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Measuring Mental Health Professionals' Trauma Care Competencies: Psychometric Properties of the Novel Readiness to Work with Trauma-Exposed Patients Scale (RTEPS)


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Abstract

Objective. A lack of training in PTSD assessment and treatment can cause nonrecognition, misdiagnosis, or mistreatment of trauma-exposed patients in clinical practice. To fill the gap of the measures of trauma care-related competencies, the current study aimed to test psychometric properties of the novel measure of Readiness to Work with Trauma-Exposed Patients Scale (RTEPS) in a sample of clinicians.

Method. The study sample comprised 279 Lithuanian mental health professionals (91% psychologists and 9% psychiatrists). The mean age of study participants was 41.09 ($SD = 10.68$), 93.9% were female. Almost half of the participants (49.1%) had more than 10 years of work experience in the field of mental health, and 61.3% of clinicians reported routinely seeing trauma-exposed patients in their clinical practice.

Results. Exploratory structural equation modeling and confirmatory factor analysis revealed that a three-factor first-order model of the 10-item self-report RTEPS comprising competencies of assessment, treatment, and affect tolerance showed the best fit for the data. Additionally, previous trauma-focused training experience but not work experience was significantly associated with perceived readiness to work with trauma-exposed patients while controlling for the rates of depression and anxiety of mental health professionals.

Conclusions. The findings of the study provide evidence of the RTEPS validity based on test content, internal structure, relations to other variables as well as internal consistency. The RTEPS scale is a brief and easily administered instrument that could be used in the context of training or clinical setting to evaluate the trauma care competencies among professionals.

Keywords: trauma, PTSD, training, treatment, competencies

Clinical Impact Statement

The current study explored properties of a novel measure of mental health professional competencies in trauma care measure - the Readiness to Work with Trauma-exposed Patients (RTEPS). The RTEPS is intended to measure core trauma care competencies: tolerance of emotionally charged trauma-related content, competencies in PTSD assessment, and treatment. We found that previous PTSD training experience, but not professional experience, was significantly associated with higher perceived readiness to work with trauma-exposed patients. The study informs of the importance of specialized training in PTSD assessment and treatment among mental health professionals to provide the best care for trauma survivors.

Measuring Mental Health Professionals' Trauma Care Competencies: Psychometric Properties of the Novel Readiness to Work with Trauma-Exposed Patients Scale (RTEPS)

Mental health professionals often see clients or patients who were exposed to at least a single traumatic experience in their clinical practice. Moreover, psychologists or psychiatrists often have to treat patients with posttraumatic stress disorder (PTSD) (Evans et al., 2013; Kessler et al., 2017; Reed et al., 2012). The data from the World Health Organization (WHO) surveys from 26 populations revealed that the lifetime prevalence of PTSD is 3.9% in the general population and 5.6% in trauma-exposed samples (Koenen et al., 2017). Due to the high prevalence of trauma exposure and PTSD in clinical samples, the trauma-informed approach is highly relevant in clinical care. Trauma-informed care is grounded on the knowledge of the trauma effects on mental health and providing adequate care to ensure high-quality services for trauma survivors.

Over the last several decades' multiple assessment tools have been developed for the assessment of trauma exposure and PTSD (Kisiel et al., 2021; Wilson & Keane, 2004). Various guidelines for the treatment of trauma-related disorders have been developed based on numerous high-quality research that proved the efficacy of the treatments for PTSD (e.g., Forbes et al., 2020). However, there is still a considerable treatment gap between the PTSD prevalence found in epidemiological studies and the diagnosed and treated PTSD globally. Reports from many countries, including expert reviews from the high-income and low-income countries, demonstrate that access to evidence-based trauma treatments is restricted, and the demand is much higher for PTSD treatments in various traumatized populations (Kazlauskas, 2017; Schäfer et al., 2018).

There are multiple reasons for PTSD treatment barriers such as a lack of resources in a community, inadequate trauma care competencies due to the limited access to trauma-focused treatment training for professionals, nonrecognition of PTSD in primary care (Ehlers et al., 2009; Kazlauskas et al., 2017), and often blaming and self-blame of the survivors (Greene, 2018). A significant barrier for PTSD treatment could also be a lack of competencies of professionals in PTSD assessment and treatment (Ehlers et al., 2009). Furthermore, asking about traumatic experiences could invoke strong emotional reactions of the survivor, and professionals, especially if they perceive themselves as lacking competencies in trauma assessment and treatment, could find it difficult to tolerate these emotions (Cook et al., 2019). Professionals experience indirect exposure to trauma because of close interactions with trauma survivors, so often are at risk of secondary traumatization. Sodeke-Gregson and colleagues (2013) indicated that a lack of experience in clinical practice predicted secondary traumatic stress in therapists working with trauma patients. However, findings of other studies (e.g., Rzeszutek et al., 2015) did not reveal any significant links between therapists' demographic or work-related variables and secondary traumatic stress. A higher emotional reactivity was related to secondary traumatic stress in the aforementioned study.

There is a growing understanding in the field of mental health that a lack of training in PTSD treatment can cause nonrecognition, misdiagnosis, or mistreatment of patients (Cook et al., 2019). The rationale behind the present study was to develop a novel measure of perceived readiness to work with traumatized patients (the RTEPS scale) in clinical practice to facilitate the evaluation of the competencies of professionals who work with PTSD patients. Several measures have been developed recently to measure the competencies of therapists in trauma care, such as therapeutic competence scale for adolescents with PTSD (Gutermann et al., 2015) or disorder

and treatment-specific competence scales for PTSD (Dittmann et al., 2017). However, these measures are primarily used in research settings and are not applicable in educational or training contexts.

Based on the growing body of literature that emphasized the importance of competencies in PTSD assessment and treatment in health care (Cook et al. 2019), previous empirical studies, and our experience in the delivery of PTSD assessment and treatment training for professionals, we developed a self-report scale that comprises items measuring perceived competencies in trauma assessment, treatment, and affect tolerance. The newly developed scale could be useful in identifying the readiness to work with trauma patients in clinical and training settings. Moreover, the proposed new RTEPS scale could be a useful tool for training programs to assess short- and long-term training outcomes.

The aim of the present study was to test the factor structure of the RTEPS in a sample of licensed and registered mental health professionals. We hypothesized that the RTEPS comprised of three competencies relevant in trauma care: (1) assessment, such as perceived ability to identify potentially traumatic experiences and assess symptoms of posttraumatic stress, (2) treatment, such as perceived ability to choose and apply treatment for patients with PTSD or complex PTSD), as well as (3) affect tolerance, which includes perceived tolerance for intense affect and trauma-related content in working with trauma patients. We also aimed to evaluate associations of the RTEPS with previous experience of training in trauma assessment and treatment, the experience of professional practice, as well as depression and anxiety levels.

Method

Sample and Procedure

The present study was a part of a larger PTSD assessment and treatment training evaluation program conducted by the Center for Psychotraumatology (PTC) at Vilnius University, Lithuania. The PTC training programs were offered as a competency building in trauma care for all mental health professionals across the country. Only registered/licensed mental health professionals, psychologists, and psychiatrists who practice in licensed health care institutions throughout Lithuania were enrolled in the study. The study was approved by the Ethics Committee for Psychological Research of Vilnius University.

Invitation to clinicians working in licensed healthcare institutions was distributed to mental health institutions in all regions of Lithuania. The invitation was also posted on social media in professional networks. Informed consent was obtained from all study participants on the online platform prior to the data collection. The participants filled in an online questionnaire of the study as a part of the registration to the post-diploma level training before the PTSD assessment or treatment training course. Data was collected online in November–December 2020.

The sample of the study comprised 279 Lithuanian mental health professionals. The age of the participants was 41.09 on average ($SD = 10.68$), 93.9% were female. The vast majority of the sample were psychologists (91.0%), and the remaining 9.0% were psychiatrists. Almost half of the participants (49.1%) had more than 10 years of work experience in the mental health area. Additionally, 61.3% of clinicians reported routinely seeing trauma-exposed patients in their clinical practice. Detailed sample characteristics are presented in Table 1.

< Table 1 about here >

Measures

Perceived Readiness to Work with Trauma-Exposed Patients Scale (RTEPS)

The RTEPS is a brief self-report measure designed to assess the professional's perceived readiness to work with trauma-exposed patients in mental health practice. The RTEPS captures perceived competencies relevant in trauma care in the three core domains: (1) assessment, (2) treatment, and (3) affect tolerance. The items of the RTEPS were developed by three Ph.D.-level mental health professionals with extensive experience in trauma-informed treatment, research, and clinical practice. After the initial list of items had been developed during the expert discussions, items from all three domains were selected and revised. Further, items of the RTEPS have been finalized after the input and discussion with several clinicians who commented on the RTEPS items. As a result of the development process, the final RTEPS scale comprised 10 items in the three domains: assessment (3 items), treatment (3 items), and affect tolerance (4 items).

The respondent is asked to rate each item on a 5-point scale (0 = *completely disagree*; 1 = *disagree*; 2 = *neither agree, nor disagree*; 3 = *agree*; 4 = *completely agree*). All items of the RTEPS are presented in Annex 1. The coding of the affect tolerance items is reversed. The final score of the RTEPS scale is the sum of all items, ranging from 0 to 40. A higher score of the scale indicates higher perceived readiness to work with trauma-exposed patients in clinical practice.

The Patient Health Questionnaire-4 (PHQ-4)

The PHQ-4 (Kroenke et al., 2009; Löwe et al., 2010), composed of four items from the widely used PHQ-9 and GAD-7 scales, was used to measure anxiety and depression in mental health professionals. The PHQ-4 scale comprises two subscales of anxiety (2 items) and depression (2 items). Each item is measured with a 4-point scale (0 = *not at all*; 1 = *several days*,

2 = *more than half the days*; 3 = *nearly every day*). The PHQ-4 has good psychometric characteristics in the general population (Löwe et al., 2010). The results of our study indicated an acceptable internal consistency of the PHQ-4, Cronbach α was .71. The inter-correlations between the two items for anxiety and depression subscales were $r = .55, p < .001$ and $r = .36, p < .001$, respectively.

Previous Training

Study participants were asked about their previous training experience in PTSD assessment or treatment with two items using binary ‘Yes/No’ responses to the following questions: “Have you ever participated in any trauma and PTSD assessment training course?”, and “Have you ever participated in any PTSD treatment training course?”.

Exposure to Trauma and PTSD in Clinical Practice

The participants provided information about the frequency of seeing trauma-exposed and PTSD patients in their daily clinical practice by responding to the two questions: “How often have you seen trauma-exposed clients in your daily clinical practice?”, and “How often have you seen clients with PTSD in your daily clinical practice?”. The 5-point scale was used to evaluate the responses to these items (1 = *never*; 2 = *rarely*; 3 = *sometimes*; 4 = *often*; 5 = *very often*).

Data Analysis

To collect the evidence of the validity of the RTEPS scale we performed several statistical procedures. First, the evidence of validity based on internal structure (AERA, APA, & NCME, 2014) was gathered by conducting exploratory structural equation modeling (ESEM) of the RTEPS using the robust maximum likelihood estimator with GEOMIN rotation (see Annex 2). ESEM is a superior statistical analysis compared to confirmatory factor analysis (CFA) or exploratory factor analysis (EFA) because it combines both features of CFA and EFA (Kline,

2011). We tested single-factor, two-factor, three-factor, and four-factor models to identify the best factor structure of the RTEPS. For the information's sake, we performed CFA (see Annex 3) for the optimal factor structure of the RTEPS, which was identified using ESEM. The model fit was indicated using statistics such as the chi-square test, the root mean square error of approximation (RMSEA), the comparative fit index (CFI), and the Tucker-Lewis fit index (TLI), the standardized root mean square residual (SRMR). A non-significant chi-square, the CFI and TLI values higher than 0.90, RMSEA values below 0.08, and values of SRMR lower than 0.08 indicate a good fit of the model (Kline, 2011). ESEM and CFA were performed using the Mplus 8.2 version (Muthén & Muthén, 2017). To compare the model fit, we evaluated the difference between the values of CFI and RMSEA. The model fit differ significantly if $\Delta\text{CFI} > .1$ and $\Delta\text{RMSEA} > .15$. The data file did not contain any missing values.

Further, we conducted a two-way analysis of covariance (ANCOVA) with two covariates aimed to collect the evidence of validity based on the relations to other variables. A two-way ANCOVA was used to test an interaction effect between two independent variables on a continuous dependent variable by controlling for one or more continuous covariates. In this case, we analyzed the interaction effect between mental health professionals' work experience and their participation in the PTSD assessment or treatment training course on the mean score of the RTEPS after controlling for professionals' mental health, i.e., depression and anxiety rates. The variable of participation in the previous trauma training was computed into a dichotomous variable (Yes/No), indicating whether the respondents participated in any kind of previous PTSD assessment or treatment training. The results of statistical analysis, in general, indicated no violations of assumptions regarding linearity, homogeneity of regression slopes, homogeneity of variance, outliers, and normality for the ANCOVA analysis of the RTEPS. Specifically, a linear

relationship was observed between both covariates and the mean score of the RTEPS for each group regarding the experience of the professional practice of mental health specialists and their previous participation in the PTSD assessment or training indicated by visual representation. The assumption of homogeneity of regression slopes was also met regarding both covariates, i.e., anxiety ($F(5, 287) = 0.323, p = .899$), and depression ($F(5, 267) = 0.396, p = .851$). The homogeneity of variances within groups was also observed since the statistics of Levene's test of homogeneity of variance was found to be statistically insignificant, $F(5, 273) = 1.596, p = .161$. We found two outliers in the data; however, we did not remove the cases since it did not change the main findings of ANCOVA. Finally, standardized residuals of the RTEPS were normally distributed within the groups ($p > .05$), except for one group in which Shapiro-Wilk's test was statistically significant, $p = .017$. The calculation of descriptive statistics and two-way ANCOVA was conducted with IBM SPSS Statistics 25.

Results

Evidence of Validity Based on the Internal Structure of the RTEPS

The model fit indices for the single-, two-, and three-factor model of the RTEPS are presented in Table 2. The four-factor model did not converge. The results of ESEM indicated that the three-factor model had the best fit in comparison with a single- or two-factor model solution, $\Delta CFI = .76$ and $\Delta RMSEA = .04$. Moreover, the results of ESEM indicated that a single-factor or two-factor model had a non-acceptable fit regarding RMSEA and TLI values. All factor loadings were higher than .4, $p < .001$ in ESEM (see Table 3) and higher than .5, $p < .001$ in CFA. We labeled three latent factors as *assessment*, *treatment*, and *affect tolerance*. The correlation coefficients between the latent factors ranged from .21 to .54, $p < .001$.

< Table 2 about here >

Good internal consistency of the RTEPS measured with Cronbach's α (.80) was found of the overall scale and acceptable for the assessment, treatment, and affect tolerance subscales with alphas of .67, .79, .75, respectively. The average score of the total RTEPS scale was 21.21 ($SD = 4.70$), ranging from 2 to 33. The means for the competency of assessment, treatment, and affect tolerance subscales were 1.88 ($SD = 0.59$), 1.70 ($SD = 0.65$), and 2.56 ($SD = 0.62$), respectively.

< Table 3 about here >

The Predictors of Perceived Readiness to Work with Trauma-Exposed Patients

The results of a two-way ANCOVA did not indicate a statistically significant two-way interaction between mental health professionals' work experience and their participation in the previous PTSD assessment or treatment training, while controlling for depression and anxiety, $F(2, 2871) = 0.683, p = .506$, partial $\eta^2 = .005$ (Figure 1). However, we found a statistically significant main effect of previous trauma care training experience on perceived readiness to work with trauma-exposed patients, $F(1, 271) = 9.584, p = .002$, partial $\eta^2 = .034$, meaning that those mental health professionals who reported experience of PTSD assessment or treatment training in the past perceived themselves as more ready to work with trauma-exposed patients, compared to those who had none previous trauma care training. A statistically significant main effect of work experience to perceived readiness to work with trauma-exposed patients was not detected, $F(2, 271) = 0.719, p = .488$, partial $\eta^2 = .005$. As already noted, these findings were adjusted for mental health professionals' depression and anxiety rates which had a statistically

significant or marginally significant main effect to perceived readiness to work with trauma-exposed patients, $F(1, 271) = 4.196, p = .041$, partial $\eta^2 = .015$ and $F(1, 271) = 3.744, p = .054$, partial $\eta^2 = .014$, respectively.

Discussion

This was one of the first studies which aimed to test a novel measure of the trauma care competencies in mental health professionals. We provided the evidence of validity based on content, internal structure, and relations to other variables, which confirm the RTEPS scale to be an appropriate measurement tool to evaluate a mental health professionals' perceived readiness to work with trauma-exposed patients. Furthermore, we found that previous training experience, but not professional experience, was significantly associated with perceived readiness to work with trauma-exposed patients while controlling for the rates of depression and anxiety of mental health specialists.

The study revealed that previous PTSD assessment or treatment training, but not professional experience, was significantly associated with perceived readiness to work with trauma-exposed patients. Research and practice show that specific therapies with a focus on traumatic experiences are the most effective in PTSD treatment (Schnyder et al., 2015). The results confirm that competencies in the assessment and treatment of trauma-related disorders have to be specific, and learning from clinical practice is not enough. Thus, lack of training could potentially result in misdiagnosis and mistreatment of PTSD in the clinical setting (Cook et al., 2019).

In line with previous studies of mental health professionals, the current study found that most of clinicians often see trauma-exposed people and patients with PTSD in their clinical

practice (Evans et al., 2013; Reed et al., 2012). Furthermore, around two-thirds of the mental health professionals in the sample reported they had no previous training in either PTSD assessment or treatment. It was rather surprising considering the rapid developments of evidence-based treatments for PTSD and increasing access to training of trauma-focused treatments in Europe (Schafer et al., 2018). The study was conducted in a training setting so the lack of training could be attributed to the motivation of the sample to seek training due to the lack of competencies in trauma care.

A short self-report scale evaluating perceived readiness to work with trauma patients is a helpful tool that could be used in clinical and educational settings. As the need for trauma-informed care is growing in various contexts, it might be relevant to assess readiness to work with trauma-exposed patients. The proposed measure can be employed for quick screening, which could help to identify needs for any additional training in psychotraumatology. The RTEPS could also be used for the evaluation of psychotraumatology training programs and training outcomes. Therefore, the proposed RTEPS scale can serve as an indicator of how the specialists are self-confident in their provided trauma-focused care and estimate clinicians' willingness to recognize and treat trauma-related disorders in their clinical practice.

PTSD is a unique mental health disorder as it develops following extremely threatening or horrific events (Bisson et al., 2015). Trauma exposed clients typically experience high anxiety and fear during the confrontation with the traumatic experiences in trauma assessment and treatment (Jaycox & Foa, 1996). Thus, the capacity of a clinician for tolerance for intense affect and trauma-related content is one of the trauma-focused competencies (Cook et al., 2019) that could act as a protective factor to avoid secondary traumatic stress (Sodeke-Gregson et al., 2013). The RTEPS scale also takes into account this aspect of tolerance of strong emotions in

trauma-focused assessment and treatments. With the mental state of the participants adjusted, in the current analysis, we found tolerance of emotionally charged trauma-related content to be an integrative part of readiness to work with trauma-exposed patients.

There are several limitations of the current study that should be addressed. While we found good psychometric properties of the RTEPS, the current study was cross-sectional, and we did not test changes of the RTEPS scores, a test-retest, and their stability in time. Further longitudinal studies should test changes of the RTEPS scores over time, preferably before and after the training to estimate sensitivity for change of the RTEPS. Moreover, the proposed novel measure is based on self-report and, while easily administered, has limitations as the validity of the measure can be compromised by the respondent. It is important to note that the study was conducted in a specific cultural context in Lithuania. Healthcare in Lithuania, similarly to other European Union countries, is of generally high quality, there is a wide network of healthcare institutions across the country, including access to mental health services. However, specific country-related peculiarities might be important for our study outcomes, such as previously reported huge lack of recognition of PTSD in national healthcare (Kazlauskas et al., 2017). Over the two decades, there has been significant progress in trauma research and treatment training in the country and Europe (Kazlauskas & Grigutyte, 2020; Kazlauskas & Zelviene, 2016; Schäfer et al., 2018). Still, the findings of the study should be tested in other countries to obtain more data on the applicability of the RTEPS in different countries. Furthermore, participants of the study included only psychologists and psychiatrists; however, other professionals, such as nurses and social workers, as members of treatment teams, are also exposed to traumatized populations often. It might be relevant to conduct studies with the RTEPS across various groups of professionals. Also, mental health professionals with more diverse work experiences should be

included in future studies. Furthermore, a closer look is needed for the RTEPS Assessment subscale since Cronbach alpha value was lower than .7 in the current study. Future studies could evaluate the internal consistency of the Assessment subscale in groups of mental health specialists in terms of specialty, work experience or training experience. Besides, it is crucial to assess professionals in clinical training which includes trauma-focused treatments, to evaluate how competencies progress over the course of training. Our study shows that not clinical experience but training is more important in building competencies of trauma care.

To sum up, we found promising results on the novel measure of professionals' readiness to work with trauma-exposed patients. Although a brief scale is not enough for the thorough evaluation of the competencies in trauma care, the RTEPS scale is an easily administered and brief instrument that could be used in the context of training or clinical setting. It could be an aid for evaluating the training programs or assessing the need for competency building and professional development.

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Table 1

Characteristics of the study sample (N=279)

Variable	Sample <i>n (%)</i>
Gender	
Male	16 (5.7)
Female	262 (93.9)
Other	1 (0.4)
Age	
Mean (<i>SD</i>)	41.09 (10.68)
Range	24-73
Profession	
Psychologist	254 (91)
Psychiatrist	25 (9)
Professional practice seniority	
<2 years	30 (10.8)
2-10 years	112 (40.1)
>10 years	137 (49.1)
Seeing patients with trauma exposure in professional practice	
Rarely	11 (3.9)
Sometimes	97 (34.8)
Often	171 (61.3)
Seeing patients with PTSD in professional practice	
Never	8 (2.8)
Rarely	88 (31.5)
Sometimes	124 (44.4)
Often	59 (21.1)
Previous training in PTSD assessment and/or treatment	
Yes	90 (32.3)
No	189 (67.7)
Mental health indicators	
Depression, <i>M (SD)</i>	1.54 (0.47)
Anxiety, <i>M (SD)</i>	1.56 (0.53)

Table 2

Model fit indices for the RTEPS using ESEM and CFA (N=279)

Model	$\chi^2(df)$	<i>p</i>	RMSEA [90% CI]	CFI	TLI	SRMR
Single-factor model (ESEM)	298.23 (35)	<.001	.164 [.147-.182]	.680	.589	.109
Two-factor model (ESEM)	110.89 (26)	<.001	.108 [.088-.129]	.897	.821	.049
Three-factor model (ESEM)	40.28 (18)	.002	.067 [.039-.094]	.973	.932	.027
Three-factor model (CFA)	60.12 (32)	.002	.056 [.034; .078]	.966	.952	.039

Note. ESEM = exploratory structural equation modeling, CFA = confirmatory factor analysis, RMSEA = root mean square error of approximation, CI = confidence interval, CFI = comparative fit index, TLI = Tucker-Lewis fit index, SRMR = standardized root mean square residual.

Table 3

Standardized factor loadings for the RTEPS using ESEM and CFA (N=279)

Item	Three-factor CFA	Three-factor ESEM		
		Assessment	Treatment	Affect tolerance
Assessment 1	.607***	.508***	.113	.014
Assessment 2	.824***	.888***	-.005	-.033
Assessment 3	.532***	.481***	.061	.001
Treatment 1	.622***	.224**	.427***	.084
Treatment 2	.845***	-.006	.909***	-.037
Treatment 3	.809***	.093	.733***	.003
Affect tolerance 1	.742***	-.004	.062	.704***
Affect tolerance 2	.574***	-.068	.001	.594***
Affect tolerance 3	.600***	-.046	.065	.583***
Affect tolerance 4	.724***	.060	-.096	.766***

Note. *** $p < .001$, ** $p < .01$

Figure 1

The relationships between readiness to work with trauma-exposed patients and professionals' work, and training experience



Annex 1

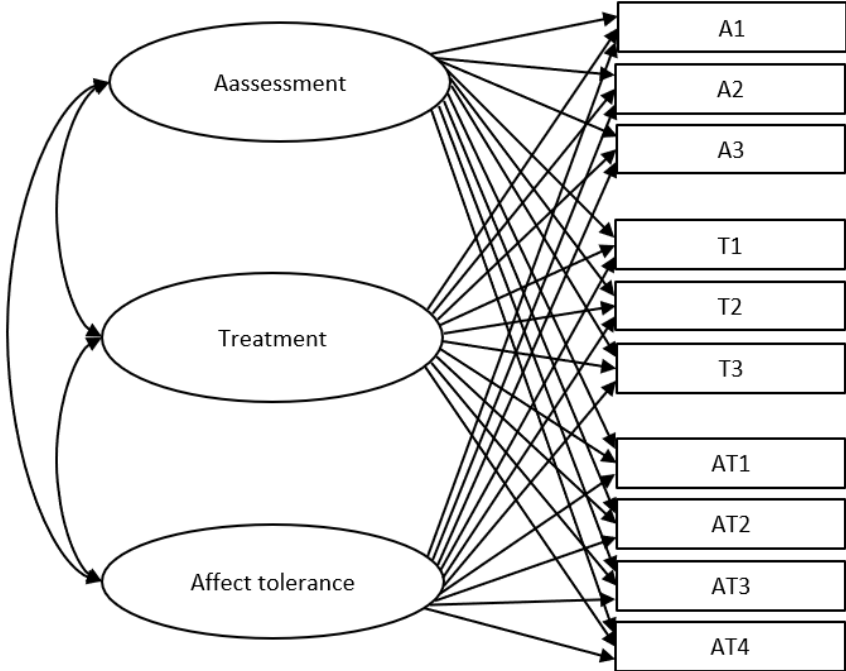
The items of Readiness to Work with Trauma-Exposed Patients Scale (RTEPS)

Subscale	Item
Assessment	I can easily identify whether my client’s experience can be described as traumatic.
	I find it quite easy to identify if my client has posttraumatic stress disorder.
	I know a sufficient number of tools (tests, scales, etc.) which I can use in order to assess the posttraumatic stress of my client.
Treatment	It is likely for me to be aware of how to help clients after identifying their posttraumatic stress symptoms.
	I am quite confident that I have enough knowledge and skills to apply therapeutic methods for traumatized clients with posttraumatic stress disorder.
	I am quite confident that I have enough knowledge and skills to help my clients with complex posttraumatic stress that is associated with severe or prolonged traumatization.
Affect tolerance	Talking with my clients about their traumatic experiences is very difficult for me ^R
	Talking with my clients about their traumatic experiences is upsetting and troubling ^R
	Talking with my clients about their traumatic experiences is eliciting hopelessness and helplessness in me ^R
	I find it hard to cope with my clients’ strong emotions, triggered by talking about their traumatic experiences ^R

Note. R = reversed item scoring

Annex 2

The schematic representation of the tested RTEPS exploratory structural equation model



Annex 3

The schematic representation of the tested RTEPS confirmatory factor analysis model

