



Trauma assessment in outpatient psychotherapy and associations with psychotherapist's gender, own traumatic events, length of work experience, and theoretical orientation

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ABSTRACT

Background: Traumatic events are strongly associated with mental health problems. At present, traumatic events and trauma-specific needs are commonly underdetected in therapeutic settings. Many mental health professionals lack key competencies for trauma inquiry and treatment.

Objective: In this study, we aimed to investigate the everyday practices of dealing with traumatic events in outpatient psychotherapy in Germany as well as the influence of the therapist's gender, own traumatic events, length of professional experience, and theoretical orientation.

Method: A total of 148 outpatient psychotherapists completed a purpose-designed online questionnaire. Therapists rated barriers and attitudes towards trauma assessment, possible requirements for enquiring about trauma, and practical aspects of trauma assessment.

Results: Barriers reported in previous studies, e.g. fear of offending the patient or exacerbating their psychological state, could not be confirmed in our sample. Overall, participating therapists felt confident in engaging with traumatic events and considered enquiring about trauma important in all patients. Group differences were found for therapist's gender, own traumatic events, length of work experience, and theoretical orientation.

Conclusions: Our results suggest that trauma training lowers barriers and raises therapists' self-confidence in dealing with patients' traumatic experiences. Therapists' characteristics effecting trauma assessment should be considered during training. Due to the increasing demand for psychotherapy, especially considering people with severe mental illness affected by traumatic events, trauma training should be obligatory for all mental health professionals.

Evaluación del trauma en la psicoterapia ambulatoria y las asociaciones con el género del psicoterapeuta, sus propios eventos traumáticos, el tiempo de su experiencia laboral y su orientación teórica

Antecedentes: Los eventos traumáticos están fuertemente asociados a problemas de salud mental. En la actualidad, los eventos traumáticos y las necesidades específicas asociadas al trauma no suelen ser detectadas en entornos terapéuticos. Muchos profesionales de salud mental carecen de las competencias para indagar sobre el trauma y tratarlo.

Objetivo: En este estudio, el objetivo fue el investigar las prácticas cotidianas del abordaje de los eventos traumáticos en la psicoterapia ambulatoria de Alemania, así como investigar la influencia que el género del terapeuta, sus propios eventos traumáticos, el tiempo de su experiencia laboral y su orientación teórica tiene sobre esto.

Métodos: Ciento cuarenta y ocho (148) psicoterapeutas de atención ambulatoria completaron un cuestionario en línea diseñado para el propósito del estudio. Los psicoterapeutas calificaron las barreras y actitudes respecto a la evaluación del trauma, los posibles requisitos para preguntar sobre el trauma y los aspectos prácticos de la evaluación del trauma.

Resultados: No se pudieron confirmar las barreras reportadas en estudios previos como, por ejemplo, el temor a ofender al paciente o el empeorar su estado psicológico. En general, los psicoterapeutas participantes sentían confianza al momento de abordar los eventos traumáticos y consideraron que el preguntar sobre el trauma era importante en todos los pacientes. Se encontraron diferencias según el género del psicoterapeuta, sus propios eventos traumáticos, el tiempo de su experiencia laboral y su orientación teórica.

Conclusiones: Nuestros resultados sugieren que el entrenamiento en trauma disminuye las barreras e incrementa la confianza de los psicoterapeutas consigo mismos para abordar las experiencias traumáticas de los pacientes. Las características de los psicoterapeutas que

ARTICLE HISTORY

Received 20 September 2021

Revised 1 December 2021

Accepted 4 January 2022

KEYWORDS

Outpatient psychotherapy; traumatic events; mental disorders; trauma assessment; therapist characteristics

PALABRAS CLAVE

Psicoterapia ambulatoria; eventos traumáticos; trastornos mentales; evaluación del trauma; características del terapeuta

关键词

门诊心理治疗; 创伤事件; 精神障碍; 创伤评估; 治疗师特征

HIGHLIGHTS

- Barriers reported in previous studies were not confirmed in our sample of therapists with a high rate of specific trauma training.
- Group differences were found for therapist's gender, own traumatic events, length of work experience, and theoretical orientation.

afectan la evaluación del trauma deben ser consideradas durante el entrenamiento. Debido a que existe un incremento en la demanda de psicoterapia, considerando especialmente a las personas con enfermedad mental severa afectadas por eventos traumáticos, el entrenamiento en trauma debería ser obligatorio para todos los profesionales de salud mental.

门诊心理治疗中的创伤评估及其与心理治疗师性别, 自身创伤事件, 工作经验时长和理论取向的关联

背景: 创伤事件与心理健康问题密切相关。目前, 在治疗环境中, 创伤事件和创伤特定需求普遍检测不足。许多心理健康专业人员缺乏创伤调查和治疗的关键能力。

目的: 在本研究中, 我们旨在考查德国门诊心理治疗中处理创伤事件的日常实践, 以及治疗师性别, 自身创伤事件, 专业经验时长和理论取向的影响。

方法: 148 名门诊心理治疗师完成了专门设计的在线问卷。治疗师对创伤评估的障碍和态度, 可能询问创伤的要求以及创伤评估实操方面进行评级。

结果: 先前研究中报告的障碍, 例如害怕冒犯患者或加剧其心理状态, 无法在我们的样本中得到证实。总体而言, 参与的治疗师对处理创伤事件充满信心, 并考虑对所有患者询问重要创伤。在治疗师性别, 自身创伤事件, 工作经验时长和理论取向方面发现了群体差异。

结论: 我们的结果表明, 创伤训练降低了障碍并提高了治疗师在处理患者创伤经历时的自信。在培训期间应考虑影响创伤评估的治疗师特征。由于对心理治疗的需求不断增加, 特别是考虑到受创伤事件影响的严重精神障碍患者, 所有心理健康专业人员都应接受创伤培训。

1. Introduction

More than 70% of people worldwide experience a traumatic event in their lifetime (Benjet et al., 2016). Traumatic events are risk factors for most mental illnesses including depression, psychosis, anxiety disorders, sleep disorders, eating disorders, sexual dysfunction, personality disorders, dissociative disorder, posttraumatic stress disorder (PTSD), somatoform disorders, and substance misuse (Bachmann, Czwikla, Jacobs, Fegert, & Hoffmann, 2021; Kessler et al., 2010; Longden & Read, 2016; Read, Sampson, & Critchley, 2016; Yeh et al., 2021). Moreover, studies showed a strong link between multiple exposure to childhood abuse and chronic illness, mental health problems, and health-risk behaviours in adulthood (Kuhar & Zager Kocjan, 2021). Nearly 50% of severely mentally ill (SMI) patients have been exposed to repeated violence and 30% is suffering from PTSD (Mauritz et al., 2016). Experiences of childhood sexual and physical abuse and neglect are associated with developmental disruptions in emotional regulation and deficits in relationship formation, which significantly increase the risk of developing a mental disorder (Cloitre et al., 2009; Hepworth & McGowan, 2013). The more severe the traumatic experience, the higher the risk of developing a mental disorder in adulthood (Cavanagh, Read, & New, 2004). In addition, traumatic experiences in childhood are often associated with deficits in psychosocial functioning (Bachmann et al., 2021).

At present, traumatic events and trauma-specific needs seem to remain commonly undetected in clients of health care services (Gfesser, Rechenberg, Glaesmer, & Schomerus, 2021; Hepworth & McGowan, 2013; Read, Harper, Tucker, & Kennedy, 2018). However, the consideration and integration of traumatic events in treatment is crucial for the creation of the individual disorder

model, therapy planning, and ultimately treatment success (Becker-Blease & Freyd, 2007; Young, Read, Barker-Collo, & Harrison, 2001). Study results show that the majority of people who use mental health services are never asked about traumatic experiences, and only 28% of abuse or neglect cases identified by researchers were documented in the respective client files, with particularly low rates for neglect (Read et al., 2018). Further results of the same study indicate that men and people diagnosed with psychotic disorders are less likely to be asked about trauma than other people are. Most clients with a history of trauma do not receive trauma-informed care or evidence-based trauma-specific treatments (Rosner, Henkel, Ginkel, & Mestel, 2010). However, Cromer, Freyd, Binder, DePrince, & Becker-Blease, 2006) found that questions about traumatic events are perceived as more important and cause less stress than other personal questions. Similarly, Cunningham et al. (2017) showed that patients perceive answering questions about trauma as no more or less distressing than answering any other question. The majority of patients with traumatic events (69%) associate their traumatic experience with their mental illness, yet only 17% perceive that this association is also seen by mental health professionals (Lothian & Read, 2002). Likewise, study results show that affected persons are strongly disinclined to spontaneously report traumatic experiences, especially when these are associated with important personal relationships (Read, McGregor, Coggan, & Thomas, 2006; Toner, Daiches, & Larkin, 2013).

Clinicians are reluctant to ask about traumatic experiences for a variety of reasons e.g. fear of re-traumatizing patients through exploration or of endangering the therapeutic relationship (Lotzin et al., 2019; Rose et al., 2011; Sugg, 1992; Young et al., 2001). Moreover, many mental health professionals lack key competencies for enquiring

about traumatic events (Lothian & Read, 2002; Salyers, Evans, Bond, & Meyer, 2004). Therapists often report feeling inadequately experienced to explore traumatic events and respond appropriately to reporting (Kazlauskas et al., 2016; Lotzin et al., 2019). In general, research indicates that a lack of trauma assessment can lead to inadequate and ineffective treatment as well as misdiagnosis, causing individuals to suffer unnecessarily long periods of symptomatic mental illness and reduced quality of life, which in turn increases healthcare costs (Hepworth & McGowan, 2013; Little & Hamby, 1996).

The aim of this study therefore was to investigate how outpatient psychotherapists engage with and perceive patient's traumatic experiences. Further aims were to explore whether therapeutic engagement with traumatic events differs between demographic characteristics (gender, own traumatic events) and professional characteristics (length of work experience, theoretical orientation).

2. Method

2.1. Participants

A purpose-designed online questionnaire was sent to all medical and psychological psychotherapists in Saxony, Germany (according to Kassenärztliche Vereinigung Sachsen (KVS) data, as of 21.10.2020). In Germany, medical psychotherapists are physicians with additional qualification in psychotherapy, while psychological psychotherapists are psychologists with additional qualification in psychotherapy. 1 050 persons were contacted (105 medical psychotherapists (10%) and 945 psychological psychotherapists (90%)). Recruitment was carried out via email. If the email address was not available, the invitation was sent by postal mail. All 1 050 individuals were contacted twice (first invitation December 2020, reminder January 2021). Of the 1 050 individuals contacted, 148 (14.1%) completed the questionnaire. Demographic characteristics are displayed in Table 1.

Compared to KVS data, the sample is representative in terms of age, gender, professional group, and theoretical orientation. However, no comparative data are available with regard to previous trauma training.

2.2. Measures

The online questionnaire included the following sections: professional competence, therapeutic relationship, patient characteristics, structural conditions necessary for exploring trauma, therapeutic handling of traumatic events, barriers in trauma assessment, therapist's attitude towards trauma assessment, and professional practice. Respondents specified their

Table 1. Demographic characteristics.

Characteristic		<i>n</i>	%
Age	25–34 years	2	1.4
	35–44 years	50	33.8
	45–54 years	56	37.8
	55–64 years	35	23.6
	>65 years	5	3.4
Gender	Male	29	19.6
	Female	118	79.7
	Diverse	1	0.7
Migration background	Yes	14	9.5
	No	134	90.5
Professional group	Psychological psychotherapist	126	85.1
	Medical psychotherapist	22	14.9
Theoretical orientation	Cognitive behavioural therapy	105	70.9
	Psychodynamic therapy	43	29.1
Length of work experience	<1 year	2	1.4
	<2 years	3	2.0
	<5 years	20	13.5
	<10 years	41	27.7
	≥10 years	82	55.4
Previous trauma training ¹	Yes	83	56.1
	No	52	35.1
	In training	13	8.8
Own traumatic events	Yes	55	37.2
	No	84	56.8
	Don't know	9	6.1

¹Curriculum Deutschsprachige Gesellschaft für Psychotraumatologie (DeGPT), Eye Movement Desensitization and Reprocessing (EMDR), Imagery Rescripting and Reprocessing Therapy (IRRT), Narrative Exposure Therapy (NET), Prolonged Exposure (PE).

level of agreement, relevance or frequency on 4- or 5-point Likert scales. Single characteristics are displayed in Table 2. (For overall characteristics, please see Appendix, supplementary files).

Procedure. The online questionnaire was created using EFS-Survey (EFS Release 21.1, Unipark, 2021, QuestBack GmbH, <https://ww2.unipark.de>). The average completion time was 24 minutes. The procedure of the study was fully explained at the beginning of the questionnaire, after which patients were asked to participate and provide informed consent. The Institutional Medical Ethics Committee (Medical Faculty, Leipzig University, Germany) approved this study (ID: 484/20-ek).

Statistical Analyses. Analyses were conducted using SPSS version 26.0 (IBM SPSS, USA). Chi-squared tests were used to compare baseline demographic and clinical characteristics. As data significantly departed from the normal distribution curve and scale levels were ordinal, Mann-Whitney-U-tests were conducted for further analysis. For data processing, the characteristics gender ('Male', 'Female'), own traumatic events ('Yes', 'No'), length of professional experience ('<10 years', '≥10 years'), and theoretical orientation ('Cognitive behavioral therapy', 'Psychodynamic therapy') were dichotomized. Due to the small number of participants, the response options 'diverse' for gender ($n = 1$) and 'don't know' for own traumatic experience ($n = 9$) were not considered for analyses. All variables were tested for group differences in gender, own traumatic events, length of professional experience, and theoretical orientation using Mann-Whitney-U-tests (see Table 2).

Table 2. Trauma assessment by gender, own traumatic events, length of work experience, and theoretical orientation.

	Gender		Own traumatic events		Length of work experience		Theoretical orientation	
	Male n = 29	Female n = 118	No n = 84	Yes n = 55	<10 years n = 66	≥10 years n = 82	BT ¹ n = 105	PT ² n = 43
	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)
Requirements for trauma assessment ^A								
Therapist has similar traumatic experiences.	1.52 (0.69)	1.19 (0.44)	1.18 (0.44)	1.44 (0.63)				
Patient has sufficient social support from family, friends, etc.	2.97 (1.09)	3.46 (0.89)						
Patient is credibly distanced from suicidality.			4.27 (0.84)	3.76 (1.07)				
Mutual sympathy					3.02 (1.21)	3.45 (1.12)	4.70 (0.54)	4.88 (0.32)
Similar age					1.52 (0.66)	1.29 (0.58)	2.30 (1.10)	2.84 (1.19)
Patient feels taken seriously					4.65 (0.60)	4.84 (0.37)	3.09 (1.29)	1.53 (1.22)
Patient feels safe							3.90 (0.96)	4.40 (0.58)
Length of work experience					4.64 (0.67)	4.80 (0.64)	3.75 (1.08)	4.12 (1.01)
Trauma-specific training							3.30 (0.99)	2.79 (1.21)
Confidence in trauma assessment							3.53 (1.02)	2.77 (1.27)
Therapist remains the same throughout the treatment period								
Possibility of high-frequency therapy sessions								
Possibility to conduct double sessions								
Barriers in trauma assessment ^B								
I feel uncomfortable asking patients about traumatic experiences.	1.81 (0.86)		1.81 (0.86)	1.45 (0.79)				
I am unsure if I need to inform the police or other authorities if patients specifically name the perpetrators.	1.60 (0.84)		1.60 (0.84)	1.33 (0.70)				

(Continued)

Table 2. (Continued).

	Gender		Own traumatic events		Length of work experience		Theoretical orientation	
	Male n = 29	Female n = 118	No n = 84	Yes n = 55	<10 years n = 66	≥10 years n = 82	BT ¹ n = 105	PT ² n = 43
	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)
I am unsure whether the patients' reported experiences are true.					1.73 (0.65)	1.51 (0.61)		
I don't have enough time to ask about traumatic experiences.					1.36 (0.67)	1.20 (0.71)		
I have the feeling that I am not professionally competent enough to deal with traumatic events with patients.					2.12 (1.10)	1.70 (0.90)		
Therapists' attitudes towards trauma assessment ^B								
Trauma assessment should be standardized.					2.85 (1.21)	2.40 (1.02)	2.76 (1.07)	2.21 (1.17)
Trauma assessment should take place at the beginning of therapy.							3.00 (1.14)	2.51 (1.06)
Severe trauma should be treated exclusively by trauma therapists.	2.97 (1.21)	3.61 (1.18)						
A good therapeutic relationship and work experience are sufficient for the treatment of severe trauma.			2.60 (1.73)	2.15 (0.99)				
Addressing traumatic events ^C								
How often do patients report traumatic events of their own accord without you asking?	3.07 (0.75)	3.51 (0.65)						
How often do you enquire about traumatic events when patients hint at such experiences?								
Exploration practice ^D								
I enquire about traumatic events in all patients, regardless of their symptoms					2.88 (0.97)	3.34 (0.76)	4.86 (0.38)	4.65 (0.61)

Scale Markings: A: 1 (not relevant) to 5 (extremely relevant); B: 1 (disagree) to 5 (fully agree); C: 1 (almost never) to 5 (almost always); D: 1 (disagree) to 4 (fully agree); ¹ = Cognitive behavioural therapy, ² = Psychodynamic therapy.

3. Results

3.1. Descriptive analyses

3.1.1. Requirements for trauma assessment

Therapists were asked to rate different requirements for trauma assessment on a 5-point Likert scale ranging from 1 (not relevant) to 5 (extremely relevant). Mean scores for the section professional competence were lowest for 'length of work experience' ($M = 2.46$, $SD = 1.51$) and highest for 'confidence in trauma exploration' ($M = 4.05$, $SD = 0.89$). Characteristics of therapeutic fit (e.g. same gender, similar age) were in general rated as relatively irrelevant ($M = 1.39$ to 1.68 , $SD = 0.61$ to 1.80), except for 'mutual sympathy', which was rated as more relevant ($M = 3.26$, $SD = 1.80$). When asked about the relevance of the therapeutic relationship, five out of seven items revealed high relevance ratings (e.g. 'therapist behaves empathically', $M = 4.68$, $SD = 0.51$). Patient characteristics received low relevance ratings (e.g. 'ability to recognize traumatic events as such', $M = 1.27$, $SD = 0.51$), except for 'credible distancing from suicidality' ($M = 4.04$, $SD = 0.99$). Ratings of structural conditions (e.g. 'possibility of high-frequency therapy sessions') revealed moderate relevance ratings ($M = 3.01$ to 3.68) but with highest standard deviations for single characteristics ($SD = 1.08$ to 1.15) compared to any other survey section.

3.1.2. Barriers in trauma assessment

This section was assessed using a 5-point Likert scale from 1 (disagree) to 5 (fully agree). Overall, therapists perceive barriers to be low, e.g. 'I am afraid that patients will stop attending therapy if I ask about traumatic experiences' ($M = 1.19$, $SD = 0.51$), 'I have the feeling that I am not professionally competent enough to deal with traumatic events with patients.' ($M = 1.89$, $SD = 1.01$). The overall agreement to barriers in trauma assessment was low ($M = 1.45$, $SD = .67$).

3.1.3. Therapists' attitudes towards trauma assessment

Again, respondents specified their level of agreement or disagreement on a 5-point Likert scale from 1 (disagree) to 5 (fully agree). Therapists' agreement varied between section characteristics, from disagreement for 'any traumatic experience should only be treated by trauma therapists' ($M = 2.15$, $SD = .10$), to agreement for 'dealing openly with traumatic events in therapy helps patients cope better with their everyday lives' ($M = 4.03$, $SD = .79$).

3.1.4. Addressing traumatic events

Therapists rated the frequency of addressing traumatic experiences on a 5-point Likert scale from 1 (never) to 5 (always). When asked about how often patients

report traumatic events of their own accord without the therapist asking, therapists answered with 'often' ($M = 3.43$, $SD = 0.70$). The reported frequency of enquiring about traumatic events when patients allude to such experiences was 'almost always' ($M = 4.80$, $SD = 0.47$). When asking patients about traumatic events, therapists used various standardized assessment methods such as the Impact of Event Scale – Revised (IES-R), the Dissociative Experience Scale (DES), the Childhood Trauma Questionnaire (CTQ), the Posttraumatic Diagnostic Scale (PDS), the Structured Clinical Interview for DSM-IV. When asked about confidence in enquiring traumatic events and responding appropriately to patients' reports, therapists answered with 'I feel mostly safe' ($M = 4.36$, $SD = 0.78$, respectively $M = 4.36$, $SD = 0.69$).

For overall results, please see Appendix, supplementary files.

3.3 Exploratory analyses

Exploratory analyses were conducted to investigate whether response behaviour differed in association with therapists' characteristics such as gender, own traumatic experience, length of work experience, and theoretical orientation. Results for requirements for trauma assessment revealed that male therapists and therapists with own traumatic events rated the characteristic "Therapist has similar traumatic experience", as more relevant than female therapists ($U = 1288.0$, $Z = -2.837$, $p = .005$) and therapists without own traumatic experience ($U = 1821.5$, $Z = -2.839$, $p = .005$). Therapists without own traumatic events rated the characteristic 'Patient is credibly distancing him-/herself from suicidality' as more relevant than therapists with own traumatic events ($U = 1696.0$, $Z = -2.806$, $p = .005$). More experienced therapists (≥ 10 years of work experience) rated the characteristics 'Mutual sympathy' higher ($U = 2146.0$, $Z = -2.233$, $p = .026$) and 'Similar age' lower ($U = 2176.0$, $Z = -2.492$, $p = .013$) compared to less experienced therapists (< 10 years of work experience). Psychodynamic therapists considered the 'length of work experience' ($U = 1651.5$, $Z = -2.642$, $p = .008$) and 'self confidence in trauma assessment' ($U = 1615.5$, $Z = -3.014$, $p = .003$) more important than cognitive behavioural therapists.

Considering barriers in trauma assessment, therapists without own traumatic events reported feeling more uncomfortable asking patients about traumatic events compared to therapists with own traumatic events ($U = 1685.5$, $Z = -2.954$, $p = .003$). Compared to their more experienced

colleagues, therapists with <10 years of work experience agreed more with the statements 'I don't have enough time to ask about traumatic experiences' ($U = 2226.5$, $Z = -2.677$, $p = .007$) and 'I have the feeling that I am not professionally competent enough to deal with traumatic events of patients' ($U = 2120.5$, $Z = -2.418$, $p = .016$).

When asked about therapists' attitudes towards trauma assessment, cognitive behavioural therapists agreed more that standardized trauma assessment should take place at the beginning of therapy than psychodynamic therapists ($U = 1683.0$, $Z = -2.530$, $p = .011$). Female therapists agreed more with the statement 'Severe trauma should be treated exclusively by trauma therapists' than male therapists ($U = 1191.0$, $Z = -2.623$, $p = .009$).

When it comes to addressing traumatic events, female therapists reported greater frequency in patients reporting traumatic events of their own accord than male therapists ($U = 1208.0$, $Z = -2.713$, $p = .007$), and cognitive behavioural therapists reported enquiring about traumatic events more often when patients hint at such experiences than psychodynamic therapists ($U = 1913.5$, $Z = -2.199$, $p = .028$).

Considering exploration practice, therapists with ≥ 10 years of work experience reported inquiring more often about traumatic events in all patients, regardless of their symptoms, than therapists with <10 years of work experience ($U = 1986.0$, $Z = -2.973$, $p = .003$).

Overall results for trauma assessment by gender, own traumatic events, length of work experience, and theoretical orientation are displayed in Table 2. Note that only statistically significant results ($p < .05$) are reported.

4. Discussion

This study investigated the everyday practice of engaging with traumatic events in outpatient psychotherapy in Germany. Most therapists in our sample consider trauma assessment for all patients as important, regardless of their symptoms. Our results show that 'confidence in trauma exploration' is rated highest in importance in the section 'requirements for trauma exploration' and that therapists with trauma training feel more confident than therapists without trauma training. Therapists in our sample disagree with the statement 'I have the feeling that I am not professionally competent enough to deal with traumatic events with patients.' Overall, dealing openly with traumatic events is perceived as relevant. Therefore, the results of our study do not confirm the barriers in trauma assessment found in previous studies (Lotzin et al., 2019; Rose et al., 2011). In contrast to previous findings, therapists in our study

rated barriers to be low. Our results even show that the surveyed therapists perceive themselves as confident in trauma assessment and in responding to patients' reports of traumatic experiences. Our findings may contrast past literature due to differences in country-specific occupational titles, as studies from different countries and authors refer to different study populations. For example, previous studies that investigated barriers in trauma assessment surveyed social workers, nurses, and SUD counselling services, while we exclusively surveyed psychotherapists who may have higher trauma competencies than other professional groups. When comparing our findings to other study results, one also needs to consider the high proportion of therapists with previous trauma training in our sample. This may have an effect on lowering barriers as therapists in our study rated barriers to be low. Almost two thirds of the participants in our study (64.9%) reported that they had received trauma training or still participate in trauma training, which may raise awareness for traumatic events. We argue that the results of the study seem to contradict the overall clinical impression that traumatic events are too rarely explored in practice. There are several potential explanations for this. There may be different understandings of what therapists and patients mean by 'exploring traumatic events'. 'Exploring' can be understood as enquiring once about traumatic events but not considering potential traumata again within the course of the treatment. Alternatively, 'exploring' could also mean asking about the patient's trauma history in a detailed and sensitive manner throughout the treatment process. Another explanation for this discrepancy may be that many people affected by a mental illness, especially those with severe mental illness who are more likely to have experienced traumatic events, do not have access to psychotherapeutic treatment. For example, while the frequency of PTSD diagnosis by professionals has more than doubled over the past 10 years, it remains below the prevalence found in epidemiologic studies, suggesting potential for improving diagnostic competencies (Bachmann et al., 2021) and indicating that many affected people do not receive treatment. According to our findings, those who receive psychotherapeutic treatment appear to be treated well. Moreover our results show that therapists' characteristics like gender, own traumatic events, length of work experience, and theoretical orientation affect trauma assessment. To raise therapists' awareness for such effects, this should be considered in psychotherapeutic training but also in somatic medical care (Gfesser et al., 2021). To emphasize one such aspect, therapists with own traumatic experiences feel more comfortable enquiring about trauma and are less concerned about suicidality than non-affected therapists. According to

our results, being self-affected by trauma can facilitate trauma assessment in patients. For therapeutic practice, one should be aware that in some patients, suicidality could only become less once the trauma has been dealt with. It is necessary to evaluate individually whether a possible destabilization through addressing traumatic events could be more helpful than a purely symptomatic treatment. Our results confirm findings regarding differences in therapeutic practice between therapists with and without own traumatic events (Little & Hamby, 1996). Furthermore, the results of our study sample contrast those of (Pruitt & Kappius, 1992), who found that younger therapists with less work experience enquire about events of sexual abuse more frequently than older therapists with more work experience. Our results show that therapists with ≥ 10 years of work experience ask about traumatic events regardless of symptoms more often than therapists with < 10 years of work experience. Accordingly, therapists with < 10 years of work experience agreed more with the statements ‘I don’t have enough time to ask about traumatic experiences’. This result might be explained by a lower treatment and administrative routine in therapists with < 10 years of work experience and a higher stress perception, insufficient trauma competencies and resulting insecurity, but also by the increasing economization of the health-care sector. This might lead to less experienced therapists not asking about traumatic events. To respond to the high number of people affected by traumatic events, often associated with mental illness, every patient should be asked for traumatic experiences, no matter the initial therapy concern. Therefore, strengthening trauma competencies should be a part of the basic psychotherapeutic training, independent of therapists’ theoretical orientation.

4.1 Limitations of the study

Several limitations should be acknowledged. First, due to voluntary participation, only those therapists responded who were interested in the topic. This may be reflected in the fact that 56.1% of the sample had completed trauma training and another 8.8% were currently in trauma training. Because of continuing education and specialization, there may be a higher level of competency in dealing with trauma in our sample compared to all outpatient psychotherapists. Due to the high number of therapists with trauma training, it seems plausible that psychotherapists with a special interest in the topic and higher trauma competencies participated in our study. Second, self-reporting is an indirect measure of actual clinical practice and allows for sources of bias such as social desirability. Despite the questionnaire being anonymous, responses may have been biased towards how

participants wished to be perceived, either by themselves or by the researchers. Third, sample size in individual groups within the sample were small and therefore have an increased risk of false negative findings, e.g. for gender: 19.6% male therapists compared to 79.7% female therapists, for theoretical orientation: 29.1% psychodynamic therapists compared to 70.9% cognitive behavioural therapists. Fourth, the term ‘traumatic experience’ might be understood differently, although the term was defined at the beginning of the survey. Finally, since the questionnaire was only sent to registered therapists in a defined German region, some aspects might not be generalized to other contexts and countries. However, therapists’ characteristics like gender, length of work experience, own traumatic events and therapeutic orientation are certainly enabling factors or barriers in trauma assessment in other contexts and countries as well.

4.2 Practical implications

Considering our findings, psychotherapists perceive themselves as confident in trauma assessment and consider dealing openly with traumatic events as relevant – at least in our sample with a high number of therapists with specific trainings. However, previous findings describe various barriers perceived by mental health professionals. As not everyone affected by a mental illness and/or traumatic event has access to psychotherapeutic treatment, the need for strengthening trauma competencies in the mental health sector – regardless of the profession – becomes clear. Facing clinical practice, severely ill patients (e.g. psychosis, eating disorders, dissociative disorder, substance misuse) with few resources (e.g. lack of social support, unemployment or low income, experiences of stigma, little or no education, delinquency) face greater barriers when accessing outpatient psychotherapy. This is for example illustrated by the results of (Epping, Muschik, & Geyer, 2017), who found that patients with low socio-economic status (SES) are under-represented in the utilization of psychotherapy. As our results show that gaining competencies through trauma training lowers barriers and raises self-confidence in dealing with patients’ traumatic experiences, one should expand trauma training for all mental health professionals, regardless of their profession.

4.3 Conclusion

Our results show that therapists in our sample regularly address trauma in psychotherapy, contrasting previous findings. Most psychotherapists in this study perceive themselves as competent in dealing with traumatic experiences and consider addressing traumatic events important. Therapists’ perception of competence in this sample might be due to specific trauma training. Our results suggest that trauma training lowers barriers

reported in previous studies. The findings of this study might be biased through the high percentage of participating therapists with trauma training and many therapists with ≥ 10 years of work experience. Both aspects are associated with a high feeling of competence. Our results show that therapists' characteristics, such as gender, own traumatic events, length of work experience, and theoretical orientation have an effect on trauma assessment. For instance, therapists without own traumatic events feel more uncomfortable asking patients about traumatic experiences compared to therapists with own traumatic events. Considering the aspect of 'own affectedness', in clinical practice often discussed as therapists' qualification criteria, our results show that affected therapists feel more comfortable in trauma assessment. We argue that own affectedness raises therapists awareness for traumatic events. Thus, experiencing traumatic events can have the same effect as promoting therapist's awareness through participating in trauma training. However, the other discussed therapists' characteristics effecting trauma assessment should be considered during training and equally apply to other professions. Due to the increasing demand for psychotherapy, especially considering people with severe mental illness affected by traumatic events, trauma training should be obligatory for all mental health professionals.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was financed by in-house research funds of the Department of Psychiatry and Psychotherapy at the University Medical Center Leipzig, Semmelweisstrasse 10, 04103 Leipzig, Germany.

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Data availability statement

The data described in this article are openly available in the Open Science Framework at <https://mfr.osf.io/render?url=https%3A%2F%2Fosf.io%2F5vgzt%2Fdownload>.

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