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Psychological well-being in therapists who are members of the UK Complex Trauma Institute

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Abstract

Therapists working within the role of professional care-giving for survivors of trauma can experience an impact to their health and well-being. The emotionally demanding nature of the role can lead to implications on professional quality of life and the manifestation of body-centred countertransference (BCT). These implications may be exacerbated when the therapist has personal experiences of childhood trauma and an insecure attachment style. The aim of the present study was to examine the relationship between childhood trauma and therapist outcomes of burnout and BCT. A cross-sectional survey of 192 trauma therapists was carried out online wherein participants completed a number of self-report measures. Hierarchical regression analyses were conducted. Results indicated that psychological distress and insecure attachment styles predicted trauma therapists' reported scores of burnout as measured by the Professional Quality of Life Questionnaire. BCT was significantly predicted by anxiety, psychoform and somatoform dissociation, and childhood emotional abuse. The study findings and clinical implications are discussed, and suggestions for future research are indicated.

Keywords: body-centred countertransference, attachment, childhood trauma, burnout

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Introduction

Working therapeutically with survivors of trauma can have an adverse impact on the professional and personal lives of the therapists engaging in these professional care-giving roles (Piedfort-Marin, 2019), significantly impacting the therapist's emotional well-being. Due to the emotionally demanding nature of this work, therapists are likely to experience burnout (Cohen & Collens, 2013), resulting from work related stress (Bell et al., 2024) and exposure to another individual's trauma narrative. The complexity of trauma work may also lead to the therapist experiencing challenging countertransference reactions (Tlali, 2022), wherein the therapist responds at a somatic level, a phenomenon known as body-centred countertransference (BCT). Understanding what factors contribute to these aspects of therapists' emotional well-being will be the focus of this study.

Body-centred Countertransference

Countertransference is experienced in different forms, with much research evidencing therapists' experiences at a cognitive and emotional level (Gubb, 2014). However, less research has focused on experiences of physical or somatic reactions within the countertransference (Egan & Carr, 2008; Gubb, 2014; Athanasiadou & Halewood, 2011). BCT is a form of countertransference that is experienced by the therapist at a physical level (Stone, 2006). As described by Pearlman and Saakvitne (1995), our affects are held physically, and therapists often respond to their clients through their bodies. BCT manifests as an unconscious bodily reaction in response to, or as a defence to, the presence of the client and their unconscious internal world, or a shared experience within the therapeutic work (Athanasiadou & Halewood, 2011).

Although experiences of countertransference were once understood to be problematic, recent views suggest it can have a positive impact within the therapeutic process, but only when the therapist is aware of its presence (Forester, 2007). Working therapeutically, BCT may serve as a tool for the therapist, allowing them to intuitively connect to the client and their internal world, as well as understand and manage the intersubjective space between them and their client (Athanasiadou & Halewood, 2011; Shaw, 2006). BCT provides the therapist with valuable information (Booth et al., 2010), and when this is channelled effectively, it can positively influence the therapeutic process. However, if the therapist is not consciously attuned to their somatic experiences, it may result in detrimental consequences, such as an absent therapist for the client (Athanasiadou & Halewood, 2011; Blackburn & Price, 2007; Heard et al., 2018; Shaw, 2006), or negative health implications for the therapist (Egan & Carr, 2005). Thus, it is important for therapists to be vigilant to this phenomenon and engage in reflective awareness (Forester, 2007).

The literature on countertransference suggests it is the therapists' own life experiences that determines how the concept manifests during therapy (Gabbard, 1995; 2001; Jacobs, 1973). It is the result of particular aspects within the client's presentation that elicit emotional and somatic reactions within the therapist (Gubb, 2014; Sandler et al., 1992). Research also indicates that BCT may be a result of the client and therapist having similar experiences, suggesting the idea of a 'shared psychological wound' (Athanasiadou & Halewood, 2011; Margarian, 2014). Thus, understanding the factors that may contribute to BCT are crucial (Hamilton et al., 2020).

Childhood Trauma

The therapist's life experiences are important in understanding the processes that occur as a result of their clinical work, particularly given that many therapists are attracted to this type of work due to their own experiences of emotional distress (Cuseglio, 2019; Stone, 2006). One factor that may contribute to BCT, is the therapist's experiences of trauma (Jacobs, 1973; Piedfort-Marin, 2019), particularly childhood trauma (CT) (Athanasiadou & Halewood, 2011). CT encompasses physical, sexual and emotional abuse, and physical and emotional neglect, as measured by the Childhood Trauma Questionnaire (Bernstein et al., 2003). These experiences interrupt cognitive, emotional and interpersonal development (Herman, 1992), and have been suggested to predispose individuals to psychological distress and greater risk of using defence mechanisms such as dissociation and depersonalisation as a way of coping (Ó Laoide et al., 2017; Sar et al., 2009; Vonderlin et al., 2018), which remain present throughout the individuals' lifetime (Katzman & Papouchis, 2023). Individuals who experience CT are vulnerable to poor emotional development, often engaging in avoidant coping to suppress the emotional needs that were not met in childhood (McCluskey, 2011), and research has indicated therapists who have experienced CT may make sense of bodily experiences through defences, such as disconnection and resistance (Athanasiadou & Halewood, 2011).

Therapists who have personal trauma experiences exhibit greater emotional and physical countertransference reactions (Cavanagh et al., 2015). Listening to clients' traumatic narratives may result in the therapists own experiences becoming activated, which may have been suppressed until meeting and experiencing a client (Cavanagh et al., 2015), leading to manifestation of BCT (Piedfort-Marin, 2019). Clients that present with similar traumatic childhood experiences to the therapist are also more likely to evoke such countertransference reactions (Cuseglio, 2019), and therapists may engage in defences such as dissociation to numb themselves against the emotional trauma and somatic experiences (Athanasiadou & Halewood, 2011; Cavanagh et al., 2015).

Attachment Style

Bowlby's (1969/1982) work on attachment theory hypothesises that one's earliest life experiences significantly shapes development, and form one's mental representations of the self and others, known as internal working models. Through early interactions with a caregiver, one learns how to navigate and manage in times of distress, through engaging in comfort seeking and emotional regulation (Ainsworth, 1989; Bowlby 1988). These consistent and reciprocal interactions between the child and caregiver lead to secure attachment relationships (Grossmann & Grossmann, 2019), wherein the individual feels worthy and deserving of affection (Kong et al., 2018). However, individuals who experience childhood trauma are more vulnerable to having experienced disruptions within their attachment bond, negatively impacting on their development (Briere, 2002), which leads to the development of insecure attachments (Zayde et al., 2019). Insecure attachments leave individuals vulnerable to poor adjustment later in life (Oliveira & Fearon, 2019), lacking in confidence, with a reduced likelihood of engaging in comfort seeking and utilising social supports when distressed (Howe, 2011; Mikulincer & Shaver, 2007). Mary Ainsworth discovered patterns of insecure attachment styles, which include insecure-anxious and insecure-avoidant (Gillath et al., 2016), influencing how one behaves and copes under stress (West, 2015). Those with anxious attachment styles are likely to worry they will be rejected or abandoned by others, hold a strong desire for connection and engage in excessive care-seeking, but experience others as unlikely to respond to their needs. Those with avoidant attachment styles are likely to deny their own emotional needs, limit closeness and interdependence, perceiving others as untrustworthy and unreliable (Kong et al., 2018; Zorzella et al., 2020).

Research on attachment styles suggests one's early attachment history later determines their ability to manage and cope with distressing emotions in adulthood (Heard et al., 2018), and guides their behaviour and ability to initiate and maintain relationships, including caregiving behaviours and helping relationships within a professional capacity (West, 2015). Insecure attachment has been evidenced as a risk factor for poor regulation of emotion in intra- and interpersonal relationships, as well as coping through dissociation (Mikulincer & Shaver, 2008). Research on those with insecure attachment styles in the caregiving profession has indicated higher levels of negative affect than those of secure attachment (Cassidy & Shaver, 2008). As one's internal working model is likely to be activated in times of stress, determining their cognitions and behaviour (Pines, 2004), and given attachment style itself can be considered a strategy for emotion regulation (Kong et al., 2018), this suggests that an insecurely attached caregiving professional's attachment style will influence how they cope and respond to stressful situations within their work (West, 2015).

Given this, it is possible that when therapists are listening to the traumatic narratives of their clients, their interpersonal attachment style may become activated, impacting how they process and respond to their own internal reaction, as well as their relationship with the client. Anxiously attached individuals may find it difficult to manage boundaries and separate their own pain from that of their clients (Bartholomew & Horowitz, 1991; West, 2015), while avoidant attachment individuals tend not to seek out disclosures in their work (Mikulincer & Shaver, 2007).

Therapist Quality of Life

Therapists are not immune to, or exempt from experiencing traumatic events in their life (Piedfort-Marin, 2019). In fact, much research states therapists often chose the role of professional caregiving due to their own experiences of trauma and emotional distress (Adams, 2013; Chu, 1988; Pines, 2004), with literature stating psychotherapists, compared to that of the general population, originate from homes that are unstable and emotionally withdrawn (Groesbeck, 1975; Racusin et al., 1981). Similar to Carl Jung's concept of the 'wounded healer' which suggests the healer's own pain may cure clients' pain (Cuseglio, 2019), trauma therapists, who had their own experiences of trauma, believed this to benefit their work due to a greater ability to express empathy and sympathy towards the client (Cavanagh et al., 2015). However, working with survivors of trauma may impact their personal and professional lives (Piedfort-Marin, 2019) as they are exposed to stories of horrific events which may have a significant emotional impact on them (Piedfort-Marin, 2019). Research has shown therapists working with victims of abuse are at greater risk of experiencing burnout (Brockhouse et al., 2011; Cohen & Collens, 2013; Egan & Carr, 2005; Reddi, 2021). It has also been suggested that due to the challenging nature of the work, this may elicit difficult countertransference reactions (Tlali, 2022).

Research has demonstrated that therapists who have experienced severe trauma in early childhood or have had similar physical experiences to that of their client are more likely to experience BCT (Jacobs 1973; Stone, 2006). Although this can be utilised as a way to learn about the client (Dosamantes-Beaudry, 1997; Pearlman & Saakvitne, 1995; Piedfort-Marin, 2019), if the therapist does not have the self-awareness to attune to this, it can impact on the therapy (Sharma & Fowler, 2016) and on the therapists health, with research evidencing a positive relationship between countertransference and sick leave in a sample of female trauma therapists (Egan & Carr, 2005). In considering this from the model of Affect Phobia (McCullough, 2003), if the client activates the therapist's unmet needs or difficult past relationships, and the therapist is unable to sit with their own emotional state, this may result in the therapist engaging in an inhibitory response or defensive caregiving, as it elicits emotional conflict from past trauma for the therapist.

Aims & Objectives

As outlined in the above literature, and reported by Lee (2017), therapists' experiences of trauma and attachment greatly influence what occurs within the therapeutic process. Thus, the aim of the present study is to explore the relationship between CT and therapist outcomes of professional quality of life and BCT, and the role of attachment style in these relationships.

Method

Participants and Procedures

Participants were qualified therapists (n = 192) working with survivors of trauma, and were recruited from the Complex Trauma Institute (CTI). An online survey was implemented via Microsoft Forms. All members of the CTI received an email invitation from the institute director to participate in the study, including the research information sheet and a direct link to complete the questionnaires. All participants provided consent prior to their participation and submission of their data.

Measures

Demographic Information

Participants provided relevant demographic and work related information including gender, age, employment status, therapist type, client population, years working with survivors of trauma, and frequency of clinical supervision.

Dissociative Experiences Scale (DES-II)

The DES-II is a 28-item self-report questionnaire that assesses psychological dissociative experiences, ranging from mild to more severe symptoms, including amnesia, derealisation and depersonalisation (Bernstein & Putnam, 1986), and can be used amongst clinical and normal populations (Saggino et al., 2020). The DES-II has three subscales for amnesia, depersonalisation/derealisation and absorption symptoms, and has demonstrated high internal reliability with a Cronbach's alpha (α) of above .90 for this version of the scale (Wright & Loftus, 1999). Cronbach's alpha values ranged from .81 to .92 in the current study.

Somatoform Dissociation Questionnaire (SDQ-20)

The SDQ-20 is a 20-item self-report questionnaire that assesses the physical and somatic experiences of dissociation, including sensory symptoms, pain and loss of motor function (Nijenhuis, 2001; Nijenhuis et al., 1996). The SDQ-20 has a high internal consistency, with a Cronbach's alpha (α) of .95 (Nijenhuis et al., 1996). Cronbach's alpha was .90 in the current study.

Body Centred Countertransference Scale (BCTS)

The BCTS is a 16-item list of bodily or somatic symptoms that therapists may experience in response to their clients (Egan & Carr, 2005). The frequency of these symptoms is captured through a likert scale type questionnaire. The scale has demonstrated acceptable internal reliability with a Cronbach's alpha (α) of .74 (Egan & Carr, 2008). Cronbach's alpha was .83 in the current study.

Experiences in Close Relationships – Relationship Structures Questionnaire (ECR-RS)

The ECR-RS is a 9-item self-report questionnaire that assesses attachment style, through assessing attachment related avoidance and anxiety in close relationships. Responses are provided through a likert scale type questionnaire (da Rocha et al., 2017; Fraley et al., 2011). The scale has good internal consistency with Cronbach's alpha (α) ranging from .78 to .91 (da Rocha et al., 2017). Cronbach's alpha values ranged from .85 to .86 in the current study.

Childhood Trauma Questionnaire – Short Form (CTQ-SF)

The CTQ-SF is a 28-item self-administered questionnaire that assesses physical and emotional abuse, physical and emotional neglect, and sexual abuse, experienced during childhood (Bernstein et al., 2003). The CTQ-SF has a good internal consistency, with Cronbach's alpha (α) ranging from .63 to .95 across the scales (Thombs et al., 2009). Cronbach's alpha values ranged from .76 to .90 in the current study.

Professional Quality of Life Scale (ProQOL-5)

The ProQOL-5 is a scale designed to assess the affect of working with survivors of trauma (Stamm, 2005), through measuring compassion satisfaction, burnout and secondary traumatic stress (Hemsworth et al., 2018). The scale has good internal consistency with Cronbach's alpha (α) ranging from .75 to .88 across the scales (Stamm, 2010). Cronbach's alpha values ranged from .75 to .85 in the current study.

Patient Health Questionnaire (PHQ-4)

The PHQ-4 is an ultra-brief 4-item self-report screening measure for anxiety and depression (Kroenke et al., 2009). There was good internal reliability for all subscales, with Cronbach's alpha (α) > . 80 (Kroenke et al., 2009). Cronbach's alpha values ranged from .74 to .76 in the current study.

Design and Analysis

A cross-sectional study design was implemented. Hierarchical multiple regression analyses were then conducted to examine the relationship between childhood trauma, attachment style and dissociation, both psychoform and somatoform, in relation to BCT and burnout. Due to the large number of predictor variables, only variables with a correlation of above .25 and an alpha level of .05 or lower were entered into the regression models. All analyses were completed using IBM SPSS version 27.0 (IBM Corp., 2020).

Results

Data Screening

Given the reasonably large sample size, significance in the distribution of skewness and kurtosis was expected, however this was not expected to 'make a substantive difference in the analysis' or underestimate the variance (Tabachnick et al., 2013). Collinearity statistics revealed that variance inflation factor (VIF) and tolerance values indicated there was no significant multicollinearity between the predictor variables for multiple regression analysis (Field, 2013).

Descriptive Statistics

Demographic information captured about the study participants are presented in Table 1, participant scores on the study variables are presented in Table 2 and the descriptive and frequencies of BCT symptoms are presented in Table 3. In the present study, the most common reported experiences of BCT within the previous six months are: muscle tension (84.8%), sleepiness (82.9%), tearfulness (80.7%) and yawning (78.6%). This finding replicates that of previous research conducted by Egan and Carr (2008), Booth and colleagues (2010) and Hamilton and colleagues (2020) who also found muscle tension (83%, 79%, 80.6%), sleepiness (92%, 76%, 72%), tearfulness (71%, 61%, 77.7%) and yawning (77%, 65%, 69.15%) to be of the most commonly reported experiences of BCT, with their findings reported respectively. A correlation matrix presents the bivariate correlational relationships between the predictor and outcome variables in Table 4.

Table 1. Demographic Information

Variable	Frequency (%) or M(*SD*)	Variable	Frequency (%) or M(*SD*)
Age	52.52 (12.56)	**Therapist Type**	
Gender		Psychotherapist	83 (41.9%)
Male	28 (14.1%)	Counsellor	41 (20.7%)
Female	163 (82.3%)	Clinical Psychologist	20 (10.1%)
Non-binary	1 (0.5%)	Counselling Psychologist	24 (12.1%)
Marital Status		Forensic Psychologist	2 (1%)
Single	25 (12.6%)	Counsellor & Psychotherapist	1 (0.5%)
Married	108 (54.5%)	Energy Healing & Light Counselling	1 (0.5%)
Co-habiting/In a relationship	33 (16.7%)		
Separated	3 (1.5%)	Craniosacral Therapist	1 (0.5%)
Divorced	18 (9.1%)	Support Worker	1 (0.5%)
Widowed	5 (2.5%)	Therapeutic Coach	1 (0.5%)
Ethnicity		In Training	4 (2%)
White/Caucasian	163 (82.3%)	Health Psychologist	1 (0.5%)
Black/African	1 (0.5%)	Psychoanalyst	1 (0.5%)
Latino	2 (1%)	Psychosexual & Relationship Therapist	2 (1%)
Asian	6 (3%)		
Mixed Race	7 (3.5%)	Marriage Family Therapist	1 (0.5%)
Other	13 (6.5%)	Recovery Coach	1 (0.5%)
Employment Type		Gestalt Psychotherapeutic Counsellor	1 (0.5%)
Full-time	67 (33.8%)		
Part-time	70 (35.4%)	Art Psychotherapist	3 (1.5%)
Self-Employed/ Private Practice	42 (21.2%)	Eye Movement & Desensitisation Trauma Therapist	1 (0.5%)
Studying	1 (0.5%)	Hypnotherapist	1 (0.5%)
Currently not working/ On sabbatical	2 (1%)	**Clinical Supervision**	
		Weekly	26 (13.1%)
Freelance	2 (1%)	Fortnightly	54 (27.3%)
Retired	4 (2%)	Once a month	105 (53%)
Voluntary	1 (0.5%)	Every six weeks	2 (1%)
By appointment	1 (0.5%)	As needed/Ad Hoc	3 (1.5%)
Client Population		Annually	1 (0.5%)
Children & Adolescents	6 (3%)	None	1 (0.5%)
		Years working with survivors of trauma	12.16 (9.15)
Adults	124 (62.6%)		
Children, Adolescents & Adults	62 (31.3%)	**Number of clients each week**	12.46 (7.00)

Table 2. Study Variables

Variable	M(*SD*)
DES-II	
Amnesia	5.02 (9.00)
Depersonalisation/Derealisation	5.11 (12.03)
Absorption	13.71 (13.50)
SDQ-20	25.97 (7.69)
BCTS	13.13 (7.69)
ECR-RS	
Avoidant	2.86 (1.34)
Anxious	1.96 (1.26)
CTQ-SF	
Emotional abuse	12.18 (5.54)
Physical abuse	7.76 (4.04)
Sexual abuse	7.97 (4.91)
Emotional neglect	13.77 (4.87)
Physical neglect	8.35 (3.56)
ProQoL-5	
Compassion satisfaction	40.81 (5.04)
Burnout	20.20 (4.77)
Secondary traumatic stress	19.98 (4.83)
PHQ-4	
Anxiety	0.99 (1.22)
Depression	0.87 (1.24)

Table 3. Frequency of Occurrences of body-centred countertransference symptoms

BCT Symptom	M (SD)	"never happened to me within the last six months" %	"happened to me at least once in the last six months" %	"happened a few times in the last six months" %	"has happened often in the last six months" %	Happened at some point during the last six months %
Muscle Tension	2.52 (0.96)	15.1	35.9	30.7	18.2	84.8
Sleepiness	2.46 (0.97)	17.2	36.5	29.2	17.2	82.9
Tearfulness	2.31 (0.92)	19.3	42.7	25.5	12.5	80.7
Yawning	2.38 (1.00)	21.4	35.9	26	16.7	78.6
Aches in Joints	2.06 (1.06)	38	32.8	14.1	15.1	62
Headache	1.94 (0.97)	40.1	34.9	15.6	9.4	59.9
Unexpectedly shifting your body	1.99 (1.01)	41.1	28.6	20.3	9.9	58.8
Stomach Disturbance	1.81 (0.94)	46.9	34.4	9.9	8.9	53.2
Dizziness	1.62 (0.88)	59.4	26	8.3	6.3	40.6
Throat Constriction	1.57 (0.81)	60.4	25.5	10.9	3.1	39.5
Sexual Arousal	1.66 (1.12)	60.4	23.4	9.9	5.7	39
Nausea	1.50 (0.72)	62.5	26.6	9.9	1	37.5
Raised Voice	1.48 (0.74)	64.6	24.5	8.9	2.1	35.5
Numbness	1.47 (0.82)	69.3	18.2	8.3	4.2	30.7
Genital Pain	1.19 (0.51)	84.9	12	2.1	1	15.1
Loss of Voice	1.15 (0.48)	89.6	7.3	2.1	1	10.4

Table 4. Correlation Matrix

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. BCTS																
2. ProQoL – CS	-.04															
3. ProQoL – B	.26**	-.63**														
4. ProQoL – STS	.33**	-.25**	.57**													
5. DES-II Amnesia	.46**	-.08	.24**	.28**												
6. DES-II Dep	.06	.05	.02	.08	.07											
7. DES-II Abs	.46**	-.04	.25**	.35**	.72**	.12										
8. SDQ-20	.51**	-.10	.27**	.35**	.72**	.05	.75**									
9. ECR-RS Avoidant	.16*	-.31**	.27**	.17*	.20*	-.04	.23**	.22**								
10. ECR-RS Anxious	.15*	-.27**	.37**	.33**	.13*	.04	.15*	.22**	.30**							
11. CTQ – EA	.28**	.00	.11	.09	.11	.10	.18**	.26**	.17*	.30**						
12. CTQ – PA	.28**	.02	.10	.10	.29**	.06	.30**	.42**	.23**	.23**	.64**					
13. CTQ – SA	.19*	.04	-.08	-.02	.22**	.04	.30**	.31**	.14*	.13*	.44**	.41**				
14. CTQ – EN	.23**	-.19*	.23**	.16*	.21*	.03	.20*	.34**	.31**	.27**	.66**	.42**	.34**			
15. CTQ – PN	.26**	-.12*	.22**	.10	.25**	.04	.29**	.39**	.32**	.23**	.62**	.57**	.40**	.67**		
16. PHQ-4 Anxiety	.33**	-.15*	.35**	.43**	.09	.11	.18*	.21**	-.02	.29**	.17**	.14**	.10	.17*	.16*	
17. PHQ-4 Depression	.18*	-.26**	.42**	.36**	.17*	.01	.22**	.22**	.09	.29**	.12	.09	.06	.11	.14*	.54**

Note. ** $p \leq 0.001$, * $p < 0.05$

Multiple Regression Analysis

Hierarchical multiple regression analyses were conducted to examine the predictive relationship to determine which variables predicted the likelihood of trauma therapists experiencing burnout and BCT.

The first regression model examined variables that predicted the presence of burnout, as measured by the ProQoL-5. Participant age, gender, anxiety and depression scores were entered in block one as control variables. Attachment anxiety and attachment avoidance were then entered in block two. The somatoform dissociation questionnaire score was then entered in block three. Step one of the model with gender, age, anxiety and depression significantly predicted the presence of burnout, $F(4,187) = 12.16$, $p < .001$, explaining 20.6% of the variance. With the addition of anxious and avoidant attachment styles in step two of the model, it added an additional 9.7% of variance in explaining burnout scores, F change $(2,185) = 12.83$, $p < .001$, with anxiety and depression remaining as significant predictors, with their beta weights .16 and .25 respectively. Both anxious and avoidant attachment styles appeared to contribute the same beta weights to the model, adding more than anxiety, but less than depression, as presented in Table 5 below. The final step did not add to the model in accounting for variance of burnout scores, F change $(1,184) = 3.13$, $p = .079$.

Table 5. Multiple regression model for prediction of burnout

Variable	β	S.E.	*p*	R^2	R^2 change
Block 1:				.206	-
Gender	-.08	.86	.21		
Age	-.04	.03	.53		
PHQ-4 Anxiety	.18	.30	.03		
PHQ-4 Depression	.32	.31	<.001		
Block 2:				.303	.097
Gender	-.10	.82	.10		
Age	-.07	.03	.26		
PHQ-4 Anxiety	.16	.29	.04		
PHQ-4 Depression	.25	.30	.002		
ECR-Avoidant	.20	.23	.002		
ECR-Anxious	.20	.26	.004		
Block 3:				.315	.012
Gender	-.11	.81	.08		
Age	-.08	.03	.23		
PHQ-4 Anxiety	.14	.29	.06		
PHQ-4 Depression	.24	.30	.003		
ECR-Avoidant	.18	.24	.006		
ECR-Anxious	.19	.26	.007		
SDQ-20	.12	.04	.08		

The second regression model examined the variables that predicted the presence of BCT in trauma therapists. Participant age, gender, anxiety and depression scores were entered in block one as control variables. Emotional abuse, physical abuse and physical neglect as measured by the childhood trauma questionnaire were then entered in block two. The dissociative experiences amnesia and absorption subscale scores, and the somatoform dissociation questionnaire score were then entered in block three. Step one of the model with gender, age, anxiety and depression significantly predicted the presence of BCT, $F(4,187) = 5.65$, $p < .001$, explaining 10.8% of the variance. With the addition of childhood trauma subscales in step two of the model, it added an additional 6.9% of variance in explaining BCT scores, F change $(3,184) = 5.11$, $p = .002$, with anxiety remaining as the only significant, $\beta = .28$. The final step of the model, with the addition of psychoform and somatoform dissociation scores, added an additional 18.8% of variance in explaining BCT scores, $F(3,183) = 17.81$, $p < .001$, accounting for a total of 36.4% of variance, with anxiety remaining as a significant predictor, $\beta = .27$. Childhood emotional abuse emerged as a significant predictor in the third step of the model, $\beta = .20$. Both amnesia and somatoform symptoms contributed beta weights of .23 and .22 respectively, adding more than emotional abuse, but less than anxiety as presented in Table 6 below.

Table 6. Multiple regression model for prediction of body-centred countertransference

Variable	β	S.E.	*p*	R^2	R^2 change
Block 1:				.108	-
Gender	.02	1.48	.82		
Age	.05	.04	.53		
PHQ-4 Anxiety	.33	.52	<.001		
PHQ-4 Depression	.01	.53	.88		
Block 2:				.176	.069
Gender	.02	1.44	.75		
Age	.03	.04	.64		
PHQ-4 Anxiety	.28	.51	<.001		
PHQ-4 Depression	-.002	.51	.98		
CTQ Emotional Abuse	.09	.13	.35		
CTQ Physical Abuse	.14	.18	.14		
CTQ Physical Neglect	.08	.19	.38		
Block 3:				.364	.188
Gender	-.008	1.29	.90		
Age	.006	.04	.93		
PHQ-4 Anxiety	.27	.46	<.001		
PHQ-4 Depression	-.09	.46	.24		
CTQ Emotional Abuse	.20	.12	.03		
CTQ Physical Abuse	-.04	.16	.61		
CTQ Physical Neglect	-.04	.18	.65		
DES-II Amnesia	.23	.08	.02		
DES-II Absorption	.10	.06	.35		
SDQ-20	.22	.10	.03		

Discussion

Research exploring countertransference experienced by therapists, has greatly focused on the cognitive and emotional aspects of the phenomenon, leaving a paucity of research exploring countertransference that is experienced at a bodily level. BCT is widely experienced by therapists (Booth et al., 2010; Hamilton et al., 2020; Margarian, 2014), with experiences varying from mild symptoms of headache to more severe or startling symptoms such as numbing of the body (Booth et al., 2010; Cuseglio, 2019; Hamilton et al., 2020; Margarian, 2014; Pearlman & Saakvitne, 1995; Stone, 2006). This study provides evidence that early life experiences, insecure attachment styles and coping styles developed, greatly shape how therapists approach and engage with professional care-giving, manage and cope with the emotionally demanding nature of the profession, and the undesireable consequences that may occur as a result of a combination of these factors. To the best of our knowledge, this study is of the first to examine the impact of these factors on the presence of BCT in trauma therapists. The study has generated findings of significance within this phenomenon, which have important clinical implications for therapists working with survivors of trauma.

In the present study, there were no reported high levels of burnout, with 64.6% of participants reporting low burnout scores. This differs from Brugnera and colleagues (2023) finding which identified up to 50% of psychotherapists experience high levels of burnout, and a recent systematic review which revealed approximately 60% of psychologists experience moderate to high levels of stress from their work (Bell et al., 2024). Hierarchical multiple regression analysis revealed burnout was significantly predicted by anxiety, depression, and both anxious and avoidant attachment style. This suggests individuals who experience mental distress, have difficulties regulating emotions, and experience interpersonal challenges, are at greater risk of burnout.

Well-being and mental distress have previously been associated with burnout (Brugnera et al., 2023; Hardiman & Simmonds, 2013; Morse et al., 2012). Brugnera and colleagues (2023) also found anxious attachment to predict burnout in psychotherapists, however avoidant attachment was not found to predict burnout, differing from the present findings. It is possible that for anxiously attached therapists who experience psychological distress, given their high fear of rejection, over-exaggerate the negative affect that arises in their work (Strauss & Petrowski, 2017), and as result over invest in their care-giving towards the client (Hazan & Shaver, 1990), ultimately emotionally over-extending themselves. Whereas therapists with an avoidant attachment experiencing psychological distress, whom are uncomfortable with closeness (Kong et al., 2018), may try limit the presence of, or engagement with, emotional material (Haroush & Koslowsky, 2020), depleting their energy. Thus, insecure attachment styles impact on therapists' response to their work (West, 2015), leaving them at greater risk of burnout. It is therefore crucial that trauma therapists consider interventions to reduce stress (Bell et al., 2024) or engage in self-care behaviours to lower their risk of reaching burnout (Di Benedetto & Swadling, 2014).

BCT manifests within the therapist in response to the interaction between the client's unfolding narrative within therapy, and the therapists own unmet needs and unresolved conflicts (Sharma & Fowler, 2016). Hierarchical multiple regression analysis revealed BCT was significantly predicted by anxiety, dissociative amnesia, somatoform dissociation, and childhood emotional abuse. This suggests that therapists who experience BCT are more likely to have experienced childhood emotional abuse, engage in psychoform and somatoform dissociative behaviours as a defensive form of coping, and experience symptoms of anxiety.

Bowlby's (1973) work on attachment theory suggested that, in the presence of childhood emotional abuse, when a child is not met with positive care-seeking interactions with their primary caregiver, they will engage in dissociative behaviours. The child does not learn how to engage in adaptive emotion regulation due to the absence of positive modelling of emotional expression (Besharat, 2010). This can result in emotion processing remaining 'stuck' at a bodily level (McHugh & Egan, 2023), which is a risk factor for somatoform dissociation (Nijenhuis et a., 2004). Childhood emotional trauma has previously been associated with psychoform dissociation (McHugh & Egan, 2023), and dissociative amnesia is assumed to be a natural way of coping in response to childhood trauma (Mangiulli et al., 2022). These dissociative ways of coping remain separated from conscious until the individual is faced with stressful situations in life (Bowlby, 1973), and become an automatic coping response over time (Zorzella et al., 2020). Somatic dissociation is believed to become reactivated when the individual is faced with reminders of their trauma later in life (McHugh & Egan, 2023).

Thus, in understanding this finding from the model of Affect Phobia (McCullough, 2003), when the therapist is actively tuned in to their client's traumatic narrative in session, trauma therapists with a history of emotional abuse are likely being triggered and in the absence of connecting to their feelings, grounding their bodies or acknowledging how their client's narrative is triggering them, this then increases their anxiety. This leads to further negative emotional and physical reactions, and in the absence of learned adaptive coping (Besharat, 2010), and in an effort to avoid these feelings the therapist then engages in defence behaviours (McCullough, 2003). These behaviours manifest both psychologically, in the form of dissociative amnesia, with therapists having an inability to recall their emotional trauma (American Psychiatric Association [APA], 2013) and physically, in the form of somatoform dissociation, where trauma related memories are stuck physically (McHugh & Egan, 2023; van der Boom et al., 2010). Somatic dissociation was moderately associated with BCT in the present study, suggesting these therapists are more likely to experience BCT.

This finding has significant implications for therapists working with survivors of trauma and have their own experiences of childhood trauma. It is important that when therapists are engaging in supervision or personal therapy, they are reflecting on what is happening within their bodies in response to their client, to identify whether they are integrating memories or they are going in to defence (Athanasiadou & Halewood, 2011), through engaging in one or both forms of dissociation. If the therapist is in defence, and unaware of their BCT reaction, as previously highlighted from past research, this may have detrimental implications for both the therapist and their client (Athanasiadou & Halewood, 2011; Blackburn & Price, 2007; Heard et al., 2018; Shaw, 2006).

Although the findings of the present study have generated new information in our understanding of BCT, they should be interpreted with the consideration of study limitations. As the study employed a cross-sectional design, it is important to note, that the research took place during the time of Russia-Ukraine war, and shortly after the Hamas-led attack on Israel that led to the Israel-Hamas war. This was reflected by a few participants in the commentary feedback section of the study questionnaires. Thus, given the nature and significance of these events, this may have contributed to greater psychological distress in those directly impacted (Khrushch et al., 2023; Xu et al., 2023), and future research may benefit from a longitudinal study design to examine these relationships over time.

Given the reported consequences for therapists and their clients as a result of therapists being unaware of their BCT, it would be beneficial to understand what factors or strategies may be able to prevent such outcomes. Future research may benefit from examining the impact of attendance at supervision or participation in personal therapy on BCT, as well as therapist quality of life outcomes. This may provide valuable information on how therapists can manage and potentially reduce the negative outcomes that can arise from engaging in an emotionally demanding profession.

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