Critchfield and Benjamen (2006) reviewed studies regarding therapist characteristics and outcomes with personality disordered patients. These findings shed light on the effect of therapist characteristics on their work with the complex trauma patient population since many of these patients to have a freestanding or comorbid diagnosis of borderline personality disorder. Critchfield and Benjamen (2006) found evidence across the literature that the following therapist characteristics relate to positive patient outcomes in those with a personality disorder: "a comfort

with emotionally intense, long-term relationships, patience, tolerance of one's own feelings regarding both the patient and treatment process, specialized training, and an approach which is open-minded, flexible and creative" (p. 255). These specific therapist characteristics support the idea that therapist variables, especially in connection to their ability to develop and maintain an appropriate relationship, tolerate personal responses during the therapeutic process, and manage the process in an open and flexible way, are exceedingly important in facilitating positive patient outcomes. It is the therapist's *ability* to manage these variables during the therapeutic process that is addressed in this study. Trauma therapist attachment style and self-differentiation mark the ways in which the therapist relates to the patient and his or her ability to tolerate the relationship, as mentioned by Crichfield and Benjamen. Trauma therapists' experience of difficulties when working with these patients and how they cope with them points to how they tolerate their own and the patient's feelings and the approach they use to manage the therapy. It is promising that the authors found that specialized training may influence patient outcomes in a positive way. In this study, it is suggested that the mechanism by which specialized training positively influences patient outcomes is via therapist outcomes (i.e. less experienced difficulties and increased positive coping).

Trauma Therapist Reactions: Difficulties and Coping

Smith, Kleijn, Trijsburg, and Hutschemaekers (2007) describe a series of three studies they conducted exploring the importance of trauma therapist reactions when working with traumatized individuals. The researchers give evidence to support that trauma therapists have a trauma-specific reaction pattern, have more cynical views of others, experience a high degree of emotional burden, have difficulties related to the

trauma patient presentation, may have different coping strategies than other therapists, and employ more active interventions with their patients.

In the first study, Smith et al. (2007) investigated the self-experienced difficulties of therapists working with traumatized patients. The researchers wanted to know what difficulties trauma therapists experienced in their clinical work, whether emotional burden is related to burnout, and if countertransference, secondary traumatic stress, or vicarious traumatization is present (Smith, Klein, Trijsburg, & Hutschemaekers, 2007). Fifteen trauma center therapists of varying backgrounds (psychiatrists, psychotherapists, art and psychomotor therapists) participated in semi-structured interviews inquiring about 2 self-experienced difficult situations, and they completed questionnaires regarding burnout, work experience, situational straying, coping, resources, countertransference, sleep disturbances, and cognitive schemas.

Smith, et al. (2007) found that therapists who work with traumatized populations experience a high level of emotional burden, but they were not significantly different in burnout level when compared to the mental health reference group (administrative and housekeeping staff at the trauma center). Trauma therapists had difficulties related to the traumatized client presentation including their post-traumatic psychopathology, the severity of their symptoms and their psychosocial troubles. The authors found some evidence to support the possibility that there are parallel processes at work when trauma therapists enter into the difficulties of the therapeutic relationship and manage the posttraumatic coping strategies of their clients. In essence, they take on some dysfunctional coping themselves. When compared to "client-centered" therapists, trauma therapists were found to have differences in their basic assumptions including a more cynical view of the "goodness of people." Perhaps highlighting the emotional burden experienced by trauma

therapists managing complex traumatic material and the therapeutic dynamics affected the trauma therapists' general perspective on others. Trauma therapists did have fewer negative feelings whereas client-centered therapists showed higher disgust, anger, anxiety, sorrow, and feelings of estrangement; possibly the effect of trauma training and experience and a trauma-referenced philosophy. There were no significant differences found in countertransference between therapist groups.

The purpose of the second study was to understand therapists' reactions to traumatic situations in comparison to other difficult situations and examine the differences in difficulties and coping between specialized trauma therapists and other non-trauma therapists (Smith, Kleijn, Trijsburg, & Hutschemaekers, 2007). Researchers interviewed five expert trauma therapists and six expert non-trauma specialized therapists who self-identified as either psychiatrists or psychologists with a psychoanalytic or client-centered approach. They were engaged in an open discussion inquiring about their personal accounts of their reactions in "emotionally taxing situations with clients and on long-term personal changes and coping with stress of the profession" (Smith, Kleijn, Trijsburg, & Hutschemaekers, 2007, p. 208).

According to the researchers, three types of difficult situations emerged: traumatic, existentially difficult, and interactional. Traumatic situations were defined as client experiences meeting criteria A for the *DSM-IV-TR* (American Psychiatric Association, 2000) posttraumatic stress disorder diagnosis. Existentially difficult situations were defined as those where the therapist experienced the intense hopelessness of the client's situation. Interactional difficulties were defined as those wherein the therapist experienced strong emotional demands of the client.

In this second study, Smith et al. (2007) found strong support for a trauma-specific reaction pattern, in which therapists had specific reactions when working with

traumatized clients. These included shock, anxiety, helplessness, intrusions, ruminations about sessions, feeling provoked, feeling carried away by strong feelings of the client, feeling overwhelmed, and somatic reactions experienced by almost all therapists. Coping strategies used to assist the therapist were talking with colleagues or others about their in-session experiences. Other reaction categories tended to cluster around the therapist's personal therapeutic style. When Smith et al. (2007) did a combined analysis for studies 1 and 2 the findings of the trauma-specific reaction pattern were replicated. It was also found that trauma therapists who worked in a specialized trauma center reported more active interventions as opposed to the other experts who reported more reflection and experiencing position in therapy. So self-identified trauma therapists seem to have differences in therapeutic style and/or skills in their work with traumatized patients in comparison to other therapists.

The finding by Smith et al. (2007), that therapist personal therapeutic style influences their reaction pattern and that trauma therapists from a specialized trauma center employ more active interventions, is a reasonable argument for studying how specialized training and experience may influence trauma therapist difficulties and coping. Therapeutic approach may alter reactions and it is possible that training in certain styles or approaches may help to relieve difficult situations and/or increase positive coping (a purpose of this study) to understand if training and experience does play a moderating role.

It is important to underscore that somewhat counterintuitive results were found regarding the effects of trauma work on expert therapists (trauma-specialized or otherwise). Even the most experienced therapists identified traumatic situations as difficult and they experienced specific and overwhelming reactions within the context of working with these traumatized clients. However, these experts did not report being

traumatized, but rather, were well-functioning and satisfied with their work. The trauma therapists working in the trauma center, in fact, did not show signs or symptoms of secondary traumatization. So according to Smith et al. (2007), there were no differences between reaction patterns of expert therapists regardless of trauma specialization. The expert trauma therapists differed in therapeutic attitude, which researchers postulated may be due to severe, posttraumatic and existential client problems saturated within their work environment. This study may help to further understand some of these mixed findings regarding the similarities and differences between expert therapists.

Smith et al. (2007) found no evidence to support negative effects of long-term trauma work on therapist well-being or in-session coping behavior; questioning the previous assumptions regarding vicarious traumatization and countertransference. So it is extremely important to research this issue further to understand if trauma therapists cope and operate differently than other therapists, or if experience mitigates these reactions. Even though the researchers found that there were no differences in reaction patterns regardless of trauma specialization, the study only looked at the expert level, and did not include trauma therapists on a continuum of trauma therapy training and experience. There is a gap in the research here, regarding the influence of trauma training and experience and the possibility of it playing a moderating role on trauma therapist difficulties and coping along a continuum of training and experience rather than just the expert level.

In study three, the researchers investigated whether therapists' trauma-reactions were specifically related to their exposure to patients' traumatic experiences. One major difference here is that the sample consisted of psychology students rather than therapists or trauma therapists. Researchers asked psychology student

participants to rate their reactions to two video-taped clinical vignettes. One vignette was of a refugee describing a traumatic experience, the other vignette was of a client diagnosed with borderline personality disorder who initially idealizes the therapist, then goes into a rage and threatens suicide. The participants completed the Therapist Reactions and Emotions questionnaire (TREq) which measures the intensity of therapist emotions and behavioral tendencies in clinical situations.

Trauma reactions, as measured by the TREq, were significantly higher for the refugee vignette and emotional distancing was significantly related to the borderline vignette (Smith, Kleijn, Trijsburg, & Hutschemaekers, 2007). Interestingly, trauma reactions were high on the refugee vignette regardless of distancing, however, with regards to the borderline vignette, participants with high distancing had significantly more trauma reactions, as opposed to those scoring low on distancing in conjunction with low trauma reactions. This finding is extremely important because it uncovers both trauma-reactions and distancing as specific reactions related to both a traumatized and a borderline client. It provides evidence of therapist difficulties and coping in their work with clients with complex trauma since their presentations include both posttraumatic and personality disordered symptoms.

However, a major limitation of the third study is its utilization of college students, rather than therapists or trauma therapists, as participants. This notwithstanding, researchers concluded that trauma reactions are specific but not limited to traumatic situations. They found that distancing signified a strong countertransference reaction to the borderline scenario. Unfortunately, the researchers did not address is the likelihood of the client as also a traumatized client. In the current study, the client is conceptualized as having complex trauma an amalgam of traumatic experiences and developmental deficits of the client. Therefore it is

possible that both traumatic reactions and distancing along with other countertransferential reactions are patterns of reaction in trauma therapists. To what extent these patterns are present, however, may depend upon work experience and expertise, as indicated by the second Smith et al. (2007) study. This current study addresses the suggestion of these researchers who call for a more comprehensive study on trauma therapist reactions and coping in difficult clinical situations.

Trauma Therapist Difficulties

A difficult clinical situation develops when skills fail during therapy or when therapists do not know how to use them (Orlinsky & Rønnestad, 2005). These difficulties have been rarely investigated in the literature (Schröder & Davis, 2004). Instead, topics within this category of ‘therapist difficulties,’ research is limited to the countertransference literature and in the specific case of the trauma therapist, the vicarious trauma or secondary traumatic stress literature (Smith, Kleijn, & Hutschemaekers, 2007). Though extremely important to understanding therapist reactions during the therapeutic process, discussions regarding countertransference (Holmqvist, 2001; Holmqvist & Armelius, 1996) and vicarious trauma/secondary traumatic stress (McCann & Pearlman, 1990; Pearlman, & Mac Ian, 1995) do not encompass all types of therapist difficulty which may include the aforementioned issues, but also extend to other areas that are more situational, or based upon skill deficits, personal issues, and/or specific patient characteristics (Schröder & Davis, 2004).

Two notable studies in this area of ‘therapist difficulties’ are reviewed here in detail, because they are the only published studies, known to this author, aside from the three previously described studies by Smith, Kleijn, Trijsburg, & Hutschemaekers (2007) that examine therapist difficulties more broadly. Davis et al. (1987) developed

a taxonomy of therapist difficulties based upon therapist feeling states (i.e. incompetent, stuck, thwarted, etc.) which was later used in the more comprehensive study of psychotherapist development by Orlinsky & Rønnestad (2005) and colleagues. Schröder and Davis (2004) discuss therapist difficulties in general, without specifying the type of therapist or patient, while Smith, Kleijn, and Hutschmaekers (2007) and Smith, Kleijn, Trijsburg, & Hutschemaekers (2007) specifically discuss trauma therapist difficulties when working with trauma patients.

Davis et al. (1987) were the first to detail types of therapist difficulties during sessions. Because there is an obvious focus on therapist difficulties encountered during therapy in therapist education, training, and supervision, Davis et al. sought out to develop a taxonomy of these difficulties that were often discussed anecdotally in these forums, but that had not been investigated and tested empirically. An initial taxonomy was developed using the authors' own experiences as a starting point. It included the following therapist difficulties and feeling states: therapist incompetence, damaging, puzzled, threatened, out of rapport, personal issues, painful reality/ethical dilemma, stuck, and thwarted (Davis et al., 1987). The findings suggest that there may be individual differences in the perception of difficult experiences. Davis et al. (1987) conclude that several factors influence these difficulties, including "therapist's awareness of the difficulty and a sense of how easily it can be articulated, factors influencing recall such as the recency and intensity of the experience, characteristics of the therapist and of the context of inquiry that govern the kind and degree of censorship that occurs and sets that the therapist may bring to the inquiry" (p.116).

The study has limitations including the use of researcher-as-participant which may lead to respondent bias in the development of the taxonomy, the lack of many women participants, participants were clinical psychologists with at least five years

post-training work, six out of seven self-identified as eclectic, theoretically oriented therapists (one psychodynamic). So it is unknown if therapists with varying levels of training and experience identify different feeling states, difficulties or experience a categorical difficulty as more troublesome. These limitations, however, are similar to those in the Smith et al. (2007) studies and findings still reveal important information regarding therapist difficulties. Davis et al. (1987) acknowledge that utilizing a larger sample may show associations between prevalence and difficulty in the categories named in the taxonomy.

The researchers make suggestions for future research including: using a broader sample of therapists, and exploring any relationship between therapist difficulties and therapist characteristics, types of patients, type of therapy, therapy setting, and therapist coping strategies used to manage difficulties. The present study attempts to address several of these suggestions specifically, since therapist characteristics were found to influence therapist difficulties according to these researchers. It provides a basis for exploring therapist characteristics such as attachment style and self-differentiation. The rationale for exploring trauma therapist attachment style and self-differentiation characteristics in this study, as mentioned earlier, has to do with how the therapist connects and relates to the complex trauma patient.

The complex trauma patient is an identified type of patient targeted in this present study because they may evoke increased difficulties for the therapist as a function of their clinical presentation and deficits in relating to others. The type of therapy examined here specifically identifies trauma therapy as working with the patient's trauma history and the subsequent effects of the trauma, and it is trauma training and experience which is explored in order to understand any influence the

training may have on therapist difficulties. Though therapist work setting is not explored in this study, Klein, Smith, Trijsberg, & Hutschemaekers (2007) did explore trauma therapist difficulties as related to working in a trauma center. Trauma therapist coping is also explored in this study as a therapist reaction and therapist outcome in the therapeutic process in working with complex trauma patients. Davis et al. acknowledge that "it should be possible to investigate the therapist's experience of difficulty and therapist efforts to cope as critical variables in the process of therapy" (p. 117).

Orlinsky and Rønnestad (2005) used factor analysis of the twenty scales by Davis et al. (1987), in their large collaborative study, to come up with three dimensions of therapists' difficulties during therapy including: professional self-doubt, frustrating treatment case, and negative personal reactions. According to Orlinsky and Rønnestad, professional self-doubt is the most common and includes how to deal effectively with a patient, confidence and ability to have a positive effect on a patient, ability to move therapy in a forward direction, and feeling demoralized by an inability to assist a patient or the inability to conceptualize the patient's problems. A frustrating treatment case is, according to these authors, stimulates a feeling of powerlessness to affect the patient's life situation, overwhelmed by a static patient relationship, experiencing anger by problems in the patient's life that seemingly makes positive patient outcomes impossible, and feeling conflicted regarding meeting equal obligations to the patient and others. The therapist's attachment style and level of self-differentiation is involved in the process of difficulties experienced in trauma therapy because it is the process of relating (and the therapist's ability to do so) that enables or incapacitates the therapist to withstand the

intensity of the relationship and tolerate the patient's emotional output in a way that moves the therapeutic process forward and elicits change.

Schröder and Davis (2004) set out to understand therapists' difficulties through their narratives by discerning between types of difficulties, categorizing these difficulties, and establishing their reliability and validity. Schröder and Davis (2004) defined three types of difficulties: transient (non-permanent difficulties involving deficits in competency), paradigmatic (enduring difficulties that are idiosyncratic to the therapist), and situational (enduring difficulties due to 'difficult' patients and/or distressing situations for the therapist). In the case of transient difficulties, not attributed to the therapist's personal characteristics, as the therapist's knowledge, technical skills, and experience develop and accrue, it is expected that the difficulties dissipate or extinguish, according to the authors. Oppositely, paradigmatic difficulties are a direct result of therapists' personal variables including personality, interpersonal aspects, interactional patterns, etc. Schröder and Davis propose that an increase in skills and experience may assist the therapist in coping with paradigmatic difficulties, but skill acquisition would not eliminate them; and the inherent characteristics of the therapist would remain constant. Unlike transient and paradigmatic difficulties, situational difficulties rely on external factors due to problematic circumstances or patients with whom all therapists at all levels of development would find difficulties. Schörder and Davis suggest that further training and experience may cause situational difficulties to subside somewhat, but since they are permanent would not rid the therapist of them.

Schröder and Davis found that as the therapist's practice length (experience) increased, transient difficulties diminished. Therapist age was a nonfactor in predicting transient difficulties, so life experience was not a precursor to this type of

difficulty. Practice length was not correlated with paradigmatic or situational difficulties, which suggests that these two types of difficulties are unchanging and are not abated by the therapist's experience. Situational difficulties were positively correlated with patients described as "difficult." Less sizable correlations existed between the "difficult patient" category and both transient and paradigmatic difficulty types. An interesting result of this study is that researchers found evidence that therapists were either somewhat or vaguely aware (described as 'pre-conscious') of their difficulties. Schröder and Davis (2004) suggest that an exploration of difficulties and difficulty types would make experiences more conscious allowing the therapist to work on these difficulties to improve their therapeutic process and to increase positive patient outcomes.

The studies of Davis et al. (1987), Schröder and Davis (2004), and the Smith, Kleijn, Trijsburg, and Hutschemaekers (2007) provide a distinctive look at the overall experience of therapists' practice difficulties with some variation between studies. Regarding definition of therapist difficulties, it is important to note here, as also pointed out by Smith, Kleijn, and Hutschemaekers (2007) that the definition of therapist difficulties used in the Smith, Kelijn, and Hutschemaekers study was based on the presenting problem and is suggested to be independent of personality variables or experience level. This is unlike other definitions of therapist difficulties which rely mostly upon therapist experience (i.e. Orlinsky & Rønnestad, 2005). Schröder and Davis (2004), however, suggest that the experience of the therapist is vital to capture in order to understand the types of practice difficulties, and how these may be approached. All of these researchers place great importance on situation-specific difficulties, the therapist's reactions, and the acknowledgment that there are some patients who are universally regarded as 'difficult patients.'

In the Schroder and Davis (2004) study, special attention is placed on the ‘difficult patient.” Delimiting this specific patient-type is critical and purposeful since the experience of therapist difficulties is prevalent (McIntyre & Schwartz, 1998). The overall level of distress experienced by complex trauma patients is very high and their presenting problems are numerous (Herman, 1992). The ability of complex trauma patients to form stable, intimate relationships is often hindered due to the biological, psychological, and social implications of their trauma histories (Turkus, 1998; Wilson, 2002). These patient characteristics, can result in especially problematic interactions within the therapist-patient therapeutic process. Many of these characteristics stem from problems with interpersonal relations as a function of extreme vulnerability, fear and uncertainty experienced by the complex trauma patient (Wilson, 2002). Patients with complex trauma presenting borderline personality traits are often perceived by their therapists as more hostile and dominant and evoke therapist reactions which may negatively affect therapeutic outcomes (McIntyre & Schwartz, 1998). As therapists recognize and better understand their difficulties with complex trauma patients it is anticipated that positive coping will result, thus encouraging positive therapeutic outcomes.

Trauma Therapist Coping

Though there is a great deal of literature on coping and there is some consensus regarding the construct of coping, but it is unclear how coping is specifically defined (Heppner, Cook, Wright, & Johnson, 1995). The definition of coping has generally been approached from either a trait or process perspective (Penley, Tomaka, & Wiebe, 2002). In the trait approach, coping styles are fixed ways of dealing with stressful situations. The process approach to coping is variable, dependent upon what the stressor requires (Penley, Tomaka, & Wiebe, 2002). The

process-oriented definition of coping, according to Lazarus and Folkman (1984), relies on both individual-specific and situation-specific circumstances and includes both cognitive and behavioural ways in which an individual manages a stressful situation that surpasses personal resources. Lazarus and Folkman (1984) describe two parts in managing the stressful situation: 1) problem-focused coping which involves attempts to change the situation and 2) emotion-focused coping which involves attempts to regulate emotional distress under the stressor. Hence, problem-focused coping is a way of regulating external conditions and emotion-focused coping is a way of regulating internal reactions under duress. For trauma therapists, the difficulties encountered within the context of the therapeutic process (including the content, process of relating, and the patients' reactions) constitutes the stressful situation. The problems and emotions evoked as a result of those stressful situations requires coping.

Whether intentional or not, therapists employ coping strategies to navigate the therapeutic process regardless if they actually benefit the therapist and/or patient (Orlinsky & Rønnestad, 2005). Moreover, trauma therapists must cope with difficulties as they emerge during trauma therapy, including their own feelings of incompetency or skill-deficits (Fernandez-Alvarez, Clarkink, Salgueiro, & Critchfield, 2006), in-session feelings (Orlinsky & Rønnestad, 2005), countertransference reactions (Smith, Kleijn, and Hutschemaekers, 2007), uncertain interpersonal and relational interactions (Wilson, 2002), and boundary issues (Gutheil, 1989), in a kaleidoscope of ways that can be functional or dysfunctional. Trauma therapist reactions to these difficulties, labeled therapist coping, include various types of reactions (for example, internal or behavioral).

There is great concern regarding the mental health and well-being of those who help individuals overcome traumatic events (Bober, Regehr, & Zhou, 2006). Trauma therapists may experience feelings of helplessness and question their therapeutic competency due to the nature of work with people in crisis who are emotionally reactive and in urgent situations (Astin, 1997). So it is important to understand how trauma therapists, under this stress, and experiencing a great deal of emotional burden (Smith, Kleijn, & Hutschemaekers, 2007), cope with these difficulties. Much of the research regarding therapist coping revolves around the therapist's personality traits, locus of control, and countertransference (Beutler, et al. 2004). Specifically regarding the treatment of trauma, trauma therapist coping is discussed in terms of vicarious trauma (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995) or secondary trauma (Jenkins & Baird, 2002; Bride, 2007), compassion fatigue (Figley, 2002), and burnout (Perron & Hiltz, 2006). The definitions are briefly discussed because these terms dominate the literature regarding trauma therapists' coping as a result of engaging in trauma work.

Vicarious trauma is "the negative transformation in the helper that results from empathic engagement with trauma survivors and their trauma material, combined with a commitment or responsibility to help them" (Pearlman & Caringi, 2009, p. 202-203). Vicarious trauma occurs when the therapist experiences traumatic stress symptoms either immediately or post-therapy which may have a cumulative effect over time and duration of exposure to traumatic material (Bober, Regehr, & Zhao, 2006). Consequently, maladaptations in cognitive schemas, and intrusive trauma imagery (i.e. nightmares, etc.) may ensue (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995). Other manifestations of vicarious trauma symptoms include avoidance behaviours, struggling to listen to the patients'

recollection of events, emotional numbing, irritability, pervasive hopelessness, cynical world view, and distrustfulness of others (Bober, Regehr, & Zhao, 2006).

Figley (2002) used the term, “compassion fatigue” to describe the caregiver’s lessened ability to empathize with the traumatized individual, and the subsequent emotions and behaviors that follow from knowing about the traumatizing event experienced. It is understood that compassion fatigue stems from the process of empathizing with a person experiencing extreme pain and suffering (Deighton, Gurris, & Traue, 2007; Wilson & Lindy, 1994; Wilson & Thomas, 2004).

The broader term of ‘difficulties’ during therapy with complex trauma patients includes reactions of the therapist not only due to the trauma material, itself, but due to the patient’s presentation and behaviors during therapy typical of complex traumatic reactions (i.e. posttraumatic symptoms, dissociative symptoms, borderline personality traits, interpersonal relationship deficits, boundary issues, etc). These difficulties may be overwhelming to therapists. Smith, Kleijn, Trijsburg, and Hutschemaekers (2007) found that when working with traumatized patients, therapists experienced shock, anxiety, helplessness, intrusions, ruminations about sessions, feeling provoked, feeling carried away by strong feelings of the client, feeling overwhelmed, and experiencing somatic reactions. Evidence of these reactions is found in the studies of Smith, Kleijn, Trijsburg, & Hutschemaekers (2007) where trauma therapists experience a high degree of emotional duress, and relational difficulties.

Wilson and Thomas (2004) include vicarious trauma, secondary traumatic stress, and compassion fatigue within the conceptualization of traumatoid states (Pearlman & Caringi, 2009). Wilson and Thomas formulated the terminology “traumatoid states” to describe trauma therapists’ reactions as a result of their

"exposure to and intense work" (p. 173) with traumatized patients. They surveyed 345 trauma therapists regarding their reactions to working with trauma patients. The researchers studied empathic strain and countertransference reactions and found five specific types of reactions: 1) intrusive preoccupation with the nature of trauma work experiences; 2) avoidance and detachment; 3) overinvolvement and identification; 4) professional alienation; and 5) professional role satisfaction. Wilson and Thomas utilized their findings to define what they termed "traumatoid states" developed by persons working with traumatized individuals. They suggest that traumatoid states may be transient, acute or chronic in duration and may cause clinically significant distress in various aspects of therapist life functioning. They particularly developed the concept to identify pathology experienced by trauma therapists and other professionals when working with traumatized individuals to distinctly identify pathological coping reactions with diagnostic characteristics. A major contribution of this work is the attempt to understand the trauma therapist experience and specific trauma therapist reactions in work with traumatized individuals. The authors point out how the potentially traumatizing effect of trauma work subjects the trauma therapist to negative coping strategies identified as traumatoid states. This is somewhat contradictory according to Smith, Kleijn, Trijsburg, & Hutschemaekers (2007) who found that trauma therapists did not experience signs of vicarious trauma, secondary traumatic stress or compassion fatigue, and there was no evidence that prolonged exposure to working with traumatized individuals had pathological effects on the trauma therapist.

These two studies differed in terms of research design, and sample characteristics, and these differences may account for their contradictory findings. The Wilson and Thomas study surveyed 345 trauma therapists from an international

pool, from various work settings and who worked with patients with a variety of different trauma histories. The Smith, Kleijn, Trijsburg, & Hutschemaekers (2007) study was a qualitative design based in the Netherlands with a significantly smaller sample size, including interviews of therapists working at a single trauma institute with a specific type of trauma (torture). This current study addresses therapist reactions to gain information regarding the potentially negative reactions experienced by trauma therapists as a result of their work or, to understand how trauma therapists may successfully cope with trauma work to offset the development of symptoms of vicarious trauma, secondary traumatic stress, compassion fatigue, or traumatoid states.

An important similarity between the Smith, Kleijn, Trijsburg, and Hutschemaekers (2007) and Wilson and Thomas (2004) studies is that both sampled experienced trauma therapists. Deighton, Gurris, and Traue (2007), report that the duration of working with this patient population has received mixed findings in terms of its effect on the development of vicarious trauma, secondary traumatic stress, compassion fatigue, and/or burnout. This is likely due to the difficulty of discerning what type of therapist reaction is related to workload, exposure to traumatic material, or the process of empathizing, etc. Smith, Kleijn, Trijsburg, & Hutschemaekers (2007) suggest that experienced trauma therapists may be coping differently because they found little evidence to support long-term negative effects caused by exposure to trauma content. However, they found increased therapist difficulties regarding their process of relating to traumatized patients. This present study attempts to address how trauma therapist experience and training may influence trauma therapist coping and difficulties in light of these mixed findings, and also includes therapist characteristics (attachment style and self-differentiation) as important variables that influence

reactions. Similar to Wilson and Thomas, though, this study specifically looks at trauma therapists who work with complex trauma patients. Therefore, this study may also shed light on potential differences in trauma therapist reactions as a function of the type of traumatized patients with whom they are working.

The impact of training and experience on coping, specifically in regards to the trauma therapist, is not discussed in the literature except as it relates to the development of vicarious traumatization. Trippany, Kress, & Wilcoxen (2004) review the impact of education and training on the trauma therapist in terms of vicarious trauma. They discussed three studies including: Follette, Polusny, and Milbeck (1994); Chrestman (1995), and Alpert and Paulson (1990), each of which give evidence that training and education in dealing with sexual abuse cases was vital to therapist's ability to cope with difficult cases. Furthermore, training decreased PTSD symptoms in therapists working with traumatized patients and specific trauma training at the graduate level reduced effects of VT from working with patients with trauma histories. Smith, Kleijn, & Hutschemaekers (2007) found that trauma therapists employed more active interventions than the other expert therapists when faced with difficulties attesting to the importance of specialized training working with trauma.

Bober, Regehr, & Zhao (2006) developed a coping questionnaire specifically for traumatized counselors which included their beliefs regarding what coping strategies will reduce the likelihood of developing secondary traumatic stress and the frequency with which they utilized coping strategies. Coping strategies included case discussions, stress management training, supervision, leisure activities, self-care activities, etc. Though very useful in understanding how trauma therapists may reduce the effects of secondary traumatic stress, the authors define coping as effective strategies used to increase the trauma therapist's self-care outside therapy. For this

current study, coping encompasses the trauma therapist's responses to difficulties both during the therapeutic process and outside therapy. Trauma therapist coping is not limited to specific strategies employed to reduce the stressful effects of trauma work.

Orlinsky and Rønnestad (2005) used the coping strategies developed by Davis, Francis, Davis, & Schröder (1987) to understand types and frequencies of those used by therapists. Six dimensions were derived using factor analyses of the twenty-six scales (one scale per coping strategy). They include: 1) exercising reflective control; 2) seeking consultation; 3) problem solving with patient; 4) reframing the helping contract; 5) seeking alternative satisfactions; and 6) avoiding therapeutic engagement (Orlinsky & Rønnestad, 2005). According to these authors, exercising reflective control includes "reviewing privately how the problem has arisen, trying to see the problem from a different perspective, containing troublesome feelings, interpreting the patient's resistant or troublesome behavior, setting limits to maintain an appropriate therapeutic frame" (p. 52). Seeking consultation is self-explanatory and includes seeking out the advice of an experienced therapist or discussing the issue with a colleague, reviewing academic material, or seeking training in a professional seminar. Problem solving with the patient includes engaging in a collaborative effort to deal with the difficulty, expressing the difficulty with the patient, or giving self "permission to experience difficult or disturbing feelings" (p. 52). Reframing the helping contract suggests that the therapist understands their need to change the therapeutic approach with the patient, or to make changes in the therapeutic contract, etc. Seeking alternative satisfactions and avoiding therapeutic engagement are coping strategies whereby therapists abandon their treatment goals as opposed to exploring ways in which to meet them Seeking alternative satisfactions implies that the

therapist seeks satisfaction away from the therapy or express upsetting feelings to someone close to the therapist. Avoiding therapeutic engagement is the most dangerous form of coping because it may potentially cause harm by the therapist's criticizing or displaying the therapists' irritation towards the patient, avoidance of the problem altogether, ignoring the difficult situation, prematurely terminating therapy, or referring the patient elsewhere (Orlinsky and Rønnestad, 2005). The first three positive coping strategies were positively intercorrelated and as a result, Orlinsky and Rønnestad created a single scale called 'constructive coping.' Constructive coping encompassed the positive aspects of exercising reflective control, seeking consultation, and problem solving with patient. Orlinsky and Rønnestad's approach to therapist coping as a function of difficulties experienced during the therapeutic process includes both problem-focused and emotion-focused aspects to coping. This is helpful in understanding both situational and emotion-derived difficulties and how the trauma therapist may cope within and outside of therapy with difficulties encountered with complex trauma patients.

Instead of focusing solely on any pathological responses and development of vicarious trauma, this study looks more broadly at a range of difficulties trauma therapists experience and coping methods employed in order to understand their reactions more comprehensively. Two variables the trauma therapist brings to therapy, which may influence reactions, are their attachment style and self-differentiation. These characteristics are important because they involve how the trauma therapist relates to others. Herman (1997) discussed that the therapist's response to the trauma survivor may include detachment, distancing, and/or identification with the trauma patient. Because many complex trauma patients have pathological and deficient ways of relating to others as a function of their histories,

how the trauma therapist relates to the patient is critical in fostering a healthy therapeutic process and helping the patient to recover. In an inverse way, therapist attachment and relational abilities can negatively impact trauma therapist reactions, thus negatively altering the trajectory of therapy and potentially retraumatizing the client. For example, Marmaras, Lee, Siegel, and Reich (2006) found a significant positive relationship between attachment style and disrupted cognitive schemas, intrusion symptoms, hyperarousal and avoidance among female trauma therapists. These findings suggest that attachment insecurity is related to other negative trauma therapist reactions and can be problematic in therapy with traumatized individuals. There is little to no research addressing these specific trauma therapist variables and so this study explores the trauma therapist characteristics of attachment style and self-differentiation and their influence on trauma therapist reactions when working with complex trauma patients.

Trauma Therapist Attachment Style

Attachment style, as applies to helping complex trauma patients, is especially significant. A patient's insecure attachment style (anxious/avoidant, dismissing or disorganized) is engaged in the therapeutic process because therapy is a relationship that activates the patient's attachment system. The therapist's attachment style is an important variable. If it lies somewhere within the insecure dimensions (anxious to avoidant, according to Mikulincer & Shaver, 2007; see also Brennan, Clark, & Shaver, 1998), it can put the relationship, therapeutic process, and the ultimate treatment and care of the complex trauma patient in jeopardy. The treatment of these patients require a therapist's active engagement in working with the therapeutic bond, repairing rifts, and teaching and modeling emotional and affect regulation (Briere & Scott, 2006; Pearlman & Courtois, 2005). According to Bowlby (1988) therapy

should attend to repairing maladaptive relational patterns which may prove difficult if not impossible, if the therapist is not securely attached.

Therapist attachment style and its effect on the therapeutic process is addressed specifically with regards to process variables and patient characteristics and outcomes. Both are presented due to the difficulty in separating the dynamic process between therapist attachment style, therapeutic process, patient characteristics, and ultimate therapeutic outcome. Therapist attachment style is explored in the literature, mostly in relationship to the therapeutic alliance (Bartholomew,1997; Black, Hardy, Turpin, & Parry, 2005; Bruck, Winston, Aderholt, & Murran, 2006; Crook & Gelso, 2000; Dozier, 1990; Eames & Roth, 2000; Meyer, Pilkonis, Projetti, Heape, & Egan, 2001; Satterfeld & Lyddon, 1998), expressed empathy (Beutler, Blatt, Alimohamed, Levy, & Angtuaco, 2006), theoretical orientation (Black, Hardy, Turpin, & Parry, 2005), problems or difficulties during therapy (Black, Hardy, Turpin, & Parry, 2005; Meyer & Pilkonis, 2001), countertransference behaviors (Ligerio & Gelso, 2002), patient attachment style (Beutler, Blatt, Alimohamed, Levy, & Angtuaco, 2006; Bruck, Winston, Aderholt, & Murran, 2006; Tyrell et al., 1999), patient outcomes (Beutler, Blatt, Alimohamed, Levy, & Angtuaco, 2006; Bruck, Winston, Aderholt, & Murran, 2006), and strategies employed during therapy (Bernier & Dozier, 2002). Literature on the attachment style of the trauma therapist, specifically, in relationship to trauma therapist variables, the therapeutic process, or patient outcomes is practically non-existent. Moreover, the literature on attachment style of the therapist (trauma therapist or otherwise) in relationship to, the complex trauma patient or personality disordered patient is limited at best. Only Marmaras et al. (2003) address the attachment style of the trauma therapist in relationship to trauma therapist outcomes (vicarious trauma).

Trauma therapist attachment style has been found to impact the therapeutic process with trauma patients (Marmaras, Lee, Siegel, & Reich, 2003). Marmaras, Lee, Siegel, & Reich (2003) examined the relationship between attachment styles and vicarious traumatization in female trauma therapists and found a significant positive relationship between attachment style and disrupted cognitive schemas, intrusion symptoms, hyperarousal and avoidance. The researchers sought to address the gap in the available research regarding the relationship between therapist interpersonal style and symptoms of vicarious trauma. Marmaras, Lee, Siegel, & Reich (2003) surveyed 375 female trauma therapists who work with adult outpatient trauma survivors and were given measures to determine their attachment style and vicarious trauma symptoms. Therapists with fearful or preoccupied attachment styles reported more disruptions in their cognitive schemas than did dismissive-avoidant or securely attached trauma therapists. The researchers suggested that securely attached trauma therapists may have felt more comfortable reporting a low level of distress, while the dismissive-avoidant therapists may have denied feeling any emotional distress. Overall, the researchers found that fearful-avoidant attachment style was the best predictor of cognitive disruptions and symptoms of distress (vicarious trauma). This current study attempts to expand the investigation by exploring the relationship of trauma therapist attachment style and their experienced difficulties and coping in their work with complex trauma patients rather than the development of vicarious trauma. The present study looks more broadly at a range of difficulties and coping the trauma therapist experiences and how work experience and training may moderate the influence of attachment style on therapist reactions. Drawing upon the work of Marmaras et al. (2003), it can be inferred that the current study would result in similar findings whereby trauma therapists who are insecurely attached (anxious or avoidant)

would experience both greater difficulties and engage in more negative coping in comparison to their more securely attached peers.

Several studies are available that show evidence of a positive relationship between therapist secure attachment style, therapeutic alliance, and therapeutic outcomes (Bruck, Winston, Aderholt, & Murran, 2006; Black, Hardy, Turpin, & Parry, 2005; Meyer, Pilkonis, Projetti, Heape, & Egan, 2001; Eames & Roth, 2000; Satterfeld & Lyddon, 1998; Bartholomew,1997; Dozier, 1990). Black, Hardy, Turpin, and Parry (2005) explored therapist attachment style and therapeutic orientation in relationship to therapeutic alliance and problems during psychotherapy. Their study included 491 participants who responded to a survey. Findings included that therapist attachment style explained a significant proportion of the variance in the development of the therapeutic alliance and problems during therapy. Therapist secure attachment style was positively correlated with good therapeutic alliance, while therapist anxious attachment styles were significantly negatively correlated with therapeutic alliance and significantly positively correlated with problems during therapy. Similarly, Meyer and Pilkonis (2001) found that therapist secure attachment was important in forming an alliance and handling difficulties in therapy. Anxious attachment style hindered forming an alliance.

Some research regarding therapist and/or patient attachment style in relationship to therapeutic alliance or therapeutic outcomes describes the possibility that the attachment system is not activated. This would explain why correlations or a predictive relationship between attachment style, therapeutic alliance, or therapeutic outcomes were not found. For example, Crook and Gelso (2000) found that therapist attachment style had no impact on working alliance with a prospective client, and that attachment style, alone, is not likely to be predictive of working alliance or

countertransference behaviors. Ligiero and Gelso (2002) looked at countertransference, therapist attachment style and the working alliance among therapists in training. No correlation was found between therapist attachment style and countertransference behaviors or working alliance, though the authors suggest that this is likely because the therapist does not see the client as an attachment figure and his/her attachment system is, therefore, not activated. Specifically, Ligiero and Gelso reference the explanation by Farber et al. (1995) suggesting that the therapist is viewed as an attachment object while the therapist does not view the client in the same way in terms of being an object of security, strength, and power. Though there are contradictory research findings, there is more evidence in support of the relationships between therapist attachment and therapeutic alliance and outcomes, rather than against it. Patients with complex trauma histories whose symptoms include borderline personality features will be particularly susceptible to the activation of the attachment system which must be a focus in the therapeutic work with these patients (Alexander & Anderson, 1994). If the trauma therapist, as a function of their own attachment insecurity, cannot engage in this work with their complex trauma patients the therapist could experience great difficulty and employ unconstructive and even damaging coping, to the detriment of the patients.

There is a general consensus that complimentary therapist and patient attachment styles effectively challenge the patient's maladaptive relational patterns (Bernier & Dozier, 2002; Wallin, 2007). There is evidence to support that securely attached therapists, with patients whose attachment styles are dissimilar tend to promote better therapeutic outcomes (Beutler, Blatt, Alimohamed, Levy, & Angtuaco, 2006; Bruck, Winston, Aderholt, & Murran, 2006; Wallin, 2007). Tyrell, Dozier, Teague, and Fallot (1999) discuss the importance of the therapist's secure attachment

to his/her capacity for emotional regulation that then enables the therapist to attend to the patient's emotional distress and assist them in learning to regulate. Patients respond more favorably to therapeutic interventions that counteract their maladaptive relational patterns (Tyrell, Dozier, Teague, & Fallot, 1999). In the case of the complex trauma patient, where emotional distress is high and affect management is low, it is crucial for the therapist to engage the patient in a way that promotes relational stability and challenge the patient's insecure attachment style.

In general, individuals with differing attachment styles have different emotional experiences and differing interactions with others (Feundeling, 1998). Overall, therapists who are anxiously attached express less empathy and are less responsive to clients who are dismissive in style (Beutler, Blatt, Alimohamed, Levy, & Angtuaco, 2006). Diamond et al. (1999) discuss borderline personality disordered patients and their attachment style as it relates to the therapist's reactions during therapy (though without attention to the therapist's attachment style). A Kernberg Transference-Focused Psychotherapy was used by a single therapist with two patients diagnosed with borderline personality disorder, one with pre-occupied insecure style and one with dismissive insecure style. The approach changed their attachment style from insecure to "earned secure" in one year (Diamond et al., 1999). Of note was the finding that the therapist was much less engaging and had a diminished therapeutic bond with the dismissive patient in comparison to the one with a pre-occupied style (Diamond et al., 1999; Beutler, Blatt, Alimohamed, Levy, & Angtuaco, 2006). Additional research is needed regarding therapist attachment style as it relates specifically to personality disordered or insecurely attached patients (Fernandez-Alvarez, Clarkin, Salgueiro, & Critchfield, 2006).

Bruck, Winston, Aderholt, & Murran (2006) explored therapist and patient introject and attachment styles in terms of their prediction of both therapeutic process and therapy outcomes. These researchers included therapists at varying levels of experience, and provided specific training to the therapist participants. Forty-six therapists and patients were recruited and assigned to one of two treatment conditions (CBT or short-term dynamic psychotherapy). Psychologists, psychiatrists, and social workers were the therapists who received a weekly training seminar and weekly supervision for one case. The age and training level of the therapists varied widely. Exclusion criteria for patients included organic brain conditions, psychosis, severe medical problems, severe major depression or bipolar disorder, active substance abuse, active suicidality, and use of psychotropic medication within the last six months.

Bruck and colleagues found that introject and attachment styles had predictive relationships in the early stages of treatment and in therapy outcomes. Differences were found between patients and therapists insofar as patient introject and attachment styles did not predict therapy outcome, but did predict in-session process, a finding which is in line with previous studies regarding therapeutic alliance, according to Bruck, Winston, Aderholt, & Muran (2006). Therapists with affiliative introject styles had more positive in-session process and their patients had better outcomes. Therapists who were fearful, dismissing, or preoccupied had both worse in-session process and therapy outcomes. Similar to findings of other studies, these researchers found that the more dissimilar the personality styles (positive introject style and secure attachment style) of the therapist and patient (negative style and insecure attachment), the more positive outcomes in terms of therapeutic process and patient improvement. The researchers also noted that therapists with a self-hating introject

style and insecure attachment had problems engaging patients in a positive therapeutic process and promoting positive outcomes.

The findings of the Bruck et al. (2006) study support the study proposed here. First, the study looks at attachment styles of both the therapist and patient, separately and in terms of therapist-patient match, in terms of its relationship to *both* the therapeutic process and outcome. Second, the findings underscore the importance of therapist secure attachment style on positive therapeutic process and outcome. Third, the findings suggest that patient attachment style is predictive of the therapeutic process, and that a therapist who is securely attached in fact promotes both a positive therapeutic process and patient improvement. Finally, although not discussed or expanded upon, these researchers found no differences in treatment conditions, and importantly, found no differences in psychiatrists and psychologists in any of the process or outcome measures (social-workers were not commented upon). This suggests that the specialized training they received may have been more important than type of education they had. The difference in what the researchers called the therapists' 'training' (though it can be argued that this may be called 'experience') was great; from less than one year to 32 years. Taken together, this is extremely interesting, since all therapists in the study received the same, specific, specialized training and supervision regarding the treatment of one patient. However, no data were reported in terms of age, experience level (what the researchers call 'training'), and introject or attachment styles in relationship to therapeutic process and outcomes, leaving many unanswered questions regarding the potential impact of experience and specific training on therapist attachment style, especially in the case of a specific patient population. The current study will specifically address the potentially moderating effect of therapist work experience and specialized trauma training on the

overall impact of therapist attachment style (and self-differentiation) on therapist difficulties and coping in the treatment of complex trauma. The potential findings could illuminate how learning (work experience and trauma training), could potentially reduce the negative impact of attachment style on the therapists' reactions (therapist difficulties and coping) on the therapeutic process.

Trauma Therapist Self-differentiation

Bowen (1978) described a construct within his family systems theory that he identified as "differentiation of self" (also referred to as self-differentiation). Bowen defines differentiation of self as the degree to which an individual can balance emotional and intellectual functioning, and intimacy and autonomy within relationships. Self-differentiation is the ability to distinguish between feeling processes and intellectual processes (Peleg-Popko, 2002). The more differentiated person is more flexible, copes well with stress and "operates equally well on both emotional and rational levels while maintaining a level of autonomy within their intimate relationships" (Skowron & Friedlander, p. 235; see also Bowen, 1976, 1978). The extent to which one is self-differentiated will ultimately determine how an individual responds to life stressors and to what extent the person will experience psychological and physical symptoms (Bartle-Haring & Probst, 2004; Skowron & Friedlander, 1998). Kerr and Bowen (1988) noted that the capacity to deal with life stress is an integral aspect of self-differentiation. In other words, individuals with a high level of self-differentiation will experience a life event with less distress than an individual with a low level of self-differentiation (Friedman, 1991). Bowen (1978) described both active and passive forms of reactivity that indicate a lack of self-differentiation (Bartle-Haring & Probst, 2004). Overall, those with a low level of differentiation are 1) emotionally reactive, hyperfocused, and involved in their intense

emotional experience and expression of feelings, 2) unable to take an ‘I’ position, defined as the ability to remain autonomous and have a clear sense of self when feeling pressured or stressed, 3) fused with others in close relationships where they are either rigid or consistently seeking acceptance and approval, and 4) emotionally cut-off since closeness with others is intensely threatening and the individual distances and detaches when feelings are too strong to manage (Bowen, 1978; Kerr & Bowen, 1988; Peleg-Popko, 2002; Skowron & Friedlander, 1998;). As an individual moves along the continuum towards a higher level of self-differentiation, they are less likely to respond to stress and more stress is required to trigger symptoms (Kerr & Bowen, 1988). Individuals who are highly self-differentiated are comfortable in intimate relationships and do not emotionally withdraw or fuse with others in order to manage their anxiety (Skowron, Holmes, & Sabatelli, 2003).

A great deal of empirical evidence supports Bowen theory and the concept of self-differentiation (Bartle-Haring & Probst, 2004; Charles, 2001; Greene, Hamilton, & Rolling, 1986; Murdock & Gore, 2004; Peleg-Popko, 2002; Perosa, Perosa, & Tam, 1996; Skowron, Holmes, & Sabatelli, 2003). Charles (2001) reviewed eight empirical studies regarding Bowen’s concepts of self-differentiation, triangulation, and fusion and found evidence to support the construct of self-differentiation. Skowron, Wester, & Azen (2004) found that degrees of self-differentiation mediated the effect of college stress on psychological adjustment. Bartle-Haring and Probst (2004) found a significant, positive relationship between emotional reactivity and psychological symptoms. Higher levels of reactivity (reflecting low levels of self-differentiation) were significantly associated with higher levels of psychological distress. Similarly, Johnson and Buboltz (2000) found that self-differentiation predicted psychological

reactivity (especially in the case of young adults). These studies support self-differentiation as an important construct related to psychological distress.

Regarding self-differentiation in those with mental health problems, Greene, Hamilton, and Rolling (1986) found that an inpatient sample had significantly lower levels of self-differentiation than a non-clinical control group. No specific research has studied the level of self-differentiation in individuals who have experienced complex trauma. However, the literature regarding boundary problems, attachment style, unstable sense of self, problematic interpersonal relationships, profound mistrust of others and other borderline personality features in individuals with complex traumatic stress suggests a low level of self-differentiation. The experience of well-being is significantly associated with self-management skills (Skowron, Holmes, & Sabatelli, 2003), and an individual's level of self-differentiation includes the ability to regulate affect, maintain a coherent sense of self, and have the capacity to balance autonomy in personal relationships (Skowron, Wester, & Azen, 2004). These are issues with persons with complex trauma and its subsequent effects on the biological, psychological, and attachment systems (Wilson, 2002). Therapists will likely find low levels of self-differentiation in their trauma patients, adding to the complexity of the relationship in ways that create difficulties for trauma therapists, especially those who themselves may have low levels of self-differentiation.

The construct of interpersonal boundaries is pertinent to self-differentiation. Both encompass concepts of personal autonomy and separation between where one person 'ends' and another 'begins.' Low self-differentiation or smaller/ 'thinner' boundaries often create dysfunctional interactions with others, and that higher self-differentiation or more/ 'thicker' (while not rigid) boundaries promote healthier and more appropriate interpersonal actions (Briere, 2002). Lopez (2001) investigated self-

other boundary regulation and adult attachment. Lopez (2001) found that high attachment anxiety and low levels of self-other differentiation were associated to self-splitting (where feelings of self shift radically); while high attachment anxiety and low emotional reactivity were associated with other-splitting (where there are high levels of doubt in close relationships). Splitting defenses are related to and part of dysfunctional coping when relational stress is experienced (Lopez, 2001). It may be inferred that if the therapist is not highly self-differentiated, he or she will have less autonomy and "thinner" boundaries, and ultimately more difficulties and greater potential for dysfunctional coping behaviours. The more differentiated a person, the more capable of taking ownership in their relationships with a greater sense of self and autonomy (Bowen, 1976, 1978; Kerr & Bowen, 1988; Peleg-Popko, 2002). During therapy with complex trauma patients, the trauma therapist's level of self-differentiation will affect the therapy in terms of their ability to remain autonomous, keep their sense of self intact, and take ownership of the therapeutic relationship.

Attachment and self-differentiation are related constructs. Emotional reactions and their regulation occur as a function of the activation of therapist and patient attachment systems (Fuendeling, 1998; Lopez, 2001; Skowron & Dendy, 2004; Wei, Russell, Mallinckrodt, & Vogel, 2008; Wei, Vogel, Ku, & Zaklik, 2005). Skowron and Dendy (2004) studied the relationship between self-differentiation and attachment, as related to effortful control. Effortful control involves the individual's capacity to consciously modulate or regulate arousal, feelings, and behavior (Derryberry & Rothbart, 1988). In this study, attachment avoidance was significantly related to emotional cut-off and attachment anxiety to emotional reactivity. Greater self-differentiation predicted greater effortful control. Not surprisingly, less emotional reactivity and the greater the ability to take an 'I' position were associated

with greater effortful control. The authors describe the importance of autonomy and togetherness, which individuals seek to balance.

Differentiation of self was part of the criteria used to test construct validity of the Experiences in Close Relationship-Scale (ECR-S), an attachment measure, in a series of studies by Wei, Russell, Mallinckrodt, and Vogel (2008). An individual's attachment anxiety or avoidance either "hyperactivates" or "deactivates" distress which directly influences their emotions and interactions with others (Wei, Mallinckrodt, & Vogel, 2008; Wei, Vogel, Ku, & Zaklik, 2005; see also Feudling, 1998). An anxiously attached individual will intensify or hyperactivate emotional expression and perhaps cling to others, while an individual with attachment avoidance will repress emotional expression and detach from others (Fuendeling, 1998; Wei, Vogel, Ku, & Zaklik, 2005). Wei, Russell, Mallinkcrodt, & Vogel (2008) found a significant relationship between emotional reactivity and anxious attachment, and emotional cut-off and attachment avoidance. In the case of both attachment security and self-differentiation, the individual must have the ability to engage in an intimate relationship whilst keeping a sense of self and separateness without cutting off from others. Hence, it is imperative to understand how both attachment and self-differentiation of the trauma therapist may influence difficulties experienced and coping strategies used within the context of the therapeutic relationship in light of the specific attachment, self-differentiation, self-regulation and boundary issues that face individuals with complex trauma histories.

Murdock and Gore (2004) explored the relationship between perceived psychological distress, self-differentiation, coping style, and psychological dysfunction. They found empirical support for Bowen's suggestion that psychological distress is moderated by the individual's level of self-differentiation.

Murdock and Gore (2004) consider coping style because of the inference that individuals who are low in self-differentiation will cope more poorly than those who are highly self-differentiated. In light of Bowen's description of self-differentiation, Murdock and Gore (2004) substantiate that poorly self-differentiated individuals would employ emotionally reactive and avoidant coping strategies whereas highly self-differentiated individuals would employ content-focused, active coping strategies. Indeed, the authors found that low differentiation of self was significantly associated with suppressive and reactive forms of coping, and highly differentiated individuals were significantly associated with reflective coping strategies. The authors discovered that regardless of coping styles, the interaction of self-differentiation and perceived stress did predict the variance in functioning. Murdock and Gore (2004) imply that coping style and self-differentiation are related, but not equivalent. It is important to note that in the Murdock and Gore study, psychological distress is the outcome variable, not coping (as coping is the dependent variable in the present study). Moreover, they suggest that future research address the issue that learning more positive forms of coping may influence self-differentiation and ultimately, psychological distress. In the present study, therapist self-differentiation may also be related to therapist coping insofar as the lower level of self-differentiation, the more difficulties experienced during practice and the less constructive coping employed.

Attachment style and self-differentiation are constructs which define an individual's propensity to merge or distance with activation of the attachment system under distress within an interpersonal relationship (Fuendeling, 1998; Lopez, 2001; Skowron & Dendy, 2004; Wei et al., 2008; Wei et al., 2005) and are therefore logical predictor variables of therapist difficulties and coping in practice. Given the

aforementioned self-differentiation literature and the relationship between self-differentiation and psychological distress, insecure attachment, and affect regulation; one hypothesis in this study is that trauma therapists with low self-differentiation will encounter more difficulties and employ more negative coping when working with complex trauma patients. It is important to understand how specific work experience and trauma training may assist in moderating the effect of self-differentiation on difficulties and problematic coping during therapy, informed by Murdock and Gore's suggestion that teaching positive coping strategies (in this case, trauma training and increased work experience) may increase the use of active, objective forms of interpersonal interactions. Training and experience may then moderate the effect of self-differentiation of the trauma-therapist in relationship to difficulties and coping when working with complex trauma patients.

Work Experience and Trauma Training

Work experience and training are considered observable states, according to Beutler, Machado, and Neufeldt (1994). There are mixed findings regarding experience and training in terms of 1) the definition of work experience and training, in general, 2) their overall effect on outcomes and 3) the therapeutic process (Roth & Fonagy, 2005). All three points are described in order to get a holistic picture of how therapist work experience and training is approached in the literature. It is important to understand how experience and training may impact the relationship between attachment and self-differentiation to therapist difficulties and coping.

Researchers approach the definition of psychotherapeutic experience or training differently (Beutler et. al, 2004). There is great variability regarding definitions of these terms and conflictual information regarding what is defined as 'experience' and what is defined as 'training' (Beutler et al., 2004). Using academic

degree to define ‘experience’ classifies new therapists with those that have been practicing for a number of years (Roth & Fonagy, 2005; Stein & Lambert, 1995). Additionally, therapist ‘experience’ is often confused with ‘expertise,’ and studies involving psychotherapist trainees often do not take into account the supervision that the trainee may or may not be undergoing (Roth & Fonagy, 2005).

Stein and Lambert (1995) point out that separating training from experience, in general, is problematic because a therapist will accrue experience as he or she is being trained. For example, they make the argument that a graduate trainee may be perceived as being more experienced after completion of an internship because they carried a larger caseload than other fellow students at the completion of their internships. Moreover, the number of cases may not accurately reflect the quality of therapy given which would possibly make distinctions between students on the novice to expert continuum (Stein & Lambert, 1995). Skovholt, Rønnestad, and Jennings (1997) propose that the development from novice to expert may take up to fifteen years or more, and may have more to do with a therapist’s ability to create a working alliance than other factors. In this study, both training and experience will be specifically defined in order to capture acquired experience, education, and specific trauma training so that it may be compounded into a cohesive construct.

Another issue regarding research on therapist training and experience include delimiting training and experience into smaller parts (Stein & Lambert, 1995). For example, Stein and Lambert (1995) disscuss the importance of the confounding aspects of trainee supervision, the definition of and acquisition of skills, problems with grouping therapists too broadly in a category of experience, implications of overall life experience, personal decision-making capability, the additive combination of therapist plus supervisor skill, caseload, and type of client population. Beutler

(1997) suggests that when researching therapist variables such as level of training, it is important to define the training specifically and avoid using academic degree in order to separate the specific effects of training in a specific area from overall amount of experience and education. Skovolt & Rønnestad (1992) also mention that most of the attention has been paid to the therapist during graduate school, leaving their years beyond this educational training neglected. In the present study, special care will be taken to inquire about education, specific trauma training, and trauma experiences both as a part of and outside the graduate program as separate entities, to address this recommendation.

Stein and Lambert (1995) did not include studies in their meta-analytic review focusing on the therapist's individual attributes and level of training in order to reduce overall confounds in their review. This is unfortunate, because vital information regarding the effect on the therapeutic process was neglected. Also, Stein and Lambert's (1995) extensive review did not include studies involving professionals with degrees at differing levels of experience. Though a comprehensive review in giving information regarding specific studies, the setting, the differentiation of therapist training level, outcomes, and drop-out effects, the authors fail to report on the type of clients seen by therapists, or their diagnoses. This may have a great deal of effect on not only therapist training level in terms of patient outcomes, but also may provide a better understanding of 1) who is dropping out and why and 2) specific type of therapist training (whether it is general training, or training regarding a specific client population). It was found that patients seem to drop out of therapy less frequently when working with more trained therapists (Stein & Lambert, 1995), and it is also well-documented that patients drop out less frequently with more experienced

therapists (Crits-Cristolph, 1991; Roth & Fonagy, 2005), but therapist training and experience with specific client population or diagnosis is not mentioned.

The lack of literature regarding specialized training and work experience with a specific group of patients is a significant gap within the available literature. How this variable affects the therapeutic process and the therapists own reactions during practice is particularly non-existent. However, it is possible that specialized training and work experience with a specific patient population may contribute to a better treatment process. Smith et al. (2007), in their study of trauma therapist reactions, make it clear that training in trauma is needed to decrease therapist difficulties and increase positive coping through professional and personal development. Since the complex trauma population is in such great need of therapists who respond to their complex issues ethically and effectively, there is a need to explore how learned experiences of the trauma therapists (work experience and training) may contribute to the therapeutic process. For example, individuals with borderline personality disorder tend to prematurely drop out of therapy and therefore do not receive the treatment they need (Bennett, Parry, & Ryle, 2006). So a related question might be if therapist trauma training and work experience with this group of complex trauma patients may lessen therapist difficulties and increase therapist coping, ultimately affecting patient outcomes (such as decreasing patient drop-out in therapy). If this is indeed the case, the trauma therapist community, training, and educational programs have more foundation to increase the availability and accessibility of training and experiential opportunities to therapists who work with this at-risk group.

Roth and Fonagy (2005) reviewed studies that looked specifically at therapist experience and the employment of specific, manualized treatments. Huppert et al. (2001) reported that therapist experience level, defined as years of clinical experience

in general rather than experience with the specific treatment model, was related to positive patient outcomes using cognitive behavioral therapy (CBT) for panic disorder. Huppert et al. studies two important issues, namely the specification of the treatment modality (CBT or exposure and response prevention) and the specification of the patient population (patients with panic disorder).

Therapeutic competence and adherence to a treatment strategy are prominent constructs within therapist work experience and training discussed throughout the literature in this area because they affect not only patient outcomes (Black et al., 2005; Roth & Fonagy, 2005), but the therapeutic process as well (Davis et al., 1987; Orlinsky & Rønnestad, 2005; Orlinsky et al., 1999;) in terms of difficulties and coping experienced by the therapist.

Much of the focus on therapeutic competence and adherence to treatment protocol, however, has been in relationship to patient outcomes (Black et al., 2005), most likely due to an emphasis on empirically supported treatments and evidence-based practice per diagnosis (Roth & Fonagy, 2005). Plus, it is imperative that therapists treat patients using research-informed conceptualizations and treatment modalities drawn from the most up-to-date knowledge base in order to provide quality, ethical care to patients (Norcross, Beutler, & Levant, 2005). Therapist competence is related to patient outcome (Barber & Meuenz, 1996, Frank et al., 1991) but it must be determined if therapist experience and training is responsible for developing that competence and what skills or qualities defines a therapist as being 'competent' (Roth & Fonagy, 2005).

Again, an exact definition of therapeutic competence is lacking (Herman, 1993; Shaw & Dobson, 1988) especially because decisions must be made that qualify what type of skillfulness is considered competent and based on what theoretical

framework (Roth & Fonagy, 2005). Roth and Fonagy (2005) conclude, after a careful review of literature in this area, that patient and therapist factors in interaction with each other must be elaborated upon before any determination may be made in the area of therapist competency and efficacy.

One way to investigate therapist training and experience in relation to efficacy and competence is to focus on the relationship to the therapeutic process. Orlinsky and Rønnestad, (2005) and Orlinsky and colleagues (1999) termed professional self-doubt as a dimension of therapist difficulties. Therapist self-efficacy, which encompasses skill-level and the therapist's perception of their ability to work with a patient (Orlinsky & Rønnestad, 2005; Orlinsky et al. 1999), may be seen at least in part as therapeutic competence. Within the therapeutic process, it is when the therapist experiences decreased self-efficacy and their skills as failing that they encounter difficulties in practice (Orlinsky & Rønnestad, 2005; Orlinsky et al. 1999). Therapists must employ strategies to cope with these difficulties, (Orlinsky & Rønnestad, 2005; Orlinsky et al. 1999) and most of the research regarding the impact of training and experience on therapist coping within trauma treatment comes from the vicarious trauma literature, as was previously discussed. To review, therapists who work with trauma survivors are less likely to experience vicarious trauma and cope more effectively if they have more training in the field . So, increasing therapist self-efficacy and skills via trauma training and work experience with this group of complex trauma patients is an obvious way to increase therapist self-efficacy and competence, decreasing overall professional self-doubt during practice and increasing constructive coping.

The literature suggests the importance of specialized training in working with personality disordered patients (Alvarez et al., 2006; Critchfield & Benjamin, 2006), a

traditionally difficult patient population with which to work and who are often complex trauma patients. Additional training and increased professional work experiences are associated with lower distress in therapists (Chrestman, 1995). A reduced number of trauma cases and more time spent in research activities is also a factor in reducing therapist distress while increased involvement in clinical activities was associated with more avoidance symptoms (Chrestman, 1995). Smith et al. (2007) found that trauma therapists employed more active interventions in comparison to other expert therapists when faced with difficulties. When specifically studying trauma therapist reactions, Smith et al. (2007) and Smith, Kleijn, Trijsburg, and Hutschemaekers (2007) recommend further study of the relationship between work experience and training and trauma therapist reactions because their studies included very experienced therapists with different types of work experience and training. These studies lay a foundation of research and provide evidence for continued investigation. This study will further address trauma training and work experience in relationship to trauma therapist reactions (difficulties and coping). However, this study will also investigate how differing levels of work experience and training may affect trauma therapist reactions, as opposed to only "expert" therapists studied by Smith, Kleijn, Trijsburg, and Hutchemaekers (2007).

Therapists' work experience and trauma training to improve their reactions within the therapeutic process are crucial therapist variables to take into consideration. Complex trauma patients have complex and debilitating mental health issues and that require constant attention from the therapist. Therapists must be able to engage in a consistently challenging therapeutic process with an ability to manage their reactions during practice in a way that is positive, and facilitates therapeutic change.

Summary

This study addresses significant gaps in the literature across several constructs. First, trauma therapists who work with complex trauma patients are overlooked in the research. The level of specificity of both the type of therapist and type of trauma patient is uncommon, especially when focusing on therapist rather than patient outcomes. Second, the study of trauma therapist reactions, as presented in this research as difficulties and coping, is limited and tends to focus solely on trauma therapist negative reactions. Most of the literature is concentrated around the traumatization (referred to as vicarious trauma) of the therapist as a reaction to working with trauma patients, rather than looking at the therapist reactions more broadly. In this case, therapist reactions are both the difficulties they encounter in the process of their work as well as the coping they employ to manage their difficulties. Third, regarding trauma therapist coping the research available targets behaviors that occur outside the therapy session rather than including trauma therapist coping behaviors both inside and outside the therapeutic process. Fourth, trauma therapist variables are largely neglected throughout the literature. The usual variables studied are the therapist's trauma history and other characteristics that may influence a negative reaction to the trauma material divulged by the patient. Trauma therapist attachment style and self-differentiation are rarely studied in the literature. This is a significant gap in the research that needs to be studied because of the complexity of the therapeutic process with complex trauma patients. Trauma therapists encounter severe relational deficits in therapy with complex trauma patients, so it is important to understand how the therapists' own attachment may be activated and how their level of self-differentiation may influence their reactions. Fifth, trauma training and experience with complex trauma patients has generally been studied regarding the

influence on empathic strain, vicarious trauma, and the like, rather than therapist difficulties and coping. Most of the studies sampled experienced or 'expert' therapists, excluding students, beginning therapists, and therapists untrained in trauma. This study attempts to capture a range of experience and trauma training through more detailed descriptions of their education, training, and experience. There are also significant gaps in the literature addressing how experience and trauma training may influence trauma therapist reactions with complex trauma patients, specifically. By understanding how trauma training and experience may moderate therapist variables attachment and self-differentiation, therapists may actively engage in lessening their difficulties experienced, and increase positive coping via enhanced experience in the field and specific training in trauma.

Conclusions

Complex trauma survivors have endured multiple traumatic experiences throughout their lifespan and struggle to remain functional and healthy on a daily basis. These survivors deserve quality mental healthcare that will enable them to heal and enjoy a stable life. Trauma therapists who treat complex trauma survivors are at risk for experiencing negative reactions as a result of their work which puts the therapist in jeopardy of delivering a reduced standard of care through a strained therapeutic relationship (Smith, Kleijn, and Hutschemaekers, 2007; Smith, Kleijn, Trijsburg, & Hutschemaekers, 2007; see also Pearlman & Saakvitne, 1995). By understanding how trauma therapist relational deficits (anxious and avoidant attachment and low self-differentiation) may be moderated through work experience and training, trauma therapists may be confident that increased training and experience may assist them in tempering their own characteristics they bring to the therapeutic relationship. This increased self-efficacy will facilitate quality therapeutic

work and ultimately bring an efficacious and hopeful treatment to complex traumatic stress survivors.

CHAPTER 3

Methodology

Design

Multiple regression analysis was used to explore the relationship between therapist attachment style (anxious attachment and avoidant attachment) and self-differentiation, and therapist difficulties and coping, with work experience and trauma training as moderators (see Figures 2a-c). Baron and Kenny (1986) describe a moderator as a "variable that affects the direction and/or strength of the relation between an independent or predictor variable and a dependent or criterion variable," (p. 174). A moderator, statistically speaking, is known as a special case of an interaction effect where it is a causal interaction effect (Wu & Zumbo, 1998). A moderator, unlike a mediator, also takes a single role as an independent variable, and does not serve a dual role, as a mediator does (i.e., as an outcome variable for the independent variable and as an independent variable). In fact, the moderator explains the strength and direction of the causal effect of the independent variable (in the current case, attachment style and self-differentiation) and the dependent variable (therapist difficulties and coping) (Wu & Zumbo, 1998). Also, because a causal relationship between anxious and avoidant attachment styles and self-differentiation, with therapist difficulties and coping has not yet been tested empirically, and the model is therefore more conceptual in nature, a moderator model is more applicable (Wu & Zumbo, 1998). Wu and Zumbo (1998) note that a causal effect is often not found because it only pertains to a subgroup of the sample rather than the entire sample. A mediator, on the other hand describes why or how an effect happens and is based upon a causal model (Holmbeck, 2006).

In this study, the predictor variables, anxious attachment style and avoidant attachment style and self-differentiation do not cause, and are not related to work experience and trauma training, though they are related to therapist difficulties and coping. Therefore, these path models are moderator, rather than mediator models. So the moderator variables work experience and training are independent variables. Moreover, the moderators should not be correlated with the independent variables in this type of design (Wu & Zumbo, 1998). Overall, the need for design control is less a problem for moderators because moderators are observed and not manipulated (Wu & Zumbo, 2008).

In light of descriptions by Holmbeck (1997), the models investigate how work experience and trauma training may moderate attachment style and self-differentiation in relationship to therapist difficulties and coping. Put another way, what is the impact of attachment style and self-differentiation on therapist difficulties and coping according to the level of work experience and trauma training? Three different models are presented to describe possible relationships between the independent variables and the three dependent variables: difficulties, constructive coping, and avoidant coping (see Figures 2a-c). Coping was separated into two dependent variables to delineate a positive and negative type of coping reflected in the scales used to measure these variables.

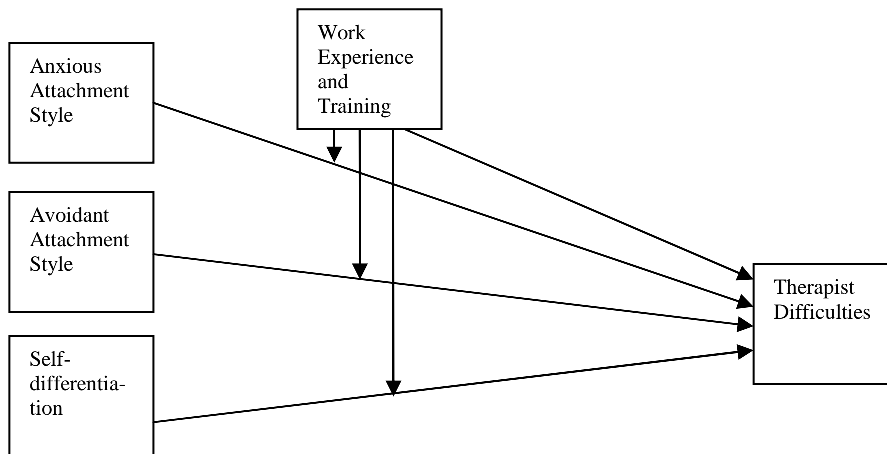

Figure 2a. Path diagram for moderator model: Difficulties.

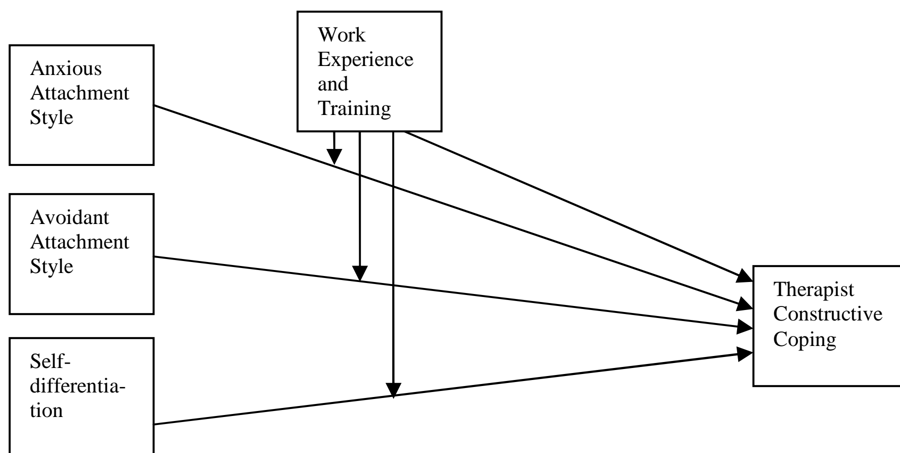

Figure 2b. Path diagram for moderator model: Constructive coping.

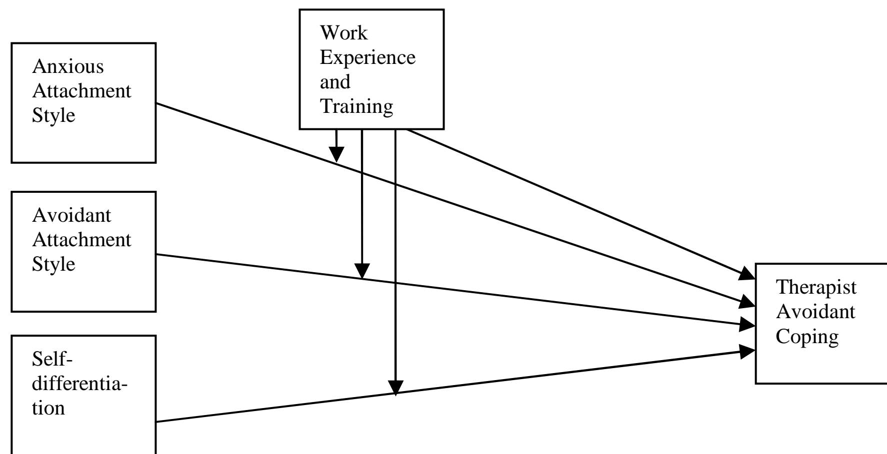

Figure 2c. Path diagram for moderator model: Avoidant coping.

Research Hypotheses

The research questions addressed in this study are:

- To what extent are trauma therapist difficulties and coping explained by anxious and avoidant attachment style, and self-differentiation?
- To what extent do work experience and trauma training moderate the relationship between anxious and avoidant attachment styles and self-differentiation on therapist difficulties with complex trauma patients?
- To what extent do work experience and trauma training moderate the relationship between anxious and avoidant attachment styles and self-differentiation on therapist coping with complex trauma patients?

The research hypotheses addressed in this study include:

1. Hypothesis 1, model A. Trauma therapists who identify as anxiously or avoidantly attached and who have a low level of self-differentiation will experience increased difficulties in their work with complex trauma patients. Trauma therapists experience difficulties in their work with trauma patients due to the complexity of the patient presentation and their trauma histories

(Smith, Kleijn, & Hutschemaekers, 2007; Smith, Kleijn, Trijsburg, & Hutschemaekers, 2007). Insecure therapist attachment is associated with more therapist distress (Black et al., 2005; Marmaras et al., 2003). Low self-differentiation is associated, in the literature, with an individual's lessened ability to cope with stressors (Friedman, 1991; Kerr & Bown, 1988).

Hypothesis 1, model B. Trauma therapists who identify as anxiously or avoidantly attached and who have a low level of self-differentiation will experience less constructive coping in their work with complex trauma patients. Trauma therapist attachment style has been found to impact the therapeutic process with trauma patients (Marmaras et al., 2003) with more secure attachment in the therapist associated with more positive coping (Marmaras, Lee, Siegel, & Rich, 2003). Low self-differentiation has been found to be related to negative coping in comparison to higher self-differentiation (Murdock & Gore, 2004).

Hypothesis 1, model C. Trauma therapists who identify as anxiously or avoidantly attached and who have a low level of self-differentiation will experience more avoidant coping in their work with complex trauma patients. Trauma therapist attachment style impacts the therapeutic process with trauma patients (Marmaras, 2001; Marmaras et al., 2003). Anxiously attached therapists (Beutler, Blatt, Alimohamed, Levy, & Angtuaco, 2006) and avoidant therapists have been found to employ negative coping (Skowron and Dendy, 2004). Low self-differentiation is related to negative coping in comparison to higher self-differentiation (Murdock & Gore, 2004).

2. Increased work experience and trauma training will moderate trauma therapist attachment and self-differentiation in relationship to trauma therapist

difficulties; in turn, this will result in decreased difficulties when working with complex trauma patients for those trauma therapists who are more versus less anxiously or avoidantly attached and those who have lower levels of self-differentiation. Training and increased professional work experiences are associated with lower distress in trauma therapists (Chrestman, 1995). Therefore, it is anticipated that training in trauma will decrease therapist difficulties and increase positive coping as suggested by Smith, Kleijn, and Hutchemaekers (2007).

3. Increased work experience and trauma training will moderate trauma therapist attachment and self-differentiation in relationship to trauma therapist coping, resulting in increased positive coping reactions (constructive coping) and decreased negative coping (avoidant coping) when working with complex trauma patients for those trauma therapists who are more versus less anxiously or avoidantly attached, and those who have lower levels of self-differentiation. Smith, Kleijn, Trijsburg, and Hutchemaekers (2007) found that experienced trauma therapists employed more active interventions when faced with difficulties and suggest that they may employ more positive coping strategies.

Sample

The participants in this study were therapists who work with patients who have experienced trauma, hereafter known as trauma therapists. The premier traumatic stress studies professional organization, The International Society for Traumatic Stress Studies (ISTSS), was the pool from which the sample was drawn. Permission was obtained from the organization’s administrative assistant to use the membership directory (a public directory for members) from which to extract a random sample of trauma therapists to contact them by email to inform them of this

study and to request their participation. This researcher is a member of the organization. Participation was voluntary. Only members working in the United States were included as potential participants. ISTSS accepts members who are professionals, students, or non-professionals. Only professionals and students were included in the sample. Other inclusion criteria were that 1) the participant must, in the last six months, have seen two or more patients for therapy, and 2) the participant must have seen at least one patient who meets criteria for having experienced complex trauma.

Procedure

The demographic questionnaire and the three instruments used in the study were translated to a web-based survey on www.surveymonkey.com, in order to maximize its dissemination and accessibility of the overall survey. Email addresses of potential participants will be collected from the ISTSS membership directory online (available to public). A random sample of email addresses were selected using an online random sample generator (http://stattrek.com). An email was sent out to the sample which included a brief description of the survey, the inclusion criteria, the length of time which it may take to complete the survey, informed consent and the importance of participating in the study. A brief endorsement of the survey, written by Dr. Christine Courtois, was included in the email. Dr. Courtois is an expert in the trauma field and her endorsement was used to potentially increase response rate. An informed consent was included in the email, and a statement alerting the participant of their anonymity if they chose to participate. Finally, the link to the survey was included in the email, so the participant would have direct access to the survey. At the conclusion of the survey the participants had the opportunity to share their email address in order to enter a drawing to win one of four $50 on-line gift-certificates to a

popular on-line bookstore. The drawing was held after the researcher had collected all surveys needed for the study. The researcher did not have access to those who wish to participate. The investigator's research assistant was the only person with access to this information and was responsible for the drawing and delivering the four on-line gift-certificates via email. The research assistant deleted all identification and email information.

The university institutional review board reviewed the research protocol and permission was given to conduct the research project. The survey would have been available to potential participants for four to six months in order to maximize return if needed, but the target sample number was reached prior to that time frame. An email was sent to the sample approximately two weeks after initial dissemination as a reminder to complete the survey. Once the survey was answered by participants the data was extracted and analyzed using the Statistical Package for Social Sciences (SPSS).

Instrumentation

Demographic Questionnaire

The demographic questionnaire was designed for this study and included 20 questions about basic demographic information and the participants' specific experiences. Some examples of basic information include questions regarding gender, age, race/ethnicity, partner status, and a description of the town in which the participant works. The primary focus of the demographic questionnaire, however, were questions regarding the participant's level of education, professional license, role at work, patient caseload, education in trauma, training in trauma, experience working with traumatized populations, and the number of complex trauma patients on participant's caseload. These questions were developed in light of the research

regarding measuring therapist education, versus training, versus experience (Roth & Fonagy, 2005), and defining complex trauma patients (Courtois, 2004; Courtois & Ford, 2009; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

The questionnaire delineates specific trauma-based educational experiences (courses versus practical experiences) during the participant's graduate degree versus trauma training post-graduate (e. g., "When you were in your master's and/or doctoral program, did you take a course regarding the understanding of and/or treatment of trauma, with the word "trauma" in the course title?"). The purpose of this question was to determine the specificity of the coursework taken.

In order to differentiate trauma graduate course work from practical experience in working with traumatized populations during the graduate degree, one question refers to specific internship/externship experiences (e.g., "When you were in your master's and/or doctoral program, did you complete an internship/externship experience specifically focusing on a traumatized population?"). Furthermore, the participant was given examples of trauma-focused work settings such as a posttraumatic disorders clinic, posttraumatic disorders inpatient unit, domestic violence agency, rape crisis center, etc. The rationale behind this level of specificity was to understand the internship/externship site and to differentiate sites that primarily serve the severely mentally ill, a broad range of patients, or general work with families, couples or individuals with adjustment issues. If participants answered this question affirmatively, they were asked to delineate the number of semesters and hours per week they spent at their trauma-focused internship/externship site.

Regarding training in trauma after the graduate degree, participants were asked these three questions: 1) "How many hours of training in the understanding of and/or treatment of trauma have you had in the last year?" (e.g., through seminars,

continuing education, and professional classes). Participants were not asked to include courses counting towards their graduate degree); 2) “How many hours of reading have you done on the understanding of and/or treatment of trauma in the last year?”; 3) “How would you describe your *overall* training in the understanding of and/or treatment of trauma *since* completing your graduate degree.” The choices included: a) **limited**- a few continuing education hours, b) **moderate**- more than a few continuing education hours, one seminar/training a year, moderate reading on trauma (e.g., 2 articles and 1-3 books), c) **intensive**- two seminars/trainings a year, some specialized training, heavy reading on trauma (e.g., several articles, and 4 books), d) **expert**- continuous seminars, training, and or other opportunities, seminar leader/teacher in the area, specialty is in trauma work, heavy reading in trauma and related research areas (e.g., several articles, 5 books, published), and e) I am currently obtaining my graduate degree. The purpose of the question was to ask the participant report their training beyond the graduate degree.

Two questions were designed to obtain information regarding the participant’s overall experience with individuals who have experienced trauma. These two questions, plus the final question, were the most difficult to develop conceptually due to the definition of trauma, the definition of the participant’s experience in working with traumatized patients, and the definition of the patient’s trauma history. These two questions differentiate between patients who have experienced a single-incident trauma and patients who have experienced multiple traumatic experiences over the lifespan. The latter refers to complex trauma as defined by Herman (1992), Courtois (2004), and Courtois & Ford (2009). Differentiating between the two types of trauma histories relates to anticipated differences in patient presentation, symptomatology, and functioning as a result of the

differing trauma histories underscored in the literature presented in Chapter 2 (e.g. Courtois, 2004; Herman, 1992; Linehan, 1993; Pearlman, 2002; van der Kolk, McFarlane, & Weisaeth, 1996; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). For example, a survivor of a horrific car accident who has otherwise had a trauma-free history (i.e. has not had the traumatic experiences during childhood and over developmental time frames), is anticipated to have more positive coping strategies, a healthier family support system and fewer issues with interpersonal relating and is more likely to develop a stronger working alliance in treatment. As discussed in Chapter 2, complex trauma survivors are more likely to have attachment problems, relational difficulties, consistent and prevalent affect-regulation issues, and other symptoms as a function of repeated and chronic trauma occurring over crucial developmental time-frames. So working with these symptoms may affect the extent to which the participants in the current study experience difficulties and employ coping strategies with complex trauma patients versus single-incident trauma patients.

The first question regarding experience with traumatized patients asked, "How would you describe your overall experience with individuals who have survived only a single-incident trauma (e.g. car accident, natural disaster, single incident rape)?" The participant was asked not to include individuals who have survived repeated traumatic experiences over the lifespan. The second question, regarding complex trauma patients, asked, "How would you describe your overall experience with individuals who have experienced repeated traumatic experiences over the lifespan?" Participants were asked to include patients who have had multiple incidences of child abuse, rape, domestic violence, attachment trauma within interpersonal relationships and other traumatic experiences. For each of the two questions, the participants are given the following answer choices: a) **limited** (one case or less per month), b)

moderate (2-3 cases per month, work with other cases as well), c) **intensive** (4 or more cases per month, work with these cases most of the time), d) **expert** (more than 4 cases per month. This is my specialty. I am known in the community for work with this population.).

Finally, the last question is extremely important and inquired about the number of complex trauma patients in the participant's case load. The question uses Courtois' (2004) definition of complex trauma, as well as the seven problem areas outlined by Herman (1992) capturing the range and complexity of symptoms experienced by complex trauma patients. Note that *DSM-IV-TR* (American Psychiatric Association, 2000) diagnoses were not used due to the possible differences in diagnoses across participants and the range of comorbid diagnoses that are often used to describe symptoms experienced by complex trauma patients, as described in Chapter 2. The question reads, "How many individuals do you have on your caseload who you would describe as: a) having been victims of repeated traumatic experiences over the lifespan, and b) who can be described as having at least five out of seven of the following: alterations in the regulation of affective impulses, alterations in attention and consciousness, alterations in self-perception, alterations in perception of the perpetrator, alterations in relationship to others, somatization and/or medical problems, and alterations in systems of meanings?"

The purpose of this question was for the participant to define his/her caseload composition over the past six months. This question was intended to capture the participant's most treatment of complex trauma patients. The participants are asked to refer to their patients who are defined within the parameters of having experienced complex trauma and who are actively experiencing multiple symptoms or complex reactions. For clarification purposes, participants were asked to identify the number

of complex trauma patients they have seen individually and the number of complex trauma patients they have seen in group therapy over the course of the past six months.

The demographic questionnaire is not without limitations. Accurately assessing educational experience, training experience, and practical experience has room for confusion. The participant may have difficulty understanding the question, may spend a lot of time trying to determine number of course credits, number of patients on his/her caseload, or hours spent receiving training. This could potentially cause frustration and de-motivate the participant from completing the survey in its entirety. The Pearlman and Saakvitne (1995) definition of trauma may also be problematic in terms of an operational definition and its placement in the questionnaire. First of all, this definition is not the definition of trauma used in the *DSM-IV-TR*, which may cause some conceptual confusion for participants and the definition itself is not used broadly by all clinicians, though it is widely accepted among researchers in the trauma field. Secondly, the placement of the definition at the beginning of the demographic questionnaire may bias the participant in some way that may cause slightly different answers to questions.

Development of Psychotherapists Common Core Questionnaire (DPCCQ) (Orlinsky et al., 1999)

Orlinsky and colleagues (1999), in cooperation with the Collaborative Research Network of the Society for Psychotherapy Research (CRN) embarked on a wide-scale research project using the Development of Psychotherapists Common Core Questionnaire (DPCCQ) to investigate the development of psychotherapists. Almost 5,000 therapists from a large international pool participated in this study. The DPCCQ (Orlinsky & Rønnestad, 2005) is a lengthy, comprehensive survey designed

to gather information regarding how psychotherapists develop over their careers, what professional and personal circumstances influence this development (positively or negatively), how their development then influences their therapeutic work and personal and professional lives, and how these patterns of therapeutic work and professional development are similar or different across different types of therapists, their theoretical orientation and other therapist characteristics. The DPCCQ has been translated into numerous languages and has been used in a variety of different countries. Due to the large scale of the study, the participants represented a highly diverse sample from over 13 countries (17% from the U.S.). The DPCCQ has 392 items including checklists, structured-response scales, and a few open-ended questions. There are ten total sections and an optional section. The entire DPCCQ was not used in this study. The section measuring therapist difficulties and therapist coping will be extracted from the DPCCQ and tested for validity and reliability in this study. Only the section measuring therapist difficulties and therapist coping were utilized.

Orlinsky and Rønnestad (2005) described their large study as "conceptually organized, systematic exploratory research…not a hypothesis-testing study…because theories of therapeutic work experience and professional development have not yet been elaborated to a point from which hypotheses can be logically derived" (p. 25). Data was collected from professional workshops, conferences, through a "snow-ball" collection, a random sample of a large professional association, and university training programs. The authors stated that the size and diverse sample made it possible to conduct certain data analyses with strong internal validity and with partial external validity. Orlinsky and Rønnestad used a step-by step approach to data analysis to investigate different levels of conceptual generalizability. The first part of

the analysis included using measures of central tendency, variability, and percentages of endorsement on certain items. Factor analysis was then used to describe different dimensions of the underlying frameworks, and principal-components analysis was used to ultimately determine underlying factor structure. Internal consistency was tested using Cronbach's alpha.

The seventh section of the questionnaire includes measurement of both therapist difficulties experienced during practice and therapist coping strategies employed when they experience those difficulties. In the current study, the directions were modified slightly (permission obtained from Dr. David Orlinsky), in order to ask participants to reflect upon their complex trauma patients only when answering the questions regarding therapist difficulties and coping. Even though a definition of complex trauma was included on the demographic questionnaire, the definition was repeated here. The first measure of therapist difficulties includes 20 items and participants were asked to use a 6-point Likert-type scale to rate the extent to which they currently feel the way each item describes (0 = never, and 5 = very often). Davis et al. (1987) were the first to detail therapist difficulties during practice. Orlinsky and Ronnestad (2005) developed the 20 items for the DPCCQ based upon this qualitative study by Davis et al. in order to assess therapist difficulties during practice. In the Davis et al. study, a taxonomy of therapist difficulties was created based on the authors' experiences (over 125 items), and was applied to 30 different therapist difficulty scenarios, and rated by an expert panel. It was found that the taxonomy could be applied to the scenarios with a high degree of reliability (Cronbach's alpha from .88 to .95). Orlinsky et al. (1999) reviewed the original, large number of descriptions of therapist difficulties by Davis et al. (1987), and ten types of difficulties were distinguished. Two quantitative scales were created for each.

With approximately 5,000 study participants, Orlinsky and Rønnestad found that the overeall average frequency with which therapists experienced each difficulty was between 1 and 2 (0 = never, and 5 = very frequently). Seven difficulties were experienced as "more than rarely" (a rating of above '1'). Seventy-six percent rated "Unsure of how to best deal with a patient" was experienced "more than rarely," along with "distressed by my powerlessness to affect a patient's tragic life situation" (59%), "unable to generate sufficient momentum to move therapy in a constructive direction" (47%), "feeling irritated with a patient who is actively blocking my efforts" (47%), "feeling demoralized by my inability to find ways to help a patient" (43%), and "feeling bogged down with a patient in a relationship that seems to go nowhere" (41%). Therapists experienced least often difficulties including, "unable to find something to like or respect in a patient" (15%), and "afraid that I am doing more harm than good in treating a patient (17%).

Orlinsky and Rønnestad (2005) used factor analysis of the twenty scales in their collaborative study to come up with three dimensions of therapists' difficulties during therapy. These three dimensions are: 1) professional self doubt, 2) frustrating treatment case, and 3) negative personal reactions. Professional self-doubt was the most common type of difficulty experienced and is described by 7 items (i.e., feeling unsure of how to best treat a patient, feeling demoralized by an inability to help a patient, having a lack of confidence in one's ability to have a beneficial effect on a patient, to name a few). Experiencing a frustrating treatment case is assessed by 6 items and include statements like "angered by factors in a patient's life that make a beneficial outcome impossible" and "distressed by your own powerlessness to affect a patient's tragic life situation." The least often experienced difficulties were negative personal reactions which include "unable to find something to like or respect in a

patient," and "unable to withstand a patient's emotional neediness." Cronbach's alpha was .77 for professional self doubt, .67 for frustrating treatment case, and .74 for negative personal reaction. There were moderately high correlations ($r = .60$), among the three dimensions, leading the researchers to a "two-level interpretation in which the three types of difficulty are viewed as particular aspects of a higher order dimension of overall difficulty" (p.51). As a result, the authors constructed "Total Difficulties" in conjunction with and to augment the three difficulty scales. Validity was not reported.

Similar to the process used for assessing therapist difficulties during practice, Orlinsky and Rønnestad (2005) referred to a qualitative study by Davis, Francis, Davis, and Schröder (1987) which included therapist narratives of the coping strategies they employ. Again, Orlinsky and colleagues developed two 6-point Likert-type scales for each of the 13 coping strategies generated by Davis and colleagues from the therapist narratives.

The coping scale consists of 26 items. After factor analyzing the data in the study, six dimensions of therapist coping were formulated including: 1) exercising reflective control (Cronbach's alpha = .59), 2) seek consultation (Cronbach's alpha = .71), 3) problem-solving with the patient (Cronbach's alpha = .60), 4) reframing the helping contract (Cronbach's alpha = .69), 5) seeking alternative satisfactions (Cronbach's alpha = .46), and 6) avoiding therapeutic engagement (Cronbach's alpha = .64). The most frequently used coping strategies, using ratings of 4 and higher as "often" included those under exercising reflective control: "reviewing privately how a problem has arisen" (58%), "trying to see the problem from a different perspective" (54%). The second-most commonly used coping strategy was that of seeking consultation: "discuss the problem with a colleague" (56%), and "consult about the

case with a more experienced therapist" (53%). Problem-solving with the patient refers to questions such as "permission to experience difficult or disturbing feelings," and "attempted to work jointly with their patients to deal with the difficulty." Reframing the helping contract includes "making changes in your therapeutic contract with the patient," for example, and this coping strategy dimension was found to be uncommon.

Seeking alternative satisfactions includes "seek some form of alternative satisfaction away from therapy," and "express your upset feelings to somebody close to you." It is important to note here that Orlinsky and Rønnestad describe this coping dimension as a negative form of coping. However, the current study questions this interpretation when both of these coping strategies may be seen as a form of self-care to deal with upset feelings, and may be, in fact, encouraged in order to prevent boundary violations against the patient. This is a conceptual limitation of the utility of the measure, but may be reconciled as part of the discussion of the data analysis and outcome depending upon the findings.

Avoiding therapeutic engagement is a coping dimension that is considered harmful to the patient and fortunately one that was used rarely, according to Orlinsky and Rønnestad. For example, "show your frustration to the patient" was utilized with a frequency of 4%, and "criticize a patient for causing you trouble" was used less than 1%. The authors created "constructive coping" because the positive coping dimensions were positively correlated and in contrast to the "avoiding therapeutic engagement" dimension. Therapists were found to engage in "constructive coping" 10 times more often than "avoiding therapeutic engagement." Validity was not reported in the study.

Only two scales from the DPCCQ were used. The reason for extracting these scales was to decrease the length of the survey, to have participants complete only items that pertain to the study, and to increase response rate due to the abbreviated length. Information regarding the reliability and validity of the therapist difficulties and therapist coping scales was restricted since they were developed for the purposes of the CRN study. However, the questions were derived from a wealth of narrative data of therapist difficulties and coping and factor analyses revealed moderate internal consistency.

Differentiation of Self Inventory (DSI) (Skowron & Friedlander, 1998)

The Differentiation of Self Inventory (DSI) (Skowron & Friedlander, 1998), is a forty-three item self-report instrument. The purpose of the DSI is to measure the "capacity to maintain autonomous thinking and achieve a clear, coherent sense of self in the context of emotional relationships with important others," (Skowron & Friedlander, 1998, p. 237). This self-report measure has the capability to test the theoretical assumptions regarding Bowen's differentiation of self, to assess individual differences in adult functioning, and to evaluate psychotherapeutic outcomes (Skowron & Friedlander). This measure is multidimensional and applies to adults who are twenty-five years and older. Bowen (1978) defines differentiation of self (self-differentiation) as the degree to which an individual can balance emotional and intellectual functioning, and intimacy and autonomy within relationships. Self-differentiation is the ability to experience both intimacy with and independence from other people (Skowron & Friedlander, 1998). Four specific constructs are measured to determine a low to high level of self-differentiation including: emotional reactivity, "I" position, emotional cutoff, and fusion with others. Skowron & Friedlander used

these four constructs in order to operationalize a range of interpersonal components of differentiation and to include intrapsychic aspects of differentiation.

Three research studies were conducted to create and validate the DSI. The measure was initially created in the first study in which the four subscales were created. The second study refined the final instrument and redefined two subscales, and the third study evaluated the DSI factor structure and explored the relationship between self-differentiation and psychological symptoms and marital satisfaction.

The first study was used to create the DSI from a pool of 96 items developed by relevant researchers in the field in order to reflect the differentiation of self. Three hundred and thirteen adults participated in the study and consisted of a random sample of faculty members, adults in the community, graduate students in mental health fields, and friends and family members of researchers. The sample mostly identified as white (82.7%), female (68%), and married (75%) with an average age of 36.8 years. Subscales were developed, and a principle component analysis was conducted to reveal four factors to account for variance including: emotional reactivity, “I position,” reactive distancing, and fusion with parents. The higher the scores on the subscales, the greater the level of self-differentiation, and the sum total of all the subscales reflects the level of self-differentiation of self whereby the higher the score, the greater the differentiation of self. High reliability was found for the DSI total scale and each of the subscales using Cornbach’s alpha to measure internal consistency. The second study, however, refined the four subscales and stronger reliabilities were found.

A second study was conducted whereby subscales were re-conceptualized in order to address the amount of variance left unaccounted for. Descriptive statistics and internal consistency reliabilities were computed on the basis of an item analysis.

One hundred sixty-nine adult participants (111 females and 58 males) completed the 78-item DSI. This version of the DSI included the Emotional Reactivity, I Position, Emotional Cutoff, and Fusion with Others subscales. "Fusion with Parents" was redefined as "Fusion with Others" and "Reactive Distancing" was replaced with "Emotional Cutoff" because they are conceptually stronger, according to the authors. An item analysis was conducted to determine the DSI's inherent factor and to also ensure that each subscale was distinct from one another. Skowron & Frielander report internal consistency reliability is estimated at .88, with test-retest correlations at .88 and .89.

The final, 43-item Differentiation of Self Inventory (DSI) includes the four subscales: emotional reactivity, I position, emotional cutoff, and fusion with others. The emotional reactivity subscale is 11 items and "reflects the degree to which a person responds to environmental stimuli with emotional flooding, emotional lability, or hypersensitivity" (p. 239). The "I position" subscale is also 11 items and which "reflect a clearly defined sense of self and the ability to thoughtfully adhere to one's convictions when pressured to do otherwise" (p. 239). The emotional cutoff subscale is 12 items which "reflects feeling threatened by intimacy and feeling excessive vulnerability in relations with others" (p. 239). These items also reflect "fear of engulfment and behavioral defenses like overfunctioning, distancing, or denial" (p. 239). The fusion with others subscale is 9 items and "reflects emotional overinvolvement with others, including triangulation and overidentification with parents" (p. 239).

In order to define level of self-differentiation, the DSI full-scale score is computed using raw scores on all items in the subscales. Raw scores on all items in the emotional reactivity, emotional cut-off, and fusion with others subscales are

reversed, along with item #35 in the “I” position subscale. The higher scores delineate the greater differentiation. Scores from all items are added and divided by the total number of items. The full-scale score is between 1 (low differentiation) and 6 (high differentiation). For scoring subscales, the scores are reversed, summed, and divided by the total number of items in that particular subscale. Similar to the DSI full-scale score, scores range from 1 to 6 where the higher the score, the greater the differentiation.

The second study results indicated that all scores were normally distributed. Skowron and Friedlander (1998) reported the following descriptive statistics:

> Subscale *means* ranged from 2.07 to 4.34 (full-scale *M* = 3.73, *SD* = 0.58). Subscale-full-scale correlations were moderate to high, ranging from .43 (Fusion With Others) to .80 (Emotional Reactivity), all ps <.001. Intercorrelations among the subscales were low to moderate, ranging from .08 (Fusion With Others and I Position) to .53 (Fusion With Others and Emotional Reactivity). Correlations between DSI subscales and SDS scores were negligible to moderate {*r* — .42 for Emotional Reactivity, r = .49 for I Position, *r* = .34 for Emotional Cutoff, and *r* = - .02 for Fusion With Others). Cronbach's alpha was used to estimate internal consistency reliabilities for the DSI full scale and each of the four subscales (DSI α = .88, Emotional Reactivity α = .84; I Position α = .83, Emotional Cutoff α = .82; Fusion With Others α = .74) (p.239).

The third study used a sample of 127 adults to evaluate the DSI’s factor structure through confirmatory analyses. The purpose of the study was also to test the theoretical assumptions made by Bowen (1976, 1978) whereby individuals who are more self-differentiated experienced less psychological symptoms and are better adjusted, and individuals who are more highly self-differentiated experienced higher marital satisfaction. Results indicated that means and standard deviations for subscale and full-scale scores were similar to the second study, as well as scores being normally distributed, and intercorrelations between subscales being moderate to negligible (Skowron & Friedlander, 1998). Skowron & Friedlander detailed the confirmatory factor analysis procedure and results to evaluate the four-factor structure

of the DSI. An item-clustering procedure was used to increase the stability of the indicators. The differentiation four-factor model, according to the four DSI subscales, was tested and found to be a good model fit, χ^2 (48, N = 137) = 89.35, p < .0001, GFI = .91, adjusted GFI = .85, χ^2/df = 1.86, RMS = .07. The DSI was found, overall, to represent a single, multidimensional construct when differentiation of self was tested a single, higher-order latent factor.

The overarching goal of the three DSI studies was to create, develop, and test a self-report instrument using a construct approach. This goal was attained and the multidimensional structure of the DSI was recognized. The four subscales, Emotional Reactivity, I position, Emotional Cutoff, and Fusion with Others were found to be distinct dimensions of differentiation of self through confirmatory factor analyses. Construct validity, and internal consistency reliability of the subscales was supported.

In this study, DSI full scale raw scores were computed because it is a continuous variable for the research design. There are some limitations to the DSI. The authors recommended that cross-validation was needed using larger samples, and demographic information on the participants should be further taken into account because cultural variables and norms may influence scores. Skowron & Friedlander discussed two potential ways to augment construct validity, further study to support the construct validity and examination to determine whether differentiation of self covaries with severity of psychiatric illness or distress.

Experiences in Close Relationship-Short Form (ECR-S) (Wei, Russell, Mallinkrodt, & Vogel, 2007)

The ECR-S (Wei, Russell, Mallinkrodt, & Vogel, 2007; Brennan, Clark, & Shaver, 1998) is a short-form version of Brennan, Clark, & Shaver's (1998) original 36-item Experiences in Close Relationship self-report attachment measure. The ECR-

S is a 12-item measure of adult attachment across two dimensions: anxiety and avoidance. Higher scores for the anxiety subscale indicate greater attachment anxiety and higher scores for the avoidant subscale indicates greater attachment avoidance. These two dimensions are well-accepted in the attachment literature to more broadly describe an overall continuous adult attachment style than categorical, attachment styles such as Hazan and Shaver's (1987) secure, anxious, avoidant, and anxious-ambivalent styles (Wei, Russell, Mallinkrodt & Vogel, 2007; Mikulincer & Shaver, 2007; Shaver & Mikulincer, 2004). The ECR-S asks participants to respond to questions using a 7 point Likert scale. The primary rationale for shortening the length of the ECR was to increase participant motivation and compliance and its accessibility and utility when employed in different types of research, such as survey research via internet, mail, or telephone. Wei et al. developed the ECR-S across six studies in order to examine the reliability, factor structure, validity, test-retest reliability, and confirmatory factor analysis. It was found to be reliable, valid, to have strong construct validity like the ECR, and to be a reliable measure of adult attachment with coefficient alphas for the ECR-S .77 to .86 for anxiety and .78 to .88 for avoidance subscales (Wei et al.). A sample question measuring anxious attachment is "I need a lot of reassurance that I am loved by my partner." A sample question measuring avoidant attachment is "I want to get close to my partner but I keep pulling back."

The original ECR, developed by Brennan, Clark and Shaver (1998) is a highly reliable and valid measure widely accepted and used to assess adult attachment (Fraley, Waller, & Brennan, 2000; Mikulincer & Shaver, 2007; Shaver & Fraley, 2004; Shaver & Mikulincer, 2004; Wei, Russell, & Mallinckrodt 2007). The ECR was originally validated with a large sample of undergraduate students where the average age was 20.36 years, 52% identified as female, 90.6% identified as white, and

94% were single. Brennan et al. (1998) reviewed all of the dimensional attachment style self-report measures developed in the 1990's and factor analyzed all of the items (323 items, 60 subscales, 14 measures). The ECR consists of 36 items, 18 of which loaded the highest on each of the dimensions. The authors defined attachment anxiety as involving fear of rejection or abandonment, an excessive need of approval, and increased distress when a partner is unresponsive. Attachment avoidance is the fear of dependence and intimacy, an excessive need for autonomy, and an unwillingness to self-disclose (Wei, Russell, Mallinckrodt, & Vogel, 2007). An insecure attachment orientation is delineated by a high score on either or both dimensions while a secure attachment orientation is delineated by low levels on the anxiety and avoidance dimensions.

In the Brennan et al. (1998) study, the ECR was found to have a high level of internal consistency among undergraduate students with coefficient alphas of .91 for the anxiety subscale and .94 for the avoidance subscale and this internal consistency remains steady across several other studies with undergraduates (Wei, Russell, Mallinckrodt, & Vogel, 2007). Lopez and Gormley (2002) showed good test-retest reliability over a 3-week time period for the former and a 6 month time period for the latter. Each showed test-retest reliabilities ranging from .68 - .71 for both anxiety and avoidance scales. In terms of validity, the ECR shows solid validity where subscales showed positive correlations with personal problems (Lopez, Mitchell, & Gormley, 2002), neuroticism (Noftle & Shaver, 2006; Picardi, et al., 2005), ineffective coping (Wei, Heppner, Mallincrodt, 2003), ineffective coping to recent major stressors (Lopez, Mauricio, Gormley, Simko, & Berger, 2001), maladaptive perfectionism (Wei, Mallinckrodt, et al. 2004), negative mood (Wei, Russell, Mallinckrodt, & Zakalik, 2004), depression (Carmichael & Reis, 2005; Zakalik & Wei, 2006), and

anxiety (Lopez et al. 2001; Weems, Berman, & Silverman, 2002; Williams & Riskind, 2004). Overall, the ECR has high reliability, construct and predictive validity (Mikulincer & Shaver, 2007; Shaver & Mikulincer, 2002). A few potential problems with the ECR include its length (Wei, et al., 2007), the possibility of response-bias (Mikulincer & Shaver, 2007), the sample consisted of younger adults, and the ECR does not give precise measures of the 45 degree rotations (i.e., secure, fearful-avoidant, preoccupied, or dismissing-avoidant) referred to by Bartholomew and Horowitz (1991). However, the ECR has been used repeatedly in the attachment field, has been translated to numerous languages, and tends to be favored over other attachment self-report measures (Mikulincer & Shaver, 2007).

Fraley, Waller, and Brennan (2000) created the ECR-Revised (ECR-R) in attempt to remedy potential scaling problems that would lead to misleading conclusions regarding theoretical frameworks, the stability of attachment patterns in the ECR, the Adult Attachment Scale (AAS; Collins & Read, 1990), Relationship Style Questionnaire (RSQ; Griffin & Bartholomew, 1994), and the Attachment Style Measure (ASM; Simpson, 1990). The authors found that the ECR was far more precise than the AAS, RSQ, and ASM. However, it is notable that all of these scales, including the ECR-R, were not able to precisely assess the secure end of the dimension as the insecure end (Fraley, Waller, & Brennan, 2000). Measuring the secure end of attachment continues to be a challenge within attachment research, although the ECR and ECR-R seem to have the best psychometric properties compared with the other three measures (Fraley, Waller, & Brennan, 2000).

It is important to note that the ECR-S does has some limitations including having slightly lower internal consistency in comparison to the ECR. The study participants were primarily undergraduates who self-identified as Euro-Americans.

Ethnic groups moderated the association between attachment anxiety and negative mood although Wei et al. found that factor loadings for the ECR were invariant across different ethnic groups. Wei et al. suggest using other assessment methods in conjunction with the ECR-S and other self-report measures across more diverse groups in the future.

Data Analysis

The relationship between the three predictor variables (anxious attachment, avoidant attachment and self-differentiation) and the criterion variables (therapist difficulties and coping) changes as a function of the moderators (work experience and trauma training). Baron and Kenny (1986) and Holmbeck (1997) describe two types of statistical analyses, multiple regression and structural equation modeling (SEM), as two accepted strategies that are appropriate to test interaction effects (moderation effects). The presumption is that the moderator effect will be linear and inverse (see Figure 3). Though SEM is often a more preferred strategy (Baron & Kenny, 1986; Holmbeck, 1997) all the variables in this study are continuous, and there is only one measured variable per construct.

Multiple regression analysis is generally more appropriate to use when both the predictor variable(s) and moderator variable(s) are continuous (Baron & Kenny, 1986; Holmbeck, 1997). It is preferred when the sample size is smaller, helps to reduce problems with power (Tabachnick & Fidell, 1996). When the moderator is measured on a quantitative, continuous scale, the statistical power is maximized using regression analysis (Cohen, Cohen, West, & Aiken, 2003; Wu & Zumbo, 1998). Also, this study uses only one measured variable per construct, which makes multiple regression a better choice for statistical analysis. As a result, multiple regression analysis will be used to study the interaction effects.

Holmbeck (1997) explained how to analyze the data using multiple regression stating that the predictor and moderator main effects and covariates are entered first, followed by the interaction of the predictor and moderator variables. After plotting main effects or regression slopes, statistical significance was tested by using post hoc comparisons of difference in group means or slopes (Wu & Zumbo, 1998). Moderation is shown when the interaction effect is significant while the predictor variables (anxious attachment, avoidant attachment and self-differentiation), and moderator variables (work experience and training) are controlled because the interaction effect shows how the predictor variables and moderator variables are working together to affect the criterion variables (therapist difficulties and coping), beyond the separate effects (Wu & Zumbo, 1998). The product terms for the analyses are listed below (Moderator = Work Experience and Trauma Training).

For dependent variable, trauma therapist difficulties:

1. Anxious Attachment Style x Moderator (A x M)
2. Avoidant Attachment Style x Moderator (V x M)
3. Self-differentiation x Moderator (S x M)

For dependent variable, trauma therapist coping:

4. Anxious Attachment Style x Moderator (A x M)
5. Avoidant Attachment Style x Moderator (V x M)
6. Self-differentiation x Moderator (S x M)

A power analysis was conducted to determine the sample size for a desired statistical power of .80 at $\alpha = .05$, for a medium effect size. Accounting for three predictor variables and a moderator variable, a sample size of $n = 84$ is needed for this study (Cohen, 1992).

Design Limitations

There are potential design limitations in this study. Some of the negative aspects of testing moderator variables using regression analysis have been mentioned. Moderator effects can be difficult to identify (Holmbeck, 1997). However, moderator effects are most often tested when a strong causal relationship is difficult to identify (Wu et al., 2008). Centering the moderator variable, estimating the effect size of the moderator and conducting a power analysis to determine an appropriate sample size to see moderation effects can reduce design flaws (Wu & Zumbo, 2008).

Human Participants and Ethics Precautions

The population investigated in this study includes educated, professional therapists who can be assumed to exercise free will in choosing to engage in this study. Confidentiality applies to participants. If participants disclose their email address for follow-up or participation in the drawing, their confidentiality will be maintained.

CHAPTER 4

The problem investigated in this study was to determine to what extent therapist work experience with complex trauma and trauma training moderates anxious and avoidant attachment styles and self-differentiation in effecting therapist difficulties and therapist coping with complex trauma patients. The results of the study are presented in this chapter. Descriptive statistics are presented first, followed by results of the regression analyses that address findings of each research question.

Descriptive Statistics

One hundred and twenty-six therapists responded to the study. Twenty were excluded who did not meet inclusion criteria or who had missing data, resulting in a sample of 106 cases. Of the 106 participants, 62.3% were female, 36.8% male, and the mean age was 49.8 (SD = 12.3, Min = 26.0, Max = 73.0). Additional demographic data including race/ethnicity, partner status, and place of work, are presented in Table 1. Most of the sample was white (93.4%), married (65.1%), and working in a large urban city (41.5%).

Table 1

Demographic Information

	N	%
Race/Ethnicity*		
American Indian or Alaskan Native	2	1.9
Asian	3	2.8
Black or African America	2	1.9
Native Hawaiian or other Pacific Islander	0	0
White	99	93.4
Hispanic, Latino, or Spanish origin (may be of any race)	2	1.9
Bi-racial or multi-racial	1	1.9
Other	4	3.8
Partner Status*		
Married	69	65.1
Single	14	13.2
Partnered	8	7.5
Widowed	3	2.8
Divorced	8	7.5
Other	2	1.9
(missing)	2	1.9
Town in which you work*		
Rural town	7	6.6
Small suburban area	12	11.3
Large suburban area	16	15.1
Small urban city	27	25.5
Large urban city	44	41.5

Note. *N = 106.

Table 2 presents participant level of education and credentials. The average number of years since graduation from their graduate program was 16.2 (SD = 12.1). Level of education is presented in two ways. First, it is presented as highest level of education attained or being attained. Second, the information is condensed and presented in rank order: 1 = undergraduate, 2 = undergraduate plus, 3 = master's, 4 =

master's plus, 5 = doctorate, and 6 = doctorate plus. The modal rank-order education level was 5.0 (SD = 1), indicating a doctoral-level degree. The highest level of education attained (or in progress of being attained) was a Ph.D. (41.5%) or when described as a doctoral-level degree, 64.2%. Most of the sample were licensed psychologists (44.3%), and 44.4% held, or also held, a typically master's level credential (i.e. licensed professional counselor, social worker).

Table 2

Education and Credentials

	N	%
Highest Level of Education*		
Undergraduate Degree	1	.9
Master's Degree (IP)	1	.9
Master's Degree	29	27.4
Psy.D.	13	12.3
Ed.D. (IP)	2	1.9
Ed.D.	4	3.8
Ph.D. (IP, pre-diss)	1	.9
Ph.D. (IP, ABD)	1	.9
Ph.D.	44	41.5
M.D.	7	6.6
M.D./Ph.D.	3	2.8
Other	3	2.8
Education (rank)*		
1-Undergraduate	1	.9
2-Undergraduate plus	1	.9
3-Master's	29	27.4
4-Master's plus	4	3.8
5-Doctorate	68	64.2
6-Doctorate plus	3	2.8
Credential*		
Licensed Professional Counselor	14	13.2
Certified Rehabilitation Counselor	2	1.9
Licensed Clinical Social Worker	20	18.9
Licensed Marriage and Family Therapist	11	10.4
Minister/Pastoral Counsel	1	.9
Licensed Psychologist	47	44.3
Psychologist, working towards licensure	4	3.8
Medical Doctor, Licensed Psychiatrist	7	6.6
Post-graduate degree, working towards licensure in my field	3	2.8
Student	3	2.8
Other	7	6.6

Note. *N = 106. "IP" refers to 'In Progress.' Education levels that were not represented in the sample are not displayed in the table (i.e. Psy.D., in progress).

Table 3 presents participant work setting and their role at work. Primary work setting, secondary work setting, followed by primary role at work, and participant role in their secondary work setting is listed. Frequency and percent are given for the sample. The primary work setting most represented in the sample was private practice (37.7%), followed by hospital (20.8%), and 'other' (17.0%). Participants' primary work role was psychotherapist (67.9%), clinical or staff supervisor (36.8%), and researcher (14.2%). Forty-eight percent reported no secondary work setting, while 16% described their secondary work setting as 'other' and 13.2% worked at a university as a secondary workplace.

Table 3

Work Setting and Role at Work

	N	%
Primary Work Setting*		
Community Mental Health Agency	11	10.4
University	7	6.6
Private Practice	40	37.7
Outpatient Psychiatric Facility	7	6.6
Hospital	22	20.8
Student	1	.9
Other	18	17.0
Role at Primary Work Setting*		
Psychotherapist	72	67.9
Clinical Supervisor	22	20.8
Staff Supervisor	17	16.0
Faculty Member	12	11.3
Consultant	9	8.5
Medical Doctor	5	4.7
Minister or Priest	1	.9
Researcher	15	14.2
Other	8	7.5
Secondary Work Setting*		
Community Mental Health Agency	2	1.9
University	14	13.2
Community College	1	.9
Private Practice	12	11.3
Outpatient Psychiatric Facility	4	3.8
Inpatient Psychiatric Facility	2	1.9
Hospital	3	2.8
Church	1	.9
No Other Work Setting	49	48.2
Other	17	16.0
Role at Secondary Work Setting*		
Psychotherapist	19	17.9
Clinical Supervisor	8	7.5
Staff Supervisor	2	1.9
Faculty Member	16	15.1
Consultant	10	9.4
Medical Doctor	2	1.9

Minister or Priest	1	.9
Researcher	5	4.7
Other	6	5.7

Note. *N = 106. Work settings and roles that were not represented in the sample are not included in the table.

The mean number of clients/patients seen in the last six months was 79.4 (SD = 116.3, Min = 1, Max = 720, Skew = 3.36). Most participants reported that they primarily work with adults (86.8%), followed by young adults (51.9%), adolescents (27.4%), children (22.6%), and older adults (21.7%).

Seventy-nine percent of participants reported not having taken a trauma course in their graduate program and 61% of participants reported not having completed an internship/externship experience focusing on a traumatized population. The mean number of hours of trauma training in the last six months was 20.3 (SD = 27.6). The mean number of hours of reading on trauma in the last six months was 52.1 (SD = 69.7).

Participant descriptions of their overall training in trauma and experience with traumatized populations are presented in Table 4. Each category was ranked 1-4 to define level of training or experience. The definitions for categories regarding overall training in the understanding of and/or treatment of trauma since completing the graduate degree were defined as: 1) *Limited:* a few continuing education hours, 2) *Moderate*: more than a few continuing education hours, one seminar/training a year, moderate reading on trauma (e.g. 2 articles and 1-3 books), 3) *Intensive*: two seminars/trainings a year, some specialized training, heavy reading on trauma (e.g. several articles and 4 books), 4) *Expert*: continuous seminars, training, and/or other opportunities, seminar leader/teacher in the area, specialty is in trauma work, heavy reading in trauma and related research areas (e.g. several articles, 5 books, published).

Definitions for categories describing either overall experience with individuals who have survived ONLY a single incidence trauma or overall experience with individuals who have experienced repeated traumatic experiences over the lifespan are: 1) *Limited*: one case or less per month, 2) *Moderate*: 2-3 cases or more per month, but work with other cases as well, 3) *Intensive*: 4 or more cases per month, and work with these cases most of the time, 4) *Expert*: more than 4 cases per month, this is a specialty and known in the community to work with this population. Most participants defined themselves as intensive or expert level in terms of overall trauma training (83%). Most of the sample described themselves as having limited or moderate levels of experience in working with individuals who have survived a single-incident trauma (75.5%). Almost three quarters of participants (73.6%) reported having intensive or expert level experience in working with individuals who have experienced repeated trauma. As a result, the participants can largely be defined as experts with regard to their trauma training and work experience with individuals with repeated trauma. Frequencies and percentages are included in Table 4.

The mean number of clients/patients with complex trauma seen individually, in the last six months was 23.9 (SD = 36.1, Med = 10.0, Mod = 5.0, Skew = 3.6). The mean number of clients/patients with complex trauma seen in group therapy, in the last six months was 11.0 (SD = 34.5, Med = 0.0, Mod = 0.0, Skew = 6.3). As a result, the mean total number of complex trauma clients/patients seen, in this sample of therapists, in the last six months was 34.9 (SD =65.2, Med = 15.0, Skew = 5.19).

Table 4

Overall Trauma Training and Experience

	Trauma Training		Experience with Single-incident Trauma		Experience with Repeated Trauma	
Description	N	%	N	%	N	%
1-Limited	6	5.7	39	36.8	2	1.9
2-Moderate	12	11.3	41	38.7	26	24.5
3-Intensive	40	37.7	8	7.5	27	25.5
4-Expert	48	45.3	17	16.0	51	48.1

Note. There is one missing value for Experience with Single-incident Trauma (.9%).

Descriptive statistics for dependent variables are presented in Table 5 (see Table 7 for correlations). Means and standard deviations are included for difficulties and the subscales for coping: constructive coping, and avoidant coping. These scales were taken from the Development of Psychotherapists Common Core Questionnaire (DPCCQ). The sample mean for difficulties was 1.05, with a range of 3.06 based upon a 5-point scale where the higher the score, the greater the difficulty. The sample mean for constructive coping was 3.47 with a range of 3.78 based upon a 5-point scale where the higher the score, the greater the utilization of constructive coping. The sample mean for avoidant coping was 1.05 with a range of 5.0 based upon a 5-point scale where the higher the score, the more avoidant coping employed. Sample means reflect little difficulty experienced, moderate constructive coping employed, and little avoidant coping utilized. Cronbach's alpha for difficulties = .93, constructive coping = .78, and avoidant coping = .75.

Table 5

Means and Standard Deviations for Dependent Variables

Variable	N	M	SD	Min-Max	Skew
Difficulties	101	1.05	.623	0.00-3.06	.848
Constructive Coping	102	3.47	.774	1.22-5.00	-.415
Avoidant Coping	104	1.05	.675	0.00-5.00	2.23

Note. The Difficulties, Constructive Coping, and Avoidant Coping subscales are from the Development of Psychotherapists Common Core Questionnaire (DPCCQ).

Descriptive statistics for independent variables are presented in Table 6 (see Table 7 for correlations). Means and standard deviations are included for anxious attachment, avoidant attachment, and self-differentiation. The Experiences in Close Relationship Scale-Short Form (ECR-S) was used to measure anxious and avoidant attachment based upon a 7-point scale where higher scores on attachment anxiety and attachment avoidance subscales reflect higher levels of attachment anxiety and attachment avoidance, respectively. The mean score for anxious attachment was 2.63 with a range of 4.67, and the mean score for avoidant attachment is 2.17 with a range of 3.17. Sample means indicate low levels of attachment anxiety and avoidance. Cronbach's alpha for attachment anxiety = .74, and attachment avoidance = .74. The Differentiation of Self Inventory (DSI) was used to measure the total score for self-differentiation based upon a 6-point scale. Higher scores indicate greater self-differentiation. The mean score for self-differentiation was 4.44 with a range of 2.58. The sample mean indicates a moderate to high level of self-differentiation. Cronbach's alpha for self-differentiation was .89.

Table 6

Means and Standard Deviations for Independent Variables

Variable	N	M	SD	Min-Max	Skew
Anxious Attachment	104	2.63	1.01	1.00-5.67	.574
Avoidant Attachment	104	2.17	.831	1.00-4.17	.870
Self-differentiation	93	4.44	.529	2.98-5.56	-.218

Note. Anxious Attachment and Avoidant Attachment scales are from the Experiences in Close Relationship Scale-Short Form (ECR-S).

Table 7

Correlations for Difficulties, Constructive Coping, Avoidant Coping, Attachment Anxiety, Attachment Avoidance, and Self-differentiation

	Correlations					
	1	2	3	4	5	6
1. DPCCQ-Diff	1					
2. DPCCQ-CoCop	.007	1				
3. DPCCQ-AvCop	.402**	.336**	1			
4. ECR-S-Anx	.228*	.014	-.260**	1		
5. ECR-S-Avd	-.085	-.136	.182	.297**	1	
6. DSI	-.403**	-.022	-.327**	-.547**	-.272**	1

Note. The DPCCQ (Development of Psychotherapists Common Core Questionnaire) difficulties scale measures difficulties, and the coping scale measures constructive and avoidant coping. The ECR-S (Experiences in Close Relationship Scale-Short Form) measures attachment anxiety and attachment avoidance. The DSI (Differentiation of Self Inventory) measures self-differentiation.
*$p < .05$. **$p < .01$.

Regression Assumptions

There are several assumptions made in regression analysis. First, it is assumed that all variables are measured without error and that independent variables are quantitative or dichotomous, the dependent variable is quantitative, continuous and unbounded (Berry, 1993), and there is linearity between the independent and dependent variables (Tabachnick & Fidell, 2001; see also Berry, 1993). Linearity was confirmed by plotting residual versus predicted values and the assumption was met through visual inspection of linearity. It is also assumed that independent variables have a non-zero variance, and that there is not perfect multicollinearity between independent variables (Berry, 1993). Non-zero variance was confirmed at .15. Predictor and moderator variables were centered to reduce problems of multicollinearity. Also, the mean value for the error term of each set of values for

independent variables is assumed to be zero, and each independent variable is not correlated with the error term (Berry, 1993). No correlation was found between the independent variables and the error term. The assumption of homoscedacticity and lack of autocorrelation is also employed in regression analysis (Berry, 1993). This was also confirmed by plotting residual versus predicted values.

Regression Analysis

Multiple regression analyses were used to determine to what extent there was a predictive relationship between independent and dependent variables. Specifically, the analyses tested to what extent therapist attachment anxiety, attachment avoidance, and self-differentiation predicted: 1) difficulties in practice with complex trauma patients, 2) constructive coping employed when working with complex trauma patients, and 3) avoidant coping employed when working with complex trauma patients. Hierarchical multiple regression analyses were used to test moderating effects and slopes were calculated for moderation effects found (one standard deviation below or above the mean for low and high levels, respectively). These analyses were used to determine moderating effects of work experience and training in the relationship between the aforementioned independent (attachment and self-differentiation) and dependent variables (difficulties and coping). Independent variables were centered in order to reduce problems of multicollinearity (Cohen, Cohen, West, & Aiken 2003, Tabachnick & Fidell, 2001). Moderation effects were tested using the product term (interaction term) of the centered predictor and moderator variables in the regression analyses.

Moderation terms were derived from six moderator variables capturing both work experience and training. The moderator variables included: education level (in ranked format), total number of complex trauma patients, total number of patients,

overall training in trauma, overall experience with single-incident trauma patients, and overall experience with repeated trauma patients. Six interaction terms were computed per independent variable (attachment anxiety, attachment avoidance, self-differentiation) for each of the three dependent variables (difficulties, constructive coping, and avoidant coping). Results of the analyses are discussed as they pertain to the study hypotheses and research questions.

Research Question 1

To what extent are trauma therapist difficulties and coping explained by anxious and avoidant attachment style, and self-differentiation?

Hypothesis 1(models A-C)

Hypothesis 1, model A. It was hypothesized that trauma therapists who identify as anxiously or avoidantly attached and who have a low level of self-differentiation will experience increased difficulties in their work with complex trauma patients. Multiple regression analyses were used to predict difficulties in relation to attachment anxiety and avoidance, and self-differentiation. The predictor variables (attachment anxiety, attachment avoidance, and self-differentiation) were entered into a simultaneous regression model predicting difficulties. The results (see Table 8) indicate that Self-differentiation (DSI) and attachment avoidance (ECR-S-Avd) were found to predict difficulties, $F(3, 102) = 9.463$, $p < .001$, and accounted for 20% of the variance (adjusted $R^2 = .195$). Self-differentiation had the greatest influence on difficulties ($\beta = -.442$) followed by attachment avoidance ($\beta = -2.2$). Thus, self-differentiation and avoidant attachment are individually negative predictors of difficulties, while attachment anxiety was not found to be a predictor of difficulties. The results partially support hypothesis 1, model A.

Hypothesis 1, model B. It was hypothesized that trauma therapists who identify as anxiously or avoidantly attached and who have a low level of self-differentiation will experience less constructive coping in their work with complex trauma patients. Multiple regression analyses were used to predict constructive coping in relation to attachment anxiety and avoidance, and self-differentiation. The predictor variables (attachment anxiety, attachment avoidance, and self-differentiation) were entered into a simultaneous regression model predicting constructive coping. Results indicated that attachment anxiety, attachment avoidance, and self-differentiation were not found to be predictors of constructive coping (see Table 9). Thus hypothesis 1, model B is not supported.

Hypothesis 1, model C. It was hypothesized that trauma therapists who identify as anxiously or avoidantly attached, and who have a low level of self-differentiation will experience more avoidant coping in their work with complex trauma patients. Multiple regression analyses were used to predict avoidant coping in relation to attachment anxiety and avoidance, and self-differentiation. The predictor variables (attachment anxiety, attachment avoidance, and self-differentiation) were entered into a simultaneous regression model predicting avoidant coping. The results indicated (see Table 10) that self-differentiation was found to predict avoidant coping, $F(3, 102) = 4.726$, $p < .05$, and accounted for 10% of the variance (adjusted $R^2 = .096$). Only self-differentiation was a predictor of avoidant coping where the lower the level of self-differentiation, the more avoidant coping employed. Self-differentiation accounted for a low percentage of the variance, however. Attachment anxiety and attachment avoidance were not found to be predictors of avoidant coping. These results indicate partial support for hypothesis 1, model C.

Table 8

Attachment Anxiety, Attachment Avoidance, and Self-differentiation Predicting Difficulties

Predictor Variable	b	SE	β
ECR-S-Anx	.040	.066	.064
ECR-S-Avd	-.166	.070	-.219*
DSI	-.536	.128	-.442**

Note. R = .467; R^2= .218. The ECR-S (Experiences in Close Relationship-Short Form) measures attachment anxiety (ECR-S-Anx) and attachment avoidance (ECR-S-Avd). The DSI (Differentiation of Self Inventory) measures self-differentiation. Attachment anxiety was not found to be a predictor of difficulties.
*p < .05. **p < .01.

Table 9

Attachment Anxiety, Attachment Avoidance, and Self-differentiation Predicting Constructive Coping

Predictor Variable	b	SE	β
ECR-S-Anx	.035	.090	.047
ECR-S-Avd	-.155	.096	-.167
DSI	-.056	.175	-.038

Note. R = .159; R^2= .025. The ECR-S (Experiences in Close Relationship-Short Form) measures attachment anxiety (ECR-S-Anx) and attachment avoidance (ECR-S-Avd). The DSI (Differentiation of Self Inventory) measures self-differentiation. Neither attachment anxiety, attachment avoidance, nor self-differentiation was found to predict constructive coping.

Table 10

Attachment Anxiety, Attachment Avoidance, and Self-differentiation Predicting Avoidant Coping

Predictor Variable	b	SE	β
ECR-S-Anx	.057	.075	.087
ECR-S-Avd	.046	.080	.057
DSI	-.354	.146	-.272*

Note. R = .349; R^2= .122. The ECR-S (Experiences in Close Relationship-Short Form) measures attachment anxiety (ECR-S-Anx) and attachment avoidance (ECR-S-Avd). The DSI (Differentiation of Self Inventory) measures self-differentiation. Neither attachment anxiety nor attachment avoidance was found to predict avoidant coping.
*$p < .05$.

Research Question 2

To what extent do work experience and trauma training moderate the relationship between anxious and avoidant attachment styles and self-differentiation on therapist difficulties with complex trauma patients?

Hypothesis 2

Increased work experience and trauma training will moderate trauma therapist attachment and self-differentiation in relationship to trauma therapist difficulties; in turn, this will result in decreased difficulties when working with complex trauma patients for those trauma therapists who are more versus less anxiously or avoidantly attached and those who have lower levels of self-differentiation. Hierarchical multiple regression analyses were used to test moderating effects of work experience and training on the relationship between attachment anxiety and avoidance and self-differentiation in predicting difficulties. Six moderator variables were used to capture work experience and training including:

level of education (in rank order), number of complex trauma patients/clients seen in the last 6 months, number of total patients/clients seen in the last 6 months, overall training in trauma, overall experience working with single-incident trauma, and overall experience working with repeated trauma. Separate analyses were conducted per potential moderating variable. Interaction terms were generated using potential moderating variables and independent variables (attachment anxiety X moderator, attachment avoidance X moderator, and self-differentiation X moderator). Predictor variables were entered into the first block and interaction terms were entered into the second block. The predictor variables were entered into the regression model simultaneously.

Self-differentiation and attachment avoidance predicted difficulties in the first model, $R^2 = .237$, Adjusted $R^2 = .206$, $F(4,96) = 7.475$, $p < .001$. In the second model, self-differentiation and attachment avoidance also predicted difficulties and experience with patients/clients with repeated trauma produced a moderating effect between attachment anxiety and difficulties, $R^2 = .332$, Adjusted $R^2 = .282$, $F(7, 93) = 6.608$, $p < .01$ (see Table 11 for moderating effects). Self-differentiation, attachment avoidance and the repeated trauma experience moderator (attachment anxiety X experience with repeated trauma) accounted for 28% of the variance (adjusted $R^2 = 28.2$). There was one significant relationship between experience with repeated trauma and attachment anxiety, $F_{change}(3,93) = 4.394$, $p < .05$. The inclusion of the moderator (interaction term) accounted for an additional 9.5% of the variance ($\Delta R^2 = .095$) beyond what is explained by the independent variables in the first model. Self-differentiation is the most statistically significant and powerful predictor, followed by attachment avoidance, then the repeated trauma moderator. However,

some of the predicting power of self-differentiation is reduced through moderation ($\beta = -.398$).

Simple slopes and the regression lines for each level of the predictors (one standard deviation below or above the mean for low and high levels, respectively) were calculated. See Figure 3. More difficulties were reported by trauma therapists with higher attachment anxiety and less experience with repeated trauma patients/clients. No other moderator effects were found. These findings partially support hypothesis 2.

Table 11

Hierarchical Multiple Regression Analyses: Experience with Repeated Trauma Moderating Effects in Predicting Difficulties

Predictor Variable	b	SE	β	ΔR^2	ΔF
Model 1				.237	7.48**
ECR-S-Anx	.038	.066	.061		
ECR-S-Avd	-.166	.071	-.222*		
DSI	-.517	.131	-.424**		
RT[1]	-.125	.063	-.176		
Model 2				.095	4.39*
ECR-S-Anx	.046	.064	.075		
ECR-S-Avd	-.197	.068	-.263*		
DSI	-.486	.128	-.398**		
RT[1]	-.132	.061	-.186*		
ECR-S-Anx X RT[1]	-.230	.081	-.326*		
ECR-S-Avd X RT[1]	.029	.092	.032		
DSI X RT	-.004	.164	-.003		

Note. RT[1] = Experience with repeated trauma. The ECR-S (Experiences in Close Relationship-Short Form) measures attachment anxiety (ECR-S-Anx) and attachment avoidance (ECR-S-Avd). The DSI (Differentiation of Self Inventory) measures self-differentiation.
*p < .05. **p < .001.

Figure 3. Moderation Effect of Attachment Anxiety on Difficulties by Experience with Repeated Trauma

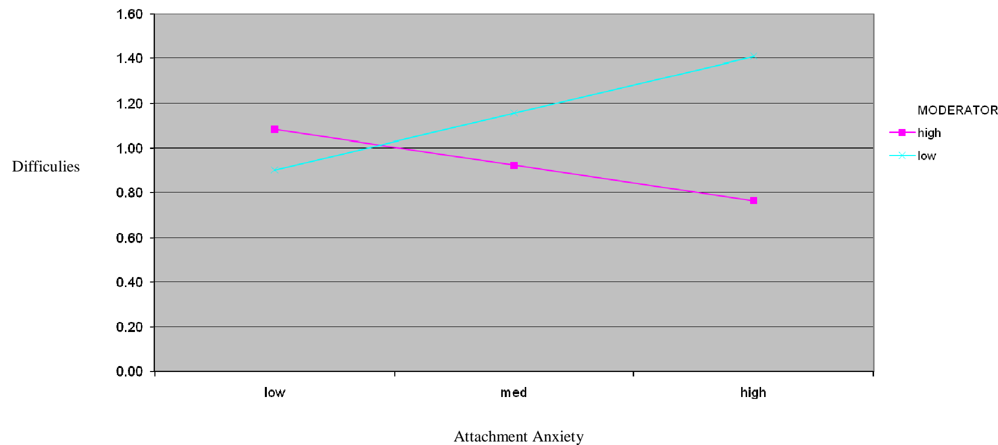

Figure 3. Interaction between Anxious Attachment and Experience with Repeated Trauma Patients/Clients (RT) (moderator) predicting Difficulties. N = 101. Values for RT are plotted using low (one standard deviation below the mean) and high (one standard deviation above the mean) values of RT and Anxious Attachment. The slope for low and high RT =.248, -.156, respectively.

Research Question 3

To what extent do work experience and trauma training moderate the relationship between anxious and avoidant attachment styles and self-differentiation on therapist coping with complex trauma patients?

Hypothesis 3

Increased work experience and trauma training will moderate trauma therapist attachment and self-differentiation in relationship to trauma therapist coping, resulting in increased positive coping reactions (constructive coping) and decreased negative coping (avoidant coping) when working with complex trauma patients for those trauma therapists who are more versus less anxiously or avoidantly attached, and those who have lower levels of self-differentiation. Hierarchical multiple regression analyses were used to test moderator effects of work experience and training on the relationship between attachment anxiety and avoidance and self-differentiation in

predicting coping. Constructive coping was tested for moderation but no significant moderating effects were found. Avoidant coping was tested as a separate, dependent variable. Six moderator variables were used to capture work experience and training including: level of education (in rank order), number of complex trauma patients/clients seen in the last 6 months, number of total patients/clients seen in the last 6 months, overall training in trauma, overall experience working with single-incident trauma, and overall experience working with repeated trauma. Separate analyses were conducted per potential moderating variable. Interaction terms were generated using potential moderating variables and independent variables (attachment anxiety X moderator, attachment avoidance X moderator, and self-differentiation X moderator). Predictor variables were entered into the first block and interaction terms were entered into the second block. The predictor variables were entered into the regression model simultaneously.

Self-differentiation and experience with single-incident trauma (ST) predicted avoidant coping in the first model, $R^2 = .154$, Adjusted $R^2 = .120$, $F(4, 99) = 4.510$, $p < .05$. Again, in the second model, self-differentiation and ST predicted avoidant coping. ST also produced a moderating effect between attachment anxiety and avoidant coping and ST produced a moderating effect between attachment avoidance and avoidant coping, $R^2 = .255$, Adjusted $R^2 = .201$, $F(7, 96) = 4.350$, $p < .05$ (see Table 12 for moderating effects). There was a significant moderating effect of ST with attachment anxiety and attachment avoidance in relationship to avoidant coping, $F_{change}(3,96) = 4.350$, $p < .05$. Self-differentiation, ST, and the ST moderators (attachment anxiety X ST and attachment avoidance X ST) accounted for 20% of the variance (adjusted $R^2 = 20.1$). The inclusion of the moderators (interaction terms) accounted for an additional 10.1% of the variance ($\Delta R^2 = .101$) beyond what is

explained by the independent variables in the first model. Moderator, ST X attachment avoidance, is the most statistically significant and powerful predictor, followed by ST, moderator ST X attachment anxiety, and self-differentiation.

Simple slopes and the regression lines for each level of the predictors (one standard deviation below or above the mean for low and high levels, respectively) were calculated. See Figures 2 and 3. More avoidant coping was reported by trauma therapists with higher attachment anxiety and more experience with single-incident trauma patients/clients (Figure 5). More avoidant coping was reported by trauma therapists with higher attachment avoidance and more experience with single-incident trauma patients/clients (Figure 4). No other moderating effects were found. These results partially support hypothesis 3.

Table 12

Hierarchical Multiple Regression Analyses: Experience with Single-incident Trauma Moderating Effects in Predicting Avoidant Coping

Predictor Variable	b	SE	β	ΔR²	Δ*F*
Model 1				.154	4.510*
ECR-S-Anx	.062	.076	.094		
ECR-S-Avd	.056	.082	.067		
DSI	-.321	.152	-.243*		
ST[1]	.119	.059	.186*		
Model 2				.101	4.350*
ECR-S-Anx	.073	.073	.110		
ECR-S-Avd	.035	.078	.043		
DSI	-.300	.150	-.227*		
ST[1]	.133	.059	.207*		
ECR-S-Anx X ST[1]	.149	.069	.232*		
ECR-S-Avd X ST[1]	.205	.078	.242*		
DSI X ST[1]	.199	.162	.139		

Note. ST[1] = Experience with single-incident trauma. The ECR-S (Experiences in Close Relationship-Short Form) measures attachment anxiety (ECR-S-Anx) and attachment avoidance (ECR-S-Avd). The DSI (Differentiation of Self Inventory) measures self-differentiation.
*p < .05.

Figure 4. Moderation Effect of Attachment Anxiety on Avoidant Coping by Experience with Single-incident Trauma

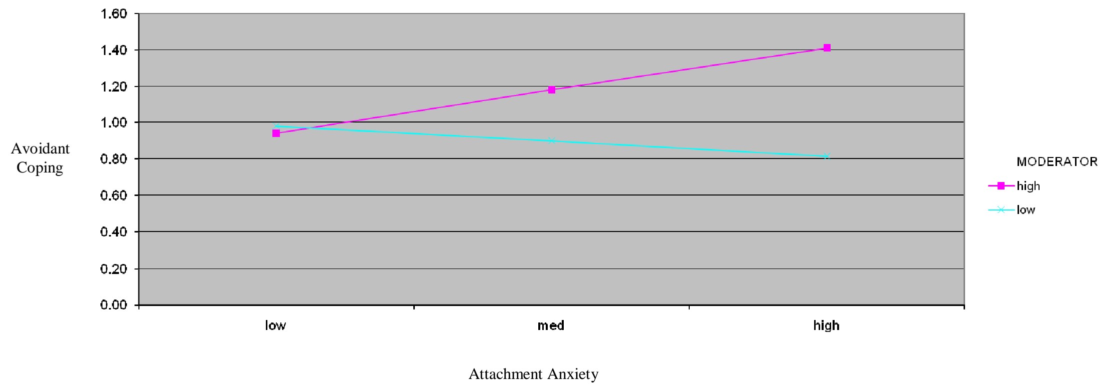

Figure 4. Interaction between Attachment Anxiety and Experience with Single-incident Trauma Patients/Clients (ST) (moderator) predicting Avoidant Coping. N = 104. Values for ST are plotted using low (one standard deviation below the mean) and high (one standard deviation above the mean) values of ST and Attachment Anxiety. The slope for low and high ST = -.084, .230, respectively.

Figure 5. Moderation Effect of Attachment Avoidance on Avoidant Coping by Experience with Single-incident Trauma

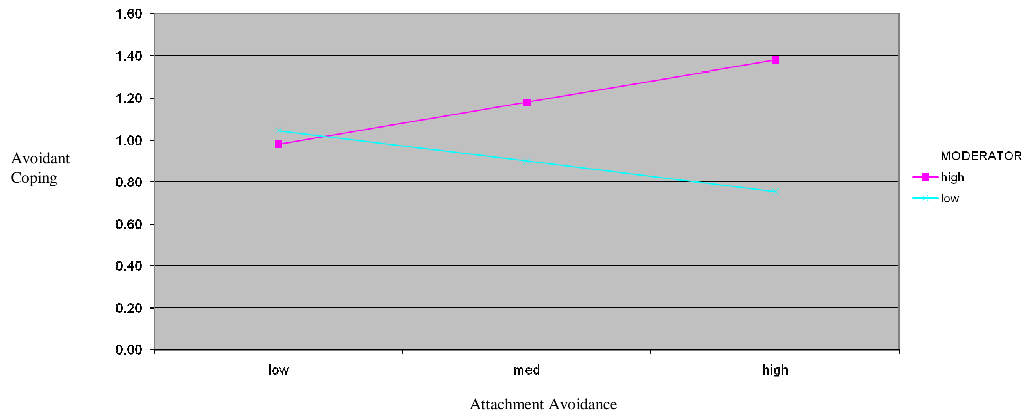

Figure 5. Interaction between Attachment Avoidance and Experience with Single-incident Trauma Patients/Clients (ST) (moderator) predicting Avoidant Coping. N = 104. Values for ST are plotted using low (one standard deviation below the mean) and high (one standard deviation above the mean) values of ST and Attachment Avoidance. The slope for low and high ST = -.122, .192, respectively.

CHAPTER 5

Therapists who work with complex trauma patients, a difficult population to treat, encounter unique challenges as a result of the trauma material presented, diagnostic complexity, self-harming behavior, suicidality, and relational deficits that can often jeopardize the therapeutic relationship (Bennet, Parry, & Ryle, 2006; Courtois, 2004; Courtois & Ford, 2009; Herman, 1992; Linehan, 1993; Marmaras et al., 2003; Pearlman & MacIan, 1995; Pearlman & Saakvitne, 1995; Smith, Kleijn, & Hutschemaekers, 2007; Wilson & Thomas, 2004). Gaining an understanding of trauma therapist reactions to complex trauma patients, what may be contributing to the difficulties they experience, and how they cope when faced with these difficulties may shed light on positive ways to manage these reactions, improve therapeutic process, work experience, and ultimately serve this vulnerable population more ethically and effectively. The problem investigated in this study was to determine to what extent therapist work experience with complex trauma and trauma training moderates anxious and avoidant attachment styles and self-differentiation in effecting therapist difficulties and therapist coping with complex trauma patients. Three hypotheses were tested in this study exploring the relationships among those constructs.

Hypotheses and Interpretations

Hypothesis 1, model A

Trauma therapists who identify as anxiously or avoidantly attached and who have a low level of self-differentiation will experience increased difficulties in their work with complex trauma patients. Attachment anxiety was not a predictor of difficulties, which does not support Hypothesis 1, model A. Self-differentiation and attachment avoidance were predictors of difficulties in practice with complex trauma

patients. The lower the levels of self-differentiation and avoidant attachment, the more difficulties encountered. This partially supports hypothesis 1, model A, in that the direction of attachment avoidance in relationship to difficulties was negative rather than positive.

Several observations may contribute to these findings. First, therapist difficulties are discussed. This study found that this sample of highly experienced trauma therapists report almost no difficulties in their work with complex trauma patients. The average reported difficulties was 1.05 (on a Likert scale where 0 = never experiencing the difficulty and 5 = experiencing the difficulty very often). Orlinsky and Rønnestad (2005) also found a low level of experienced difficulties in their large comprehensive study on psychotherapists and how they develop. They found that psychotherapists scored an average somewhere between 1 and 2. The current trauma therapist sample is slightly below that average. It is important to distinguish, however, that in the current study, participants were asked to report on their difficulties regarding complex trauma patients specifically, as opposed to difficulties with patients in general, which was the case in the Orlinsky and Rønnestad study. This finding seems somewhat expected given the previous research by Orlinsky and Rønnestad, yet it is contradictory to some of the writing and research in the trauma field (Deighton, Gurris, & Traue, 2007; Figley, 2002; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Wilson & Thomas, 2004). One possibility is that this particular sample was largely made up of experienced, expert-level trauma therapists. Implications regarding this general finding are explored in detail throughout the discussion.

Smith, Kleijn, & Hutschemaekers (2007) found that trauma therapists do experience difficulties related to their work with traumatized patients including a high

level of emotional burden, difficulties regarding the psychopathology, complexity of symptoms, and psychological problems. So it is surprising that the participants in this study did not articulate difficulties in working with complex trauma patients. Smith, Kleijn, & Hutschemaekers (2007) found that trauma therapists experienced fewer negative feelings towards their traumatized patients in comparison to 'client-centered' therapists who work with trauma survivors. This finding, regarding few trauma therapist negative feelings towards their traumatized patients, was also found in the present study.

Schrøder and Davis (2004) present the importance of therapist experience level to the understanding of different types of difficulties the therapist may have in hopes of addressing them. This sample includes a high percentage of expert-level trauma therapists, a factor which may have influenced the study's outcomes. The instrument may have been too broad to capture specific difficulties that trauma therapists encounter as these may differ from the experience of generalist therapists. The difficulties scale utilized in this study may have been too general to identify specific experienced difficulties unique to the expert-level trauma therapist. An alternative instrument may be needed to include the specific, and potentially unique range of difficulties expert-level trauma therapists encounter. This may draw attention to what extent the difficulties are affecting their work with complex trauma patients. Smith, Kleijn, Trijsburg and Hutchemaekers (2007) used qualitative analysis in order to extract difficulties experienced by trauma therapists and did determine a set of unique difficulties. The Therapist Reactions and Emotions Questionnaire (TREq) (Smith, Kleijn, Hutschemaekers, & Trijsburg, 2007) was used to capture therapist reactions to clinical vignettes of difficult situations. Though more tailored to

trauma therapists, it may not be extensive enough and still too general to capture trauma therapist difficulties in detail.

Another possibility that may have contributed to participants reporting little to no difficulties may be their familiarity and understanding of the questions being presented resulting in the need to present themselves in a positive way, also called 'faking good' (Baer & Schwartz, 1991). Participants in the sample are highly educated, experienced, and knowledgeable who, as a function of their education and training, have had experience and perhaps expertise in psychology research and practice. This may have impacted participant responses, especially when questioning their personal and professional reactions to patients and relationship styles. Participants may have avoided reporting difficulties, incompetenc, coping problems, or difficulty relating.

Finally, the finding that these trauma therapists are not experiencing difficulties is that they have reported honestly and are not, in fact, encountering difficulties in their work with complex trauma patients. Smith et al. (2007) reported that trauma therapists are not experiencing difficulties as severe and may not be experiencing vicarious or secondary traumatization to the extent that was previously believed. These authors found that the expert therapists in their study were not traumatized, but were well-functioning, satisfied in their work, and not displaying signs of secondary trauma. Overall, no negative effects of long-term trauma work were found, raising questions about vicarious trauma and countertransference (Smith, Kleijn, Trijsburg, & Hutschemaekers, 2007). The current study appears to reflect these findings and lends support to the possibility that expert therapists who are highly exposed to trauma material and working consistently with the traumatized population are functioning well and in fact experiencing fewer difficulties in their

work with complex trauma patients. Further research is needed to determine if clinical expertise in trauma and continued exposure to trauma work serves as a protective factor as one has more experience and is more equipped to work with this population.

General findings regarding the sample's reported attachment styles are important due to their implications for all hypotheses in the study. Low levels of both attachment anxiety and attachment avoidance were found in the sample, indicating more that these trauma therapists tended to be of the secure attachment style. The average attachment anxiety score was 2.63 and the average attachment avoidance score was 2.17, based upon a 7- point Likert scale where the higher the score the more anxiously or avoidantly attached, respectively.

Attachment anxiety was not found to be predictive of difficulties with complex trauma patients. This finding is contradictory to Meyer and Pilkonis (2001) who found it was important the therapist not be anxiously attached to form an alliance; Black, Hardy, Turpin, and Parry (2005) where anxious attachment was significantly negatively correlated to therapeutic alliance and significantly positively correlated with problems during therapy; and Marmaras, Lee, Siegel, and Reich (2003) who found that female trauma therapists with fearful or preoccupied attachment styles reported more disruptions in their cognitive schemas. Though these studies examined slightly different constructs of difficulties in relationship with attachment style (i.e. therapeutic alliance, problems during therapy, and disruptions in cognitive schemas), they all reflectdifferent types of difficulties. It is surprising that in this study, attachment anxiety was not predictive of more difficulties experienced; nor was less attachment anxiety predictive of fewer difficulties experienced. This finding is more congruent with Crook and Gelso (2000) and Ligiero and Gelso

(2002), who found that attachment style had no impact on working alliance or countertransference behaviors. Ligiero and Gelso (2002) and Farber et al. (1995) explained that their findings may be due to the therapist not perceiving the client as an attachment figure, thus not activating their attachment system. This may be true in this study, especially given that the participants are experienced, expert-level trauma therapists who also may not view their clients as attachment objects. However, this study also presents mixed findings on this issue where attachment was moderated in relationship to avoidant coping suggesting that some attachment activation is present.

A particularly surprising finding in the study was that *the less* avoidantly attached the trauma therapist, the more difficulties experienced with complex trauma patients. This finding makes some intuitive sense considering the more avoidant an individual, the less likely he or she will recognize or experience difficulties as a function of the avoidance. The finding suggests that avoidant attachment in the sample which is influenced difficulties experienced, and perhaps reported. Chrestman (1995) also found that increased involvement in clinical activities was associated with more avoidance symptoms, in comparison to therapists also involved in research activities, for example. Given that this group of trauma therapists is very active in clinical work with complex trauma patients, the finding does support Chrestman (1995). Marmaras, Lee, Siegel, and Reich (2003) also found a somewhat similar outcome where dismissive-avoidant female trauma therapists reported less disruptions in their cognitive schemas. The authors also suggest that these dismissive-avoidant therapists may be denying any emotional distress. In this study, a similar pattern may have occurred where the less avoidantly attached, the more difficulties experienced.

Another consideration regarding attachment avoidance may be the experience and expertise level of these trauma therapists. The amount of time spent as trauma

therapist may have systematically caused some level of desensitization to the trauma work, and/or their attachment system may not be activated, or not activated in the same way as other therapists (lesser experienced trauma therapists or non-trauma therapists). Wilson and Thomas (2004) reported that avoidance and detachment was one of five specific types of reactions reported by trauma therapists. Further investigation may shed light on whether or not this type of reaction pattern is even more prevalent among experienced, expert-level therapists. Ligero and Gelso (2002) and Farber et al. (1995) suggest that the therapist may not view the client as an attachment object and therefore, the therapeutic relationship may not be activating the therapist's attachment system.

Findings regarding participants' self-differentiation is important to explore. The participants reported a moderate to high level of self-differentiation (Mean = 4.44, based upon a 6-point Likert scale where the higher the score, the more self-differentiated). The average level of self-differentiation was higher than the average self-differentiation score reported in the creation of the instrument where the mean was 3.47 (Skowron & Friedlander, 1998). Bowen (1978) proposed that self-differentiation is at least partially biological and may be somewhat fixed over the lifespan, unlike attachment organization which may change over time (Feeney, 1999). It is important to note that this sample of expert-level, experienced trauma therapists were found to have a higher level of self-differentiation, which meaning they were better equipped to tolerate stressful situations.

Self-differentiation proved to be the strongest predictor variable in this study. Self-differentiation had the greatest influence on difficulties where trauma therapist self-differentiation predicted difficulties experienced with complex trauma patients. The lower the self-differentiation, the greater the difficulties experienced. This

finding is congruent with the general definition of self-differentiation and the research supporting the construct where the extent to which one is self-differentiated determines how the person will respond to a stressor (Bartle-Haring & Probst, 2004; Skowron & Friedlander, 1998). Individuals with a low-level of self-differentiation experience a life stressor with more distress than individuals with a high-level of self-differentiation who experience the same life stressor (Friedman, 1991). Such was the case in this study, where trauma therapists with lower levels of self-differentiation experienced more difficulties.

Hypothesis 1, model B

Trauma therapists who identify as anxiously or avoidantly attached, and who have a low level of self-differentiation will experience less constructive coping in their work with complex trauma patients. Attachment anxiety, attachment avoidance, and self-differentiation were not found to be predictors of constructive coping, which does not support hypothesis 1, model B.

Coping was divided into 'Constructive Coping' and 'Avoidant Coping' as a result of the coping scale used and the need to delineate between positive and negative coping reactions. Participants reported a moderate level of constructive coping employed when working with complex trauma patients (Mean = 3.47, based upon a Likert scale where 0 = never employing the constructive coping skill and 5 = very often employing the constructive coping skill). Similar results were found by Orlinsky and Rønnestad (2005) in their large study of psychotherapists where therapists were utilizing significantly more constructive coping strategies and rarely using avoidant coping strategies. Overall, it appears that these trauma therapists are coping relatively well in their work with complex trauma patients. Though these results were expected in this study, it is somewhat surprising that the average

utilization of constructive coping is not higher, especially since the sample reflects almost no difficulties encountered.

No significant moderating effects were found in relationship to constructive coping. As a result, the findings suggest there is no significant relationship between attachment style and self-differentiation in relationship to constructive coping. Since these trauma therapists seemed to be securely attached and self-differentiated, it is surprising that these variables did not relate to constructive coping utilization. This finding is counter-intuitive and is an area that needs further exploration. A few possibilities are that there is an element of participant faking on the coping scale, or that 'constructive coping' was not fully captured within the context of the instrument for this particular sample of experienced, expert trauma therapists.

The broader question asked relative to constructive coping is, what *are* the predictors of constructive coping for these trauma therapists? It appears as though experienced, expert-level trauma therapists are coping relatively well and employing very little avoidant coping strategies, but it is unclear how they are coping well, and what predicts this positive coping. This finding adds to the current literature regarding mixed findings on trauma therapist coping (Deighton, Gurris, & Traue, 2007) and that experienced trauma therapists appear to cope in a unique way (Smith, Kleijn, Trijsburg, & Hutschemaekers, 2007). Deighton, Gurris, and Traue (2007) postulated that these varied findings may be due to the problem of understanding what type of therapist reaction is a result of workload, exposure to traumatic material, or the process of empathizing and relating. The results of this study underscore the need for a more comprehensive coping instrument that focuses on several aspects of internal and behavioral coping patterns including: pathological, traumatic reactions to client material, internal reactions, in-session feelings and responses, educational and

training enhancement, self-care strategies, and other general coping reactions. Though the constructive coping scale in this study was found to be reliable and has been tested on a large sample of psychotherapists world-wide, it may be that trauma therapists identify constructive coping differently than do general psychotherapists. So a future research topic would be to identify potentially unique positive coping strategies utilized by expert therapists who work with complex trauma therapists. Based upon this study, and informed by the findings of Smith, Kleijn, Trijsburg, and Hutschemaekers (2007), a qualitative study may be useful to gather detailed data regarding unique coping strategies used by trauma therapists who work with complex trauma patients and to use these findings to create a quantitative measure that captures their experiences more specifically which may include general coping strategies, in-session coping, coping outside of session, and self-care strategies used to manage difficulties. Understanding how experienced, expert-level trauma therapists cope well, and what predicts their constructive coping strategies would be helpful in continued training and education, and increase the liklihood of positive work experience for trauma and non-trauma therapists who work with complex trauma patients.

Neither attachment anxiety nor attachment avoidance was found to be predictive of constructive coping. This is an interesting finding given the assumption of some negative relationship between attachment anxiety/avoidance and constructive coping where the less anxiously or avoidantly attached, the more constructive coping employed. However, no relationship was found. Neither attachment anxiety nor attachment avoidance predicted avoidant coping. Again, there would be an intuitive assumption that the less anxiously or avoidantly attached, the less avoidant coping utilized, but this relationship was not found. The relationship (or non-relationship)

between attachment and coping for these trauma therapists needs further exploration to understand if there continues to be a lack of relationship between them, and if so is it due to the possibility suggested by Ligiero and Gelso (2002) and Farber et al. (1995) where the attachment system is inactivated for this particular group of trauma therapists. Another explanation may be that the constructive coping scale used in this study did not capture the positive coping actually utilized by these trauma therapists. Bober, Regehr, & Zhao (2006) developed a coping questionnaire for trauma therapists, but their instrument focused on therapist's beliefs about what may protect them from trauma symptoms, with a focus on specific strategies used outside of session to increase their self-care and work against secondary traumatic stress. This instrument does not address in-session coping or other potentially unique coping strategies used by trauma therapists who work with complex trauma patients. Though Orlinsky and Rønnestad (2005) inquire about more comprehensive coping strategies, they do not include specific constructive coping strategies that trauma therapists may be utilizing as a function of their work with complex trauma patients. Further investigation, informed by Smith, Kleijn, Trijsburg, & Hutschemaekers (2007) study, may include a qualitative study to identify potentially unique constructive (and destructive) coping strategies used by trauma therapists, followed by the development of a quantitative instrument based upon the findings.

Self-differentiation did not predict constructive coping in this study whether it be a negative or positive relationship (lower self-differentiation predicting less constructive coping or higher self-differentiation predicting more constructive coping, respectively). This is a surprising finding given that a high level of self-differentiation is associated with self-regulation and the ability to consciously modulate feelings and behavior (Derryberry & Rothbart, 1988). Also, the finding that

self-differentiation did not predict constructive coping is contradictory to Murdock and Gore's (2004) finding where highly self-differentiated individuals employed more positive, active, and reflective coping strategies. This may support the possibility articulated earlier that constructive coping strategies are identified differently and unique to the expert trauma therapist population. Another explanation, congruent with this study's finding that these expert-level therapists are experiencing fewer difficulties, may be that since these therapists do not perceive difficulties they are then not employing a constructive coping response. More research is needed to understand this particular outcome.

Hypothesis 1, model C

Trauma therapists who identify as anxiously or avoidantly attached, and who have a low level of self-differentiation will experience more avoidant coping in their work with complex trauma patients. Attachment anxiety and attachment avoidance were not found to be predictors of avoidant coping, not providing support for hypothesis 1, model C. Self-differentiation was a predictor of avoidant coping where the less self-differentiated, the more avoidant coping utilized, therefore partially supporting supporting hypothesis 1, model C.

Participants reported a low level of avoidant coping employed when working with complex trauma patients (Mean = 1.05), congruent with the psychotherapist development study by Orlinsky and Rønnestad (2005). Attachment anxiety and attachment avoidance did not predict avoidant coping. This is a surprising finding given the assumption that attachment avoidance would relate to avoidant coping due to an avoidant style suggesting an avoidant response. Smith, Kleijn, and Hutschemaekers (2007) did find that when trauma therapists were faced with difficulties, they used more active (as opposed to avoidant, or non-utilization of)

interventions in comparison to other expert, non-trauma therapists. On the other hand, Chrestman (1995) found that increased involvement in clinical activities was associated with more avoidant symptoms. The current study findings appear to substantiate the use of non-avoidant coping strategies regardless of attachment style, but the lack of relationship between attachment (especially attachment avoidance) and avoidant coping needs further study because it is unclear as to why the therapist's coping reaction does not mirror their process of relating. It is possible that some level of avoidance could be due to the way participants answered the survey. Though a possibility may be the inactivation of the attachment system, as suggested by Ligiero and Gelso (2002) and Farber et al. (1995), in the case of experienced, expert-level trauma therapists in therapy with complex trauma patients, moderation was found in the relationship between attachment and avoidant coping.

Self-differentiation was a predictor of avoidant coping where the less the self-differentiation, the more avoidant coping employed. This is congruent with Murdock and Gore's (2004) finding that poorly self-differentiated individuals employed avoidant coping strategies. Individuals who experience emotional cut-off (a subtype of lower self-differentiation) will repress emotional expression and separate themselves from others, similar to individuals who are avoidantly attached (Wei, Russell, Mallinckrodt, & Vogel, 2008). Therefore it is understandable given that individuals who have a low level of self-differentiation have a lower tolerance of stress and the assumption may be made that they will employ more negative or avoidant coping strategies. It is important to note that although self-differentiation was a predictor of avoidant coping, it accounted for a small portion of the variance. So further investigation is needed to understand both why there were not a stronger association and what other predictor variables may be accounting for avoidant coping.

Other potential predictors for future investigation include the therapist's perceived ability to detach or distance from the patient, level of numbness or desensitization to the traumatic material presented by the patient, the therapist's value system related to a positive perception of avoidance (perhaps related to race/ethnic identification), and/or the therapist's perception of self-efficacy and competency in working with complex trauma patients. Also, given the strong data that suggests avoidant attachment is closely related to low self-differentiation (specifically emotional cut-off) (Fuendeling, 1998; Lopez, 2001; Skowron & Dendy, 2004; Wei, Russell, Mallinckrodt, & Vogel, 2008; Wei, Vogel, Ku, & Zalik, 2005), it is surprising that attachment avoidance did not predict avoidant coping.

Hypothesis 2

Increased work experience and trauma training will moderate trauma therapist attachment and self-differentiation in relationship to trauma therapist difficulties; in turn, this will result in decreased difficulties when working with complex trauma patients for those trauma therapists who are more versus less anxiously or avoidantly attached and those who have lower levels of self-differentiation. Experience with repeated trauma patients/clients was found to moderate the relationship between attachment anxiety and difficulties experienced with complex trauma patients/clients. More difficulties were reported by trauma therapists with higher attachment anxiety and less experience with repeated trauma patients/clients. Fewer difficulties were reported by trauma therapists with lower attachment anxiety and more experience with repeated trauma patients. The implications of these results are discussed. The work experience and training variable is explored and the problem of utilizing it as either a unified moderator or separate moderators is discussed. The results and implications of moderation outcomes are reviewed. The different moderation

outcomes found depending upon type of experience with a particular group of trauma patients/clients is explored. Moderating effects on attachment style in relationship to difficulties, and moderating effects on self-differentiation in relationship to difficulties is discussed.

One challenge in this study was collapsing work experience and trauma training into one variable. A factor analysis was conducted to potentially identify groupings of work experience and training variables that could define work experience and trauma training more cohesively. Unfortunately, the factor analysis did not extract theoretically meaningful elements that could be described in a unified manner. This analysis substantiates the overall difficulty faced by researchers defining and studying effects of education, work experience, and training due to the complexity of these constructs and how often they are intertwined (Beutler et al., 2004). It is likely that this inability to gain clarity contributed to the difficulty in testing for moderation effects in this study. However, a particular gap in the literature has been the lack of study of specialized training and work experience with a specific group of patients. This study attempted to address these issues specifically and did find differences in utilizing different education, training, and experience moderator variables.

Due to the problem of combining trauma work experience and training into a unified variable, six variables were used to capture work experience and training: 1) level of education (in rank order), 2) number of complex trauma patients/clients seen in the last 6 months, 3) total number of patients seen in the last 6 months, 4) overall training in trauma, 5) overall experience with single-incident trauma, and 6) overall experience with repeated trauma. After analyses and testing moderation effects, one moderation effect was found in relationship to difficulties.

Results showed that experience with repeated trauma moderated the relationship between attachment anxiety and difficulties. More difficulties were reported by trauma therapists with higher attachment anxiety and less experience with repeated trauma patients/clients. No other moderation effects were found. Therefore, there is some discernment between work experience, trauma training and education where experience with repeated trauma did play a moderating role independent of any other work experience, training, or education variables.

Since delimiting therapist training and experience can be so problematic (Stein & Lambert, 1995) the findings of this study support the utility of specifically defining type of training and experience with distinct populations. This finding supports Beutler's (1997) suggestion that therapist variables and level of training should be defined precisely as much as possible, utilizing academic degree alone should be avoided, and type and effects of training in a specific area should be distinguished from overall experience and education. The fact that other work experience, training and education variables did not yield moderation effects helps to confirm overall differences in these constructs and aids in supporting the need for future research to specifically define and delimit aspects of work experience, training, and education.

Overall training and overall experience in trauma did not yield any moderation effects regarding attachment style and self-differentiation in relationship to difficulties. This is contrary to Smith, Kleijn, & Hutschemaekers (2007) proposition that training in trauma is needed to decrease difficulties (and increase positive coping). The findings of the current study suggests that it is the overall experience with complex trauma patients that seems to decrease difficulties regarding attachment anxiety, and that it is self-differentiation and attachment avoidance that predict difficulties with complex trauma patients. These results also suggest that there are

differences in working with different types of traumatized populations. Experience working with patients/clients with single-incident trauma did not produce a moderating effect in relationship to difficulties, suggesting there are unique differences in the effects of work experience with different traumatized populations.

Further research is needed to understand differences between trauma training effects (or non-effects) and experience with traumatized populations in relationship to trauma therapist reactions. Increased professional development strategies (education, training, and experience) do not seem to assist more anxiously attached trauma therapists so it is possible that other development strategies, some of which more personal than professional, (personal psychotherapy, increased personal support, etc.) may be warranted. Future research is certainly needed in this area given that there is a general assumption that professional development is the key to improvement, and though it may be necessary to increase competency and skill, other forms of development (personal, experiential) may be helpful to affect trauma therapist reactions.

Other interesting outcomes were the lack of moderation in the relationship between attachment avoidance and difficulties, or self-differentiation and difficulties. Given the finding that self-differentiation and attachment avoidance predicts difficulties with complex trauma patients, finding no moderation in these relationships suggest that neither work experience, training, nor education has an effect on individuals reporting higher (or lower) attachment avoidance or self-differentiation. Crook and Gelso (2000) and Ligero and Gelso (2002) did not find a predictive relationship between therapist attachment style and countertransference or working alliance. The authors propose that the therapist's attachment system may not be activated. Though this could be a potential explanation in not finding a moderating

relationship between attachment avoidance and difficulties in this study there are differences in the effect on difficulties depending upon type of attachment style (anxious or avoidant). A moderating effect is present regarding attachment anxiety, but not attachment avoidance. It appears that the attachment system is being activated, but with different outcomes (i.e., there is a moderating effect with regard to attachment anxiety, and there is no effect with regard to attachment avoidance), otherwise no effects would be found. Crook and Gelso (2000) and Ligero and Gelso (2002) investigated therapists in general and did not discern between type of therapist or client. So it is possible that the therapist's attachment system may be activated with complex trauma patients, but not activated with others. This supports Alexander and Anderson's (1994) suggestion that the therapist's attachment system is more susceptible to activation when working with patients who have trauma histories and borderline personality features. Further research is needed to explore the differences in therapist attachment activation with different groups of clients. For example, a series of studies looking at attachment styles of different groups of therapists in terms of experience level, expertise, and specialty, and their reactions in therapy with different groups of patients (i.e. complex trauma patients, adjustment disordered patients, severely mentally ill patients, non-diagnosed patients) may yield interesting findings regarding differences in attachment activation depending upon therapist characteristics, type of patient seen, and perhaps a critical point where attachment is activated or inactivated.

This study did not find a moderating relationship between self-differentiation and difficulties, and only one moderating relationship was found between attachment anxiety and difficulties. Self-differentiation is the degree to which an individual can balance emotional and intellectual functioning, and intimacy and autonomy within

relationships (Bowen, 1978). Self-differentiation identifies an individual's capacity to manage a stressor where lower self-differentiated individuals experience more distress given a particular life stressor as opposed to highly self-differentiated individuals who experience the same stressor (Friedman, 1991; Kerr & Bowen, 1988). Wei, et al. (2008) found a significant relationship between self-differentiation and attachment where emotional reactivity is related to attachment anxiety and emotional cut-off is related to attachment avoidance. Findings of the current study suggests that self-differentiation and attachment operate differently in relationship to difficulties experienced with complex trauma patients. This conclusion is contradictory to literature suggesting the interaction between attachment and self-differentiation. Attachment style and self-differentiation define an individual's propensity to merge and to individuate within an interpersonal relationship (Lopez, 2001; Skowron & Dendy, 2004; Wei, et al., 2008; Wei, Vogel, et al., 2005). Further exploration is needed to discuss how trauma therapist self-differentiation and attachment uniquely function in relationship to therapist reactions, especially given that in this study, self-differentiation is a strong predictor of difficulties. Work experience and training did not affect the relationship between self-differentiation and difficulties experienced with complex trauma/patients clients. It is possible that another type of moderator may influence this relationship (increased social support, etc.). For example, there may be differences in how certain types of support (professional support versus personal support, therapist self-care) influence trauma therapist experienced difficulties with complex trauma patients.

Hypothesis 3

Increased work experience and trauma training will moderate trauma therapist attachment and self-differentiation in relationship to trauma therapist coping, resulting

in increased positive coping reactions (constructive coping) and decreased negative coping (avoidant coping) when working with complex trauma patients for those trauma therapists who are more versus less anxiously or avoidantly attached, and those who have lower levels of self-differentiation. No moderating effects were found regarding constructive coping. Moderation effects were found regarding avoidant coping. Experience with clients/patients with single-incident trauma moderated the relationship between attachment anxiety and avoidant coping. More avoidant coping was reported by trauma therapists with higher attachment anxiety and more experience with single-incident trauma patients/clients. Experience with clients/patients with single-incident trauma also moderated the relationship between attachment avoidance and avoidant coping. More avoidant coping was reported by trauma therapists with higher attachment avoidance and more experience with single-incident trauma patients/clients. The lack of relationships between attachment, self-differentiation, moderators and constructing coping are examined.

The fact that only two moderation effects were found in regards to coping outcomes in relationship to work experience and training is surprising. Trippany, Kress, & Wilcoxen discuss three studies (Folette, Polusny, & Milbeck 1994; Chrestman, 1995; and Alpert & Paulson, 1990) that underscore the strong relationship between training and education and therapist coping with difficult trauma cases. These studies reported that training decreased PTSD symptoms in trauma therapists and that specific graduate-level trauma training was needed to reduce effects of vicarious trauma in those therapists with personal trauma histories. Though these studies specifically reviewed vicarious trauma, they only discussed trauma therapist negative coping. Trippany, et al. (2004) found support for the fact that experience and training affects trauma therapist reactions.

Findings of the current investigation were that only a specific type of experience (with patients/clients with single-incident trauma) was a viable moderator of attachment anxiety and attachment avoidance on therapist coping. This finding supports the need to separate types of work experience, training, and education into separate variables, and it provides support for different effects of working with certain types of traumatized populations. Future studies may also focus on the possibility that experienced, expert-level therapists may employ more self-care strategies which may serve as a protective factor against negative coping and experienced difficulties in a way that work experience and training are not moderating. Again, gaining more detailed information (via both qualitative and quantitative study) of these expert trauma therapists regarding their reactions would provide insight into protective and risk factors in working with complex trauma patients.

The direction of the relationship between attachment and avoidant coping by experience with single-incident trauma is notable. Trauma therapists who reported more avoidant coping who had higher attachment anxiety had more experience with individuals with single-incident trauma backgrounds suggesting that the greater amount of experience with single-incident trauma contributed to higher attachment avoidance of those who are anxiously attached. Similarly, trauma therapists who reported more avoidant coping with higher attachment avoidance also had more experience with single-incident trauma. Therefore, the greater amount of experience with single-incident trauma contributed to higher attachment avoidance of those who are avoidantly attached.

In the current study, experience with single-incident trauma is negatively affected trauma therapists who were more anxiously or avoidantly attached. These findings support much of the literature regarding therapy process and outcomes of

therapists who are insecurely attached (Beutler, et al., 2006; Black, et al., 2005; Bruck, et al., 2006; Marmaras, et al., 2003; Meyer & Pilkonis, 2001; Tyrell, et al., 1999). Anxiously attached therapists have difficulty forming therapeutic alliances (Meyer & Pilkonis, 2001), have problems during therapy (Black, et al., 2005), and more disruptions in their cognitive schemas (Marmaras, et al., 2003). Avoidantly attached therapists may deny emotional distress but experience more cognitive disruptions and symptoms of distress (Marmaras, et al., 2003).

The negative impact of experience with individuals with single-incident trauma offer some support for the vicarious trauma, secondary traumatic stress, and compassion fatigue literature which suggest that continued exposure to traumatized individuals puts therapists at risk for developing symptoms of distress, cognitive disruptions, and decreased ability to empathize with clients (Figley, 2002; Jenkins & Beard, 2002; McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995). However, it is important to underscore that overall training and experience in trauma and experience with individuals with repeated trauma histories did *not* moderate the relationship between attachment and avoidant coping, which is contradictory to the aforementioned literature regarding exposure to traumatized individuals. The current study highlights differences in the effects of working with individuals with different types of trauma exposure, making it important to further investigate this issue.

This study found no significant relationships or moderating effects between attachment anxiety, attachment avoidance, self-differentiation and constructive coping. Possibilities for this outcome were previously explored, but it is important to re-iterate that predictors for constructive coping and what may moderate constructive coping (especially with these experienced, expert-level trauma therapists) needs

further investigation. Only self-differentiation was found to be a predictor of avoidant coping, but there was no moderation effect where any work experience or training variable influenced this relationship. This finding is contrary to Murdock and Gore (2004) who propose that teaching positive coping skills to lower self-differentiated individuals improves positive coping strategies. The present investigation suggests that experience and training (or education) is not helping to lower self-differentiated trauma therapists' degree of avoidant coping strategies. Furthermore, though self-differentiation was found to be a predictor of avoidant coping, work experience and training variables were not found to moderate the relationship, a finding that supports the previous explanation that self-differentiation is operating uniquely from attachment, and other potential moderators (i.e. personal support, etc.) and must be further investigated to assist lower self-differentiated trauma therapists in their reactions to complex trauma patients. These trauma therapists need alternatives to help them cope with their reactions to complex trauma patients outside of additional work experience and training. For example, future studies could focus on increased self-care, personal support, decreased caseload of complex trauma patients, etc., to potentially help these therapists cope with the difficulties they are experiencing with this patient population.

General Observations

Some of the overall demographic information collected in the sample was unexpected. For example, 93% of the sample was white, so there was almost no racial/ethnic diversity in the sample. About 83% of the participants also described themselves at an intensive or expert-level in terms of overall trauma training and experience. The mean age was 49. So this study largely reflects white, middle-aged, expert-level trauma therapists. This is an important finding given that the traumatized

population is ethnically diverse and Black and Hispanic individuals are more likely to experience child maltreatment and witness domestic violence in comparison to Whites, and therefore has implications in trauma treatment and service utilization (Roberts et al., 2011). Most of the sample were psychologists working in private practice and over 65% classified themselves as working in an urban city. The demographics of the client population with whom these therapists are working are unknown and should be included in future research. Given that inner-city populations are minorities who are disadvantaged and have a high level of childhood and adult trauma exposure with a high lifetime occurrence rate of PTSD (Gillespie, et al., 2009), it is a rational extrapolation that most of these traumatized individuals who have little means may not be receiving private-practice clinical care, especially since minorities are less likely to seek treatment for posttraumatic stress in comparison to Whites (Roberts et al., 2011). This may contribute to perceived difficulties by therapists and so it is necessary to explore the importance of client demographics in relationship to trauma therapist reactions. For example, it is possible that self-differentiation and attachment activation may differ depending upon client cultural aspects, but this would need to be investigated in future research. There is a larger question here regarding a lack of culturally diverse, expert-level trauma therapists. It is important to understand why minority therapists are not represented in the sample, if there is a lack of cultural diversity among trauma therapists in general, and/or why ethnically diverse therapists from the U.S. are not members of a large international trauma society where they may potentially receive support, education, and training.

Over 62% of the sample was female which reflect the trend of more females in psychology professions (Norcross, Karpiak, & Santoro, 2005). Over 70% of the participants reported being married or partnered. This may or may not be a reflection

of attachment, and may provide some insight into personal level of support and whether partnered status influences trauma therapist reactions. Further research is needed to determine to what extent, if any, partner status may affect therapist work.

Most of the sample described the Ph.D. as their highest level of education attained (41.5%). When education was collapsed into rank-order, 64.2% of the participants held a doctoral-level degree (i.e., Ed.D., Psy.D., Ph.D., M.D., etc.). Over 44% were licensed psychologists and an additional 44% held (or also held) a traditionally master's level credential. About 68% identified as psychotherapists. So this particular sample of trauma therapists studied can largely be described as doctoral-level psychotherapists.

In terms of work experience, the average number of years since graduation from the participants' graduate program was 16.2 years. Looking at current work experience within the past 6 months, the average number of total patients seen was 79.4, though it is important to note that the maximum number of patients seen was reported to be 720. It is possible that psychiatrists working in a hospital setting reported a much larger number of patients seen due to the nature of their work thus affecting the average. The average number of complex trauma patients seen in the past six months per therapist was 34.9 (23.9 seen individually, 11.0 seen in group therapy). So the sample consists of experienced trauma therapists currently seeing a large number of complex trauma patients who make up approximately 44% of their caseload. It is extremely important to understand the experience level of the participants sampled because it reflects very little variability on the novice to experienced spectrum and appears to have affected outcomes regarding difficulties experienced and coping strategies utilized.

This study attempted to identify the type and amount of trauma training received by participants. Seventy-nine percent did not take a trauma course in their graduate program, and 61% reported not having completed an internship/externship experience focused on trauma. This may be expected given that the average number of years since completing their program was about 16 and specific trauma courses seem to only recently be offered in some graduate programs.

Current trauma training was at a much greater level. The average number of hours of trauma training in the last six months was 20.3 and the average number of hours spent reading about trauma was about 50. This is high given general requirements for continuing education hours for licensure and that these hours are specifically focused on trauma, however, these findings are consistent with the experience and expertise of the sample. This sample is currently well-trained and well-read in the understanding of and/or treatment of trauma. It is important to note that the sample pool was a large, international trauma association. Participants already self-selected by joining, paying for, and being an active member of a research and practice-based trauma association. This limits the generalizability of the findings to some extent and may have excluded therapists who work with complex trauma patients but who may not identify as 'trauma therapists' and who: do not recognize complex trauma, are not as experienced or trained in trauma, are not able to pay association fees, or do not have the time to devote to membership.

Participants were asked to describe their overall level of training and experience in trauma. Eighty-three percent reported intensive or expert-level overall training in the understanding of and/or treatment of trauma since completing their graduate degree. Again, this self-report reveals a highly trained, expert-level sample. About 76% reported a moderate or intensive level of overall experience with

individuals who have survived only a single-incident trauma. Though still experienced with this particular group of trauma patients, the participants are reporting less expertise. This may be due to a bigger caseload of complex, 'repeated trauma', patients or may be due to the participants' conceptualization of single-incident trauma and the difficulty in discerning patients with single versus repeated traumatic experiences. What *is* evident, however, is that participants did make a distinction between these traumatized populations and *did* report differences in their experience level between the two. Understanding these differences and how trauma therapists approach, treat, and react to these populations differently is an important future direction of research. Approximately 74% of the sample described their overall experience in working with individuals who have experienced repeated trauma at the intensive or expert-level. So overall, these trauma therapists, in the current sample, are doctoral-level practicing psychotherapists who are highly experienced, highly trained, expert-level therapists who work with complex trauma patients often, a highly selective group.

Limitations and Future Directions

There are several limitations to the present study. First, the sample was a highly experienced, expert-level group. There was little variability in experience level, training, and expertise. As a result, the findings reflected a more homogeneous sample and little comparisons could be drawn as a function of experience, training, or expertise which may help account for some lack of relationships between variables. In turn, this may have influenced the ability to test moderator effects such that when predictive and moderation effects were found the degree of variance accounted for was generally low. It is unknown how this sample approximates the population of trauma therapists in general, limiting its generalizability.

A large, international trauma association was used from which to recruit participants. This served as a type of self-selection since membership indicates a certain level of experience, expertise, and understanding of trauma work. In the future, drawing a sample of therapists from the more general therapist population (i.e., a general therapist association) may capture variability in experience, expertise, and understanding of trauma work. It may also provide a more culturally diverse group of therapists and reflect a greater range of therapist reactions in working with complex trauma patients. A positive research and clinical implication is that this study provides a picture of the experienced, expert-level trauma therapist population. This study captures who these therapists are, where and how they are working, what reactions they are having, and their process of relating, information that helps to learn how they cope. Future studies should focus on comparing this group of experienced, expert-level trauma therapists with less experienced trauma therapists or those who do not identify as "trauma therapists." By understanding experienced, expert-level trauma therapist reactions, less experienced therapists may be able to improve their clinical experience with complex trauma patients, a clinical implication of this study.

Another limitation of the study is the potential level of knowledge and awareness that participants may have had when completing the instruments, all of which were self-report. The possibility of same source bias should be considered a limitation. Although considered a reputable tool, the attachment measure used in this study was not normed for therapists. A different attachment instrument may be needed to gain more accurate information on therapist attachment. This study investigated professional psychotherapists who, by definition, have some level of knowledge and competency in psychology research and perhaps experience with the instruments themselves. The participants may have held personal biases surrounding

the questions and/or may have engaged in under-reporting their reactions and process of relating. This would certainly affect findings and limit conclusions. Another research implication of the study is a need for more precise and comprehensive instruments that reflect, more accurately, trauma therapist reactions (both difficulties experienced and coping employed). More specific instruments would offer a broader context of trauma therapist reactions, not only pathological reactions, or general coping, but a range of internal and external reactions. This would help to define trauma therapist reactions more specifically, aid in understanding what is influencing them, and how they can be managed more positively.

The inability to classify work experience and trauma training into a unified variable was also a limitation to this study. Because no meaningful groupings were found from the factor analyses, work experience and trauma training had to be identified as singular moderator variables. This hindered the ability to test a more comprehensive work experience and training moderator. This results in another research implication of this study, that it is problematic to combine education, experience, and training into a single predictor. This study contributes to research suggesting the importance of differentiating work experience, training, and education variables. This research implication stresses the need for more detailed data gathering regarding work experience, training, and education when conducting investigations of their effects.

A major clinical implication of the study is that experienced, expert-level therapists appear to be securely attached. Because little insecure attachment was found, it is less likely that the therapeutic relationship and process, and the treatment of the patients by therapists in this study is being compromised by attachment-related impairments (Briere & Scott, 2006). In terms of clinical implications and therapist-

patient match, it is also positive that these therapists are securely attached creating a complimentary attachment style to the insecure patient, helpful since attachment styles that are dissimilar tend to promote better therapeutic outcomes (Beutler, et al., 2006; Bruck, et al., 2006; Wallin, 2007). These trauma therapists are also more self-differentiated and are more than one standard deviation (.06) above the population originally studied by Skowron and Friedlander (1998) suggesting that this sample was more highly self-differentiated in general. Therefore, their capacity to handle stress is assumed to be greater. This is extremely important given the intensity of the therapeutic work and the complexity these trauma patients bring to therapy.

Despite the limitations of the present study, a major finding of this study is that the results do not support the literature with regard to the effect of clinician exposure to traumatized persons. The current study does not support that increased exposure to the traumatized population puts the therapist at risk for developing pathological reactions, vicarious trauma or compassion fatigue, or that prolonged exposure to this population will harm the therapist in some way, except in the case of working with individuals who have experienced single-incident trauma. However, even the findings in this study are mixed since experience with individuals with repeated trauma did not contribute to negative coping and decreased difficulties for anxiously attached therapists. This study supports some of the more targeted research on trauma therapists, especially experienced, expert-level trauma therapists, whereby increased exposure to this traumatized population seems to produce fewer difficulties and more positive coping. More specifically, this research supports that prolonged exposure to and expertise with the *complex trauma population* may be related to positive trauma therapist reactions. A research implication of this finding is to support additional investigation of these factors to understand the unique ways in

which experienced, expert-level therapists are managing their exposure to the complex trauma population and what may be serving as protective factors in their reactions to these patients. Looking at other personal characteristics (e.g. social support, their own trauma history, etc.) that may contribute to fewer difficulties and more constructive coping is another future research possibility. A clinical implication of this finding is that experienced, expert-level trauma therapists are experiencing positive reactions in their work with complex trauma patients, they are able to work primarily and extensively with this difficult population, and they are seeking out current trauma training/education on a regular basis. As a result, complex trauma patients seen by these trauma therapists are receiving care from trauma therapists who appear to be dedicated to their work and experiencing few negative reactions.

Conclusions

The purpose of this study was to examine how therapist attachment style, self-differentiation, work experience and trauma training, therapist difficulties and therapist coping are uniquely related in the therapeutic process with complex trauma patients. Expected relationships between some of these variables were found in some cases but not in others.

The make-up of the sample provided valuable insight and prompted further questioning about the population in general, and the variables tested. Participants were mostly white, middle-aged, doctoral-level psychotherapists (most of them psychologists) in private practice who are highly trained in trauma, very experienced working with complex trauma patients, and who self-describe as experts. The lack of racial/ethnic diversity amongst these expert trauma therapists encourages questions of accessibility to trauma education, training, experience, and membership to professional trauma associations for therapists from diverse backgrounds; as well as

other general influences white experts may have on the treatment and understanding of trauma. Little variability in terms of experience and expertise were reflected in the sample, leaving room for speculation as to how this may have affected findings. So it can be concluded that this study is more usefully generalized to the experienced, expert-level trauma therapist population.

Very few difficulties were reported by these participants. Considering the level of experience they report, it is possible that they are experiencing a low level of difficulty with complex trauma patients as a function of their experience level. From this sample, it is not possible to extrapolate findings to non-expert trauma therapists nor experienced and expert-level (or otherwise) non-trauma therapists. Another consideration is that the trauma therapists sampled view difficulties differently with regard to working with complex trauma patients so their difficulties were not represented in the instrument, or perhaps they identify difficulties in a unique way in comparison to other therapists working with a more general population. Other possibilities such as 'faking good,' and under-reporting should also be considered in interpreting the findings of this study and would be useful to consider for future research. A notable finding is that degree of self-differentiation appeared to have the greatest impact on difficulties. Attachment style was not a strong predictor of difficulties though some predictive relationship between attachment anxiety and difficulties was found. Given that attachment style and self-differentiation are closely related in the literature (Feudling, 1998; Wei, et al., 2008) and are constructs that help define the process of interpersonal relating, additional investigation is needed to understand how they are differentially influencing (or not influencing) difficulties. In this study, attachment appeared to be playing a conflicting role in relationship to trauma therapist reactions where attachment is not necessarily predictive, but is

influenced through moderation: attachment anxiety and difficulties experienced with complex trauma patients, and attachment (anxiety and avoidance) and avoidant coping employed. Attachment style may be activated for trauma therapists working with complex trauma patients, but not generally activated with other types of patients. Moreover, trauma therapist reactions do seem to differ depending upon type of trauma experienced by the patient.

This study yielded surprising results regarding trauma therapist coping. The therapists in this sample reported generally constructive coping and were not found to be employing avoidant coping strategies. However, no relationship was found between attachment, self-differentiation, and constructive coping. Surprisingly, not even secure attachment (low attachment anxiety and low attachment avoidance) nor high self-differentiation predicted more constructive coping. Again, further investigation is needed to determine if trauma therapists are defining coping differently, employing unique positive coping strategies dissimilar to other therapists, or under-reporting their coping reactions in some way. Self-differentiation appeared to be the only predictor of avoidant coping, but was not moderated by education or training. Further research is needed to understand how attachment style and degree of self-differentiation might differ as they affect trauma therapist reactions. More research is needed to understand how exposure to complex trauma patients and traumatic material may in fact not be as detrimental as originally assumed, and perhaps may influence experienced therapists by reducing difficulties, avoidant coping, and increasing constructive coping strategies.

Future research regarding the resilience of these experienced, expert-level therapists is important. These therapists are able to treat a large caseload of complex trauma patients while experiencing few difficulties and employing positive coping

strategies. It would be helpful to study the specific practices of self-care and personal characteristics that contribute to their resiliency. For the next generation of trauma therapists, such profiles could help educators screen for personal characteristics that contribute to better coping with trauma content. For professional associations, such profiles would help bolster ethical codes that require continuing education as well as ongoing self-care for therapists specializing in trauma work. This knowledge would allow therapist educators, trainers, and supervisors to build resiliency in their student and novice therapists.

Further investigation is needed to understand to what extent experience with complex trauma patients versus trauma training may be beneficial to the clinician and what may be effective in positively enhancing trauma therapist reactions in those who are poorly self-differentiated and/or insecurely attached. The findings of this study support an influence beyond professional development, such as personal development, in conjunction with or as an alternative to increased training or experience in order to effect positive change in therapist reactions.

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Appendix

Demographic Questionnaire

Please read and answer the following **22** questions carefully. If you choose "other" please specify your response in the line provided. If you choose "combination of the above" please write down the letters of the choices that apply to you (e.g. a, c, & f).

For the purposes of this questionnaire, please refer to the following definition of trauma:

Trauma: the unique individual experience associated with an event or enduring conditions in which 1) the individual's ability to integrate affective experience is overwhelmed, or 2) the individual experiences threat to life or bodily integrity (Pearlman & Saakvitne, 1995)

1. What is your gender?
    a. Male
    b. Female
    c. Transgender

2. What is your age? ____

3. How do you describe your race/ethnicity? Check all that apply

    a. American Indian or Alaska Native
    b. Asian
    c. Black or African American
    d. Native Hawaiian or Other Pacific Islander
    e. White
    f. Hispanic, Latino, or Spanish origin (may be of any race)
    g. Bi-racial or multi-racial (please check all that apply)
    h. Other (please describe)________________________

4. What is your partner status?
    a. Married
    b. Single
    c. Partnered
    d. Separated
    e. Widowed
    f. Divorced
    g. Would rather not say
    h. Other (please describe)__________________

5. How do you describe the town in which you work?
    a. Rural town
    b. Small suburban area
    c. Large suburban area
    d. Small urban city
    e. Large urban city

6. What is the highest level of education you have attained (or are in the progress of attaining)?
    a. Undergraduate degree
    b. Master's degree (in progress)
    c. Master's degree
    d. Psy.D. (in progress)
    e. Psy.D.
    f. Ed.D. (in progress)
    g. Ed.D.
    h. Ph.D. (in progress, pre-dissertation phase)
    i. Ph.D. (in progress, All But Dissertation)
    j. Ph.D.
    k. M.D. (in progress)
    l. M.D.
    m. M.D./Ph.D.
    n. Other (please describe)__________________

7. What year did you graduate from your graduate program (highest level attained)? *If you have not graduated from a graduate program write "in progress."

    ____

8. How would you describe your current credential(s)? Check all that apply
    a. Licensed professional counselor
    b. Licensed rehabilitation counselor
    c. Licensed clinical social worker
    d. Licensed marriage and family therapist
    e. Minister/ Pastoral counselor
    f. Licensed psychologist
    g. Psychologist working toward licensure
    h. Medical doctor, licensed psychiatrist
    i. Two or more of the above (please indicate letters here):______________
    j. Post-graduate degree, working towards licensure in my field
    k. Student
    l. Other (please describe)____________________

9. How would you describe your PRIMARY work setting?
    a. Community mental health agency
    b. University
    c. Community college
    d. Private practice
    e. Outpatient psychiatric facility
    f. Inpatient psychiatric facility
    g. Hospital
    h. Church
    i. Not applicable. I am a student

   j. Other (please specify) ______________________________

10. How would you describe your PRIMARY role at work? Check all that apply
    a. Psychotherapist
    b. Clinical supervisor
    c. Staff supervisor (including executive director, director of clinic, etc.)
    d. Faculty member
    e. Consultant
    f. Medical doctor
    g. Minister or priest
    h. Researcher
    i. Student
    j. Other (please specify)______________________________

11. How would you describe your SECONDARY work setting(s)?
    a. Community mental health agency
    b. University
    c. Community college
    d. Private practice
    e. Outpatient psychiatric facility
    f. Inpatient psychiatric facility
    g. Hospital
    h. Church
    i. Not applicable, I am a student
    k. Other (please specify)_______________________________
    l. No other work setting

12. How would you describe your role(s) in your SECONDARY work setting? Check all that apply
    a. Psychotherapist
    b. Clinical supervisor
    c. Staff supervisor (including executive director, director of clinic, etc.)
    d. Faculty member
    e. Consultant
    f. Medical doctor
    g. Minister or priest
    h. Researcher
    i. Student
    j. Other (please specify)______________________________
    k. No other work setting/role

13. What is the estimated ***number** of clients/patients you have seen in the past 6 months?___________

    *estimated number of clients/patients, NOT number of sessions or hours

14. What age-group of clients/patients do you primarily work with? Check all that apply
    a. Children (1-12)
    b. Adolescents (13-17)

c. Young Adults (18-25)
d. Adults (26-64)
e. Older Adults (65 +)

15. (i.) While in your graduate program, did you take a course regarding the understanding of and/or treatment of trauma, with the word "trauma" in the course title?
    a. Yes
    b. No

    (ii.) If you answered "yes" to the above question, how many credits was this course (or combined credits if you took more than one trauma course)?

    ______ credits

16. (i.) In your graduate program, did you complete (or are you completing) an internship/externship experience specifically focusing on a traumatized population? (posttraumatic disorders clinic or posttraumatic disorders inpatient unit, domestic violence agency, rape crisis center, etc.)
    a. Yes
    b. No

    (ii.)If you answered yes to the above question, how many months and estimated hours per week was this internship/externship experience?

    ______months at__________hours per week

17. How many hours of training in the understanding of and/or treatment of trauma have you had in the last six months? (e.g. seminars, continuing education, professional classes) Do NOT include courses counting towards your graduate degree.

    ___________ estimated hours of trauma training in the last 6 months

18. How many hours of reading have you done on the understanding of and/or treatment of trauma in the last 6 months?

    ___________ estimated hours of reading in trauma in the last 6 months

19. How would you describe your overall training in the understanding of and/or treatment of trauma **since** you completed your graduate degree?
    a. **Limited**: A few continuing education hours
    b. **Moderate**: More than a few continuing education hours. One seminars/training a year. Moderate reading on trauma (e.g. 2 articles and 1-3 books)
    c. **Intensive**: Two seminars/trainings a year. Some specialized training. Heavy reading on trauma (e.g. several articles, and 4 books).
    d. **Expert**: Continuous seminars, training, and or other opportunities. Seminar leader/teacher in the area. Specialty is in trauma work. Heavy

reading in trauma and related research areas (e.g. several articles, 5 books, published).
   e. I am currently obtaining my graduate degree.

20. How would you describe your overall experience with individuals who have survived ONLY a single-incident trauma? (e.g. car accident, natural disaster, single incident rape) Do NOT include individuals who have survived repeated traumatic experiences.
    a. **Limited**: One case or less, per month
    b. **Moderate**: 2-3 cases or more per month, but I work with other cases as well
    c. **Intensive**: 4 or more cases per month. I work with these cases most of the time
    d. **Expert**: More than 4 cases per month. This is my specialty. I am known in the community to work with this population.

21. How would you describe your overall experience with individuals who have experienced repeated traumatic experiences over the lifespan? (e.g. multiple incidences of child abuse, rape, domestic violence, attachment trauma within interpersonal relationships and other traumatic experiences)
    a. **Limited**: One case or less, per month
    b. **Moderate**: 2-3 cases or more per month, but I work with other cases as well
    c. **Intensive**: 4 or more cases per month. I work with these cases most of the time
    d. **Expert**: More than 4 cases per month. This is my specialty. I am known in the community to work with this population.

22. In the last 6 months, how many individuals have been on your caseload who you would describe as having *complex trauma* defined as: a) having been victims of repeated traumatic experiences over the lifespan, AND b) who can be described as having **at least 5 out of 7** of the following:

    - alterations in the regulation of affective impulses
    - alterations in attention and consciousness
    - alterations in self perception
    - alterations in perception of the perpetrator
    - alterations in relationship to others
    - somatization and/or medical problems
    - alterations in systems of meanings

    _____Total estimated number of clients/patients with complex trauma seen individually, in the last 6 months.
    _____Total estimated number of clients/patients with complex trauma seen in group therapy, in the last 6 months.