A controlled study into the (cognitive) effects of exposure treatment on trauma therapists

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Abstract

Several researchers have reported on therapists’ symptoms as a result of trauma treatment, such as disruptions in cognitive schemata and symptoms resembling PTSD-symptoms. Thus far, however, no studies compared the symptoms of trauma therapists and non-trauma therapists. In the present study, both trauma therapists (n = 20) and non-trauma therapists (n = 19) were included. During semi-structured interviews, both therapist groups reported negative and positive effects of their work with patients on their personal and professional functioning. Trauma therapists reported more often changes of cognitions due to trauma work. Results from questionnaires, however, showed that compared with norm-standards and compared with non-trauma therapists, trauma therapists did not show enhanced psychopathology nor distorted cognitive schemata. It is concluded that although exposure treatments with trauma patients are associated with therapists’ distress, therapists seem able to cope with it in a healthy way. © 2001 Elsevier Science Ltd. All rights reserved.

1. Introduction

Several controlled studies have demonstrated that exposure techniques are effective in the treatment of patients with PTSD (Foa et al., 1999; Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998; Tarrier et al., 1999). During the exposure sessions the patient is repeatedly asked to describe the traumatic event in detail.

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Most patients find these sessions very distressful, as do the therapists, since they too are exposed to the details of the trauma.

In 1974, Haley was the first to report on the intense and overwhelming feelings of fear experienced by the therapists of Vietnam veterans (Haley, 1974). He defined these symptoms as being a result of countertransference. In recent years, it is believed, however, that these symptoms are not the result of the therapist's psychopathology, but are the normal and inevitable result of working with traumatized patients (Wilson & Lindy, 1994). McCann and Pearlman (1990) introduced the concept ‘vicarious traumatization’ to describe the result of empathic engagement with the trauma stories told by patients. Unlike countertransference, vicarious traumatization is not specific to the interaction with one patient, but it refers to the cumulative effect on the therapist resulting from working with various patients over a period of time.

Disruptions in cognitive schemata may occur as a result of being involved in trauma work: changes in the therapist’s frame of reference, such as changes in his/her view of the world and beliefs about the self and others (safety, intimacy, etc.). Furthermore, some therapists report symptoms resembling PTSD-symptoms, such as nightmares, intrusive thoughts, amnesia, derealization, and somatoform complaints. According to Figley (1995), as a result of their involvement with trauma patients, some therapists may even develop a Secondary Traumatic Stress Disorder (STSD), an adjustment disorder characterized by symptoms identical to PTSD. STSD-symptoms are observed in several groups of professionals, besides trauma therapists, working with traumatized people. These include rape researchers, emergency workers, mental health professionals, counsellors, hospital staff and rescue workers (Alexander et al., 1989; Dyregrov & Mitchell, 1992; Folette, Polusny, & Milbeck, 1994; Genest, Levine, Ramsden, & Swanson, 1990; Lyon, 1993; Pearlman & MacIan, 1995; Raphael & Wilson, 1994; Schauben & Frazier, 1995). Although most authors of articles and textbooks on exposure therapy for PTSD acknowledge the fact that trauma work may be distressful for the therapist (e.g. Foy et al., 1996; Litz & Roemer, 1996; Neumann & Gamble, 1995; Pearlman & Saakvitne, 1995; Richards, Lovell, & Marks, 1994; Wilson & Lindy, 1994), only a few studies have examined empirically the negative effects of trauma work on the therapists. Schauben and Frazier (1995), using structured questionnaires, studied the effects of trauma work on 148 female therapists working with victims of sexual abuse. They found that the more PTSD patients the therapists had in their caseload, the more negative effects (STSD symptoms, disrupted beliefs about their self-concept and less confidence in others) they reported. Therapists who made use of active coping-strategies, like problem-solving, humour and asking for emotional support and advice, showed fewer symptoms than therapists who did not. No relationship was found between the therapists’ previous traumas and the current symptoms. Along with the difficult aspects of their work, the therapists also reported some enjoyable ones, such as watching patients grow and change. Pearlman and MacIan (1995) performed a comparable study on 188 male and female therapists. They found therapists with a personal trauma history to have more disruptions of cognitive schemata and more symptoms, especially when they were inexperienced.
Despite the above studies, some aspects of the effects of trauma work on therapists are still unclear. First, it is unclear whether the negative effects of trauma treatments have been overestimated in previous reports, since no controlled studies including non-trauma therapists have been conducted. In addition, the response rate in the above studies was moderate, in most cases below 50%; the negative effects of trauma work may be overgeneralized at the expense of the positive side-effects of trauma work due to responder bias. Second, the effects of trauma work on the therapist’s professional functioning is seldom questioned. Knowledge of the effects of trauma work could lead to the development of more effective self-care strategies for the therapists, thus providing PTSD patients with the best possible treatment.

In the present study, the effects of therapeutic work on personal functioning and health, effects on professional functioning, changes in cognitions and self-care strategies were compared for trauma and non-trauma therapists, using semi-structured interviews and questionnaires.

2. Method

2.1. Therapists

We randomly selected several institutions and mental health organizations for involvement in this study. Therapists working at the selected institutions were approached by telephone and were kept ignorant of the study’s purpose. They were told that we were conducting a study about personal experiences relating to carrying out psychotherapy in general. We approached 39 therapists. They all agreed to participate, giving a response rate of 100%. Therapists seeing PTSD patients for at least 4 h per week and applying exposure techniques were assigned to the trauma group; therapists without previous experience in trauma work and without PTSD patients in their current caseload were assigned to the non-trauma group.

The trauma group consisted of 8 men and 12 women, with a mean age of 40.5 years (SD 7.8, range 29–54). Their experience in working with trauma victims ranged from 1 to 20 years, with a mean of 8 years. The therapists had a mean of 6.7 h of PTSD treatments a week (range 4–14, SD 3.5). Seven therapists treated predominantly PTSD patients (more than 40% of their caseload).

The non-trauma group consisted of 7 men and 12 women, with a mean age of 39.5 years (SD 9.2, range 24–58). None of them were seeing PTSD patients at the time, and they had no experience with trauma work.

2.2. Interviews

An appointment was made for the face-to-face interview. The interview was semi-structured and the questions had been tested in a pilot study (n = 2). The questions served to gather information relating to the following subjects: (1) the impact of the treatments on the personal and professional functioning of the therapist (e.g. “Do some treatments have an influence on your personal functioning or your professional...
functioning?”), (2) changes in cognitions: (e.g. Do you think differently about the world or yourself as a result of your treatments?, (3) self-care strategies and preventive actions to deal with involvement in difficult accounts (e.g. “Do you take any actions before or during the sessions to cope with the accounts you hear?” and “Do you talk to colleagues about what the patients tell you?”). The interviews lasted an hour, were conducted by graduate psychology students and were audiorecorded. The audiorecords were transcribed verbatim. The transcripts were coded by placing each therapist statement in the most appropriate category. Ten of the 39 tapes (randomly selected) were coded independently by two different raters. Inter-rater agreement (percentage agreement across categories) was 84%.

2.3. Questionnaires

In addition to the interview, the following questionnaires were completed:

The Traumatic Stress Belief Scale (TSI Belief Scale; Pearlman & MacIan, 1994); This scale measures disrupted cognitive schemata that are considered sensitive to traumatic experiences and vicarious traumatization. We used four subscales of the TSI Belief Scale which were considered sensitive to trauma therapy effects: safety (self and others), trust (others) and intimacy (others). Examples of items are: I generally feel safe from danger, I worry a lot about the safety of loved ones, You can’t trust anyone, Sometimes when I’m with people, I feel disconnected. The items were rated by the therapists on 6-point scales (disagree strongly to agree strongly). The World Assumptions Scale (WAS; Janoff-Bulman, 1989) was used to measure basic cognitive assumptions about the world and the self. The 32 items were each rated on a 6-point scale (disagree strongly to agree strongly). The scale consists of three subscales: benevolence of the world, meaningfulness of the world and self worth. Examples of items are: People are naturally unfriendly and unkind, Generally, people get what they deserve in this world, and I am basically a lucky person.

Finally, the Symptom Checklist-90-Revised (SCL-90; Dutch version: Arrindell & Ettema, 1986) total score was used as an indication of general distress and symptoms.

2.4. Analysis

Differences in occurance of the reported effects between trauma and non-trauma therapists during the semi-structured interviews were tested using \( \chi^2 \) tests. With regard to differences on the questionnaires, independent \( t \)-tests were conducted.

3. Results

Table 1 presents an overview of the interview and questionnaire results for trauma and non-trauma therapists. Below, these findings are clarified, and illustrated by quotes of the therapists.
3.1. Effects on personal functioning and health

3.1.1. Subjective reports

Eleven trauma therapists reported PTSD-like symptoms in their personal life, such as (1) re-experiencing: I sometimes get images at home of accounts patients have given me during the day (…) For instance, while I am doing the dishes (…) at moments I’m not really thinking about patients (…) it surprises me; (2) avoidance behaviour: I see and hear enough of people and their misery. I don’t feel like having a lot of social contact. I want to be alone, and watch some soap operas or read a simple book; and/or (3) increased arousal: I am hypervigilant in certain situations. For instance when I’m walking in a forest and I see a stranger coming towards me, I’m more conscious of danger, more alert and cautious than I ever was before. Six of the non-trauma therapists reported comparable symptoms: they sometimes dreamt about their patients or they avoided listening to the personal problems of others on social occasions. The difference in number of therapists reporting PTSD-symptoms in the

### Table 1
Differences between trauma- and non-trauma therapists on both qualitative (number of therapists) and quantitative (mean/SD) data

<table>
<thead>
<tr>
<th></th>
<th>Trauma therapists</th>
<th>Non-Trauma therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( n = 20 )</td>
<td>( n = 19 )</td>
</tr>
<tr>
<td>1. Effects on personal functioning and health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD-symptoms</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Physical complaints</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Marital or sexual problems</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>SCL-90 total score</td>
<td>110.7 (15.5)</td>
<td>108.1 (22.8)</td>
</tr>
<tr>
<td>2. Effects on professional functioning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative effects</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Positive effects</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>3. Cognitive changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative changes</td>
<td>15</td>
<td>2(^{a})</td>
</tr>
<tr>
<td>Positive changes</td>
<td>15</td>
<td>8(^{b})</td>
</tr>
<tr>
<td>TSI belief scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety (self)</td>
<td>1.9 (0.5)</td>
<td>1.9 (0.4)</td>
</tr>
<tr>
<td>Safety (others)</td>
<td>2.1 (0.5)</td>
<td>2.1 (0.5)</td>
</tr>
<tr>
<td>Trust (others)</td>
<td>2.4 (0.4)</td>
<td>2.3 (0.5)</td>
</tr>
<tr>
<td>Intimacy (others)</td>
<td>2.1 (0.5)</td>
<td>2.1 (0.7)</td>
</tr>
<tr>
<td>WAS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benevolence world</td>
<td>34.6 (4.5)</td>
<td>34.9 (4.8)</td>
</tr>
<tr>
<td>Meaningfulness world</td>
<td>36.0 (4.6)</td>
<td>36.0 (7.1)</td>
</tr>
<tr>
<td>Self-worth</td>
<td>53.2 (5.5)</td>
<td>51.3 (6.6)</td>
</tr>
<tr>
<td>4. Self-care strategies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talking with colleagues</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td>Supervision</td>
<td>3</td>
<td>12(^{b,c})</td>
</tr>
</tbody>
</table>

\(^{a}\) \( p < 0.001 \).
\(^{b}\) \( p < 0.05 \).
\(^{c}\) \( p < 0.01 \).
two groups was statistically not significant ($\chi^2(1)=2.17$, ns). In addition, an approximately equal number of trauma therapists ($n=6$) and non-trauma therapists ($n=5$) reported work-related physical complaints, such as headache, tiredness, nausea or trembling ($\chi^2(1)=0.07$, ns).

Six trauma therapists reported marital or sexual problems due to their trauma work; After being confronted with stories of sexual abuse, physical contact disgusts me so much that it feels like I’m locked within myself and can’t be approached by my partner. Or: I cannot appreciate jokes about women and sex anymore. My husband tells them often and they used to make us laugh a lot, but now I get angry, which he doesn’t understand. Two non-trauma therapists also reported marital problems in relation to their work as a therapist. One of them said: My husband blames me for listening to the problems of other people, but not longer listening to his. The difference in occurrence of reported marital or sexual problems was statistically not significant ($\chi^2(1)=2.27$, ns).

3.1.2. Questionnaire reports

On the SCL-90, both groups scored within the normal range when compared to norm scores, and no statistically significant differences could be found between the trauma and non-trauma therapists ($t(37)=0.43$, ns).

3.2. Effects on professional functioning

3.2.1. Subjective reports

Eleven trauma therapists and five non-trauma therapists reported negative effects on their professional functioning ($\chi^2(1)=3.3$, ns). Nine trauma therapists reported that they experienced the exposure sessions with PTSD patients as being more difficult, more emotionally draining, and more tiring than treatment sessions with other patients. These very strong and sincere emotions have a great impact on me. I feel sorry for the patient and I have the feeling I'm torturing him with the treatment. And, when that happens, although I know I'm doing the wrong thing, I sometimes terminate the exposure session. These trauma therapists reported that, for the above-mentioned reasons, they avoided asking for further details of the trauma during the sessions, or prematurely terminated the session, even though they well knew that asking for details is a crucial component of exposure work with trauma victims. The nature of the trauma seems to be related to the degree of burden on the therapists: most trauma therapists experienced traumas involving (sexual) violence or children as the most difficult and interfering. Treatment of the victims of road or domestic accidents is seen by the therapists as less stressful, because no intentional perpetrators are involved. Three of the non-trauma therapists also reported avoidance of asking for details, especially in the case of sexual problems.

Four trauma therapists said that they dissociate at difficult moments. Sometimes patients tell me such horrible things that they get to me and I feel I can be more empathic if I dissociate from their stories during the session. Three trauma therapists and two non-trauma therapists told us they sometimes felt numb: After hearing all those terrible stories, one more scarcely affects you. Four trauma therapists reported that they felt less empathic towards patients with a relatively less shocking story:
With some patients I think: ‘Don’t bore me with your simple problems, you should hear what other people have had to endure’. Several therapists reported that they felt that this numbness and reduction in empathic reaction was a threat to the therapist–patient relationship.

Despite these difficulties, 15 trauma therapists and ten non-trauma therapists saw their work as very fulfilling and satisfactory ($\chi^2(1) = 2.1$, ns). One trauma therapist put it this way: The beautiful side of these treatments is that people feel they can pick up their lives again in spite of all the awful and sad things that they have been through. They feel that the tide can change in their favour and it is a great joy to share that with them. Six trauma therapists reported having had traumatic experiences in their personal lives, and all of them said that these experiences helped them in their work with trauma victims: I feel connected to the victims I treat because of my own personal history. Contributing towards their recovery gives me a kick or It sometimes happens that some stories touch you more because of your own experiences(…). I lost a baby myself, and (…) when it comes up in the treatment, it affects me more than other stories. But I don’t find that difficult; instead, I feel I can make a worthwhile contribution because I know exactly what they are going through. The non-trauma therapists indicated that their work is very fulfilling because they are really able to help people who have serious problems.

3.3. Cognitive changes

3.3.1. Subjective reports

Significantly more trauma therapists ($n = 15$) than non-trauma therapists ($n = 2$) mentioned negative cognitive changes due to their therapeutic work ($\chi^2(1) = 16.5$, $p < 0.001$). Some trauma therapists ($n = 9$) reported being more suspicious: When I see someone—in the train, for instance—I find myself thinking: ‘Maybe you abuse your little daughter’, or: ‘That man over there may seem very nice, but all the while…’. In addition, they said that they were more aware of what could happen to them, and that they had lost their naivety. Two non-trauma therapists reported comparable cognitive changes, such as viewing the world and others more negatively or being more suspicious. Besides negative changes, trauma therapists also reported more positive cognitive changes than non-trauma therapists ($\chi^2(1) = 4.4$, $p < 0.05$); it made them feel better prepared and thus better able to deal with possible incidents in the future.

3.3.2. Questionnaire reports

With regard to the questionnaires, therapists in both groups scored within the normal range on the TSI Belief Scale when compared with norm scores as established by McCann and Pearlman (1990). No significant differences were found between the trauma therapists and the non-trauma therapists on either the TSI Belief Scale (safety self: $t (37) = 0.40$, ns; safety others: $t (37) = 0.03$, ns; trust others: $t (37) = 0.10$, ns; intimacy others: $t (37) = 0.14$, ns) or the WAS (benevolence world: $t (37) = 0.42$, ns; meaningfulness world: $t (37) = 0.01$, ns; self-worth: $t (37) = 0.13$, ns).
3.4. Self-care strategies

3.4.1. Subjective reports

All therapists use self-care strategies to protect themselves from the possibly negative effects of their work. Talking with colleagues about the patients—preferably informally—was the most frequently reported. More of the non-trauma therapists ($n = 12$) than the trauma-therapists worked under supervision ($\chi^2(1) = 9.55$, $p < 0.01$). Only three trauma therapists had their work supervised, and, strikingly enough, these were the most experienced trauma therapists. When asked why they did not attend supervision, several trauma therapists reported that they regarded supervision in an official group setting as too unsafe an environment in which to talk about personal problems arising from their work. Other trauma therapists said that they regarded themselves as having enough work experience and were thus no longer in need of supervision, or that supervision was too expensive or too time-consuming.

Other self-care strategies mentioned by therapists in both groups were: writing their experiences down after sessions, working part time, sports, living outside the working area, talking with friends, and avoiding watching the news on television. The preventive strategies mentioned by the trauma therapists were: the importance of balancing their caseload—i.e., not including too many trauma patients in one day—and taking breaks between patients.

4. Discussion

Nearly all trauma therapists reported some effects of trauma work on their personal functioning and health. These effects seem similar to the PTSD symptoms of re-experience, avoidance, and increased arousal. These findings are in line with those reported in previous research. However, non-trauma therapists also experienced side effects from their treatments. Based on the interviews, no significant differences in personal functioning and health were found between the two groups. Also on the symptom checklist, both groups scored within the normal range when compared to norm scores, and no significant differences could be found between the trauma and non-trauma therapists.

With regard to professional functioning, more than 50% of the trauma therapists said that they find the trauma sessions difficult and that they avoid or dissociate during the sessions, or experience feelings of numbness. These are, again, symptoms or strategies often reported by trauma victims. However, similar symptoms were reported by therapists not working with trauma victims, indicating that these symptoms may be relatively common when working with patients.

Strikingly, during the interviews, far more trauma therapists than non-trauma therapists reported that, as a consequence of their trauma work, they think differently about the world, other people or themselves on issues such as safety, trust and intimacy. On the questionnaires, however, we could not find any difference
between the trauma and non-trauma therapists with regard to cognitions. In addition, all therapists seemed to have ‘healthy’ cognitions when compared to normscores. One explanation for the discrepancy between the results from the interviews and the questionnaires is that changes in cognitions in itself are not per definition pathologic. Instead, changes in cognitions are part of the natural process of overcoming stressful events. It seems that trauma therapists were able to assimilate the traumatic accounts related by patients into their cognitive schemata, or adequately accommodate their cognitions to the stories (Resick & Schnicke, 1993). In other words, trauma therapists seemed to be able to achieve a healthy adaptation of their cognitions. The fact that trauma therapists did not only report more negative but also more positive cognitive changes may have added to this healthy adaptation.

In conclusion, though during the interviews certain symptoms reported by trauma therapists, such as re-experiencing, avoidance and change in cognitions, resemble PTSD-symptoms, there are no indications, on basis of the severity of these complaints, of secondary stress symptoms. Furthermore, it was found that similar symptoms are experienced by therapists who do not work with trauma victims. These findings implicate that negative effects of trauma work, reported in previous studies, may have been overestimated. Based on the findings of the present study, the impression is that trauma therapists rather seem to healthy adapt to the difficulties they are confronted with in the course of their trauma therapies.

One might argue that trauma therapists who were indeed suffering from secondary stress syndromes, would already have stopped working in this field or were on sick leave, and therefore not represented in a study such as the current one. It would be interesting to see if there was any relationship between the effects of trauma work and figures on burnout and absence from work due to mental illness. The balance between negative and positive side effects may well be of importance in this.

Our conclusion that trauma therapists seem to be relatively healthy and adaptive, may be (partly) due to their use of effective self-care strategies, in order to protect themselves from the negative side effects of their work. Talking with other colleagues in an informal setting is the one most frequently mentioned. With regard to supervision, however, we found that significantly more non-trauma therapists than trauma therapists worked under supervision. Although discussing problems with others is considered very important, it is also deemed surprisingly difficult for trauma therapists. Several therapists seemed to be ashamed of doing so, because of cognitions such as ‘I’m a professional, I should be able to cope with it’ or ‘If I suffer from complaints, that shows that I’m incompetent’. There is consensus in the literature that supervision is of great importance for therapists, especially for trauma therapists (Foy et al., 1996; Litz & Roemer, 1996; Pearlman & Saakvitne, 1995; Richards et al., 1994; Schauben & Frazier, 1995), regardless of their years of experience in the field.

As another self-care strategy, some therapists mentioned the importance of balancing their caseload. More so than in other disorders, therapists working in the
trauma field tend to specialize in trauma treatment (Schauben & Frazier, 1995). Given our and previous research results, however, it would be wiser for therapists to balance out their caseload with other patients. Several other self-care strategies were mentioned by the therapists, and they appeared to be rather creative when experimenting with these. This is as it should be, since self-care is a very personal issue and what works for one therapist will not necessarily work for another. The present study would seem to indicate that there is no need to create specific debriefing activities for trauma-therapists. Indeed, this is supported by the fact that there is scant empirical evidence that such interventions prevent psychopathology following trauma (Bisson, Jenkins, Alexander, & Bannister, 1997; Hobbs, Mayou, & Harrison, 1996), and they may even have adverse effects.

The design and procedure of this study made it possible to clarify some important issues with regard to secondary traumatization. In the first place, by including a control group of non-trauma workers, the effects of trauma therapy could be compared with those of non-trauma therapies. Second, by approaching therapists personally, we achieved a 100% response rate, which minimalized the chance of a selective bias in responders. Lastly, by combining both qualitative and quantitative methods, we were able to both get more insights into the therapists’ subjective experiences, and, at the same time, relate those answers to objective standards.

On the other hand, however, this study had some limitations. In the first place, it was very difficult to make up a ‘pure’ control group, since most therapists, whether or not they specialize in trauma work, are confronted by traumatic stories told by patients. Another limitation is that the groups were relatively small, which limits the generalizability of the conclusions. Furthermore, the interview findings were sometimes hard to interpret, because interviewers did not always confine themselves to the set questions.

Despite these limitations, we may conclude that trauma therapists did not seem to have more severe problems or symptoms than non-trauma therapists, which is consistent with Mahoney’s findings (1997) that psychotherapists are, in general, more healthy than previous research suggests, and that symptoms are reported regardless of their background, theoretical framework or specialization. However, despite our conclusion that trauma therapists seem to be more healthy and adaptive than has been suggested in previous studies, it would be simplistic to deny the possible negative side effects of trauma work. It seems important, therefore, that both trauma therapists and all other therapists be aware of the possible negative side effects of working in this profession and that they employ self-care strategies in order to prevent them. We hope that this article will make therapists aware of the need to take their own well-being into account and that it will stimulate open communication between colleagues.

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References


