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What Psychotherapists Have to Teach Us About Childhood Developmental Trauma: The Roles of Attachment Orientation and Coping Strategy

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THE GRADUATE COLLEGE
WESTERN MICHIGAN UNIVERSITY
KALAMAZOO, MICHIGAN

Date May 21, 2012

WE HEREBY APPROVE THE DISSERTATION SUBMITTED BY

Rebecca Klott

ENTITLED WHAT PSYCHOTHERAPISTS HAVE TO TEACH US ABOUT CHILDHOOD DEVELOPMENTAL TRAUMA: THE ROLES OF ATTACHMENT ORIENTATION AND COPING STRATEGY

AS PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE

DEGREE OF Doctor of Philosophy

Counselor Education and Counseling Psychology (Department)

Counseling Psychology (Program)

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APPROVED

Date August 28, 2012

Dean of The Graduate College
Psychotherapists have been found to have higher rates of childhood developmental trauma when compared to non-clinicians, yet they do not report more distress. The current study added to the literature regarding the experiences of psychotherapists and explored a theoretical model integrating attachment and coping as mediators for the relationship between childhood developmental trauma and psychological distress among psychotherapists.

A total of 130 masters’ level psychologists participated in this study. These participants were asked to complete the following measures: The Child Abuse and Trauma Scale (Sanders & Becker-Lauser, 1995), the Ways of Coping-Revised (Folkman & Lazarus, 1985; Folkman, Lazarus, Denkel-Schetter, DeLongis, & Gruen, 1986), the Brief COPE (Carver, 1997), the Experiences in Close Relationships-Revised (Fraley, Waller, & Brennan, 2000), the Brief Symptom Inventory (Derogatis & Melisaratos, 1983), and a demographic survey.

Descriptive statistics, correlations, and path analyses were employed to investigate the variables of childhood developmental trauma, attachment, coping, and
distress. Participants reported higher levels of childhood developmental trauma than did normed samples, were more likely to use problem-focused coping over emotion-focused coping when encountering work-related stressors, and were not significantly more distressed than were non-patient normed samples. However, the participants had higher levels of both attachment anxiety and avoidance than did the normed samples. Finally, an exploratory path analysis model in which childhood developmental trauma's effects on distress were hypothesized to be all indirect through the variables of anxious attachment and emotion-focused coping was found to be plausible. Findings were discussed and suggestions for future research were made.
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Rebecca Klott
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CHAPTER I

STATEMENT OF THE PROBLEM

Introduction

Many people have experienced childhood developmental trauma in the form of physical, sexual, emotional abuse, and/or neglect. Multiple studies have established that such experiences are not rare. For example, in a survey of United States’ citizens, Briere and Elliot (2003) found that as many as 14% of men and 32% of the women surveyed had experienced childhood sexual abuse and over one in five had experienced physical abuse during childhood. Furthermore, in another national survey, Felitti et al. (1998) found that over 10% of adults reported having experienced physical abuse during childhood, 22% reported having been sexually abused, and 10% surveyed had experienced emotional abuse. Furthermore, Dong et al. (2004) described that exposure to one type of childhood developmental trauma significantly increases the likelihood of exposure to another type.

During the past two decades, researchers have found that individuals who experienced trauma during childhood in the form of physical, sexual, emotional abuse, and/or neglect are more likely to experience difficulties in adulthood when compared to other groups. For instance, when compared to individuals with no history of childhood developmental trauma, individuals with such a history have been found to experience higher incidences of depressive disorders, somatic problems, substance abuse, and suicidal behaviors during adulthood (Anda, et al., 2006; Joiner, et al., 2007; Springer, Sheridan, Kuo, & Carnes, 2007; Widom, DuMont, & Czaja, 2007). They also have more interpersonal relationship problems (Crawford & Wright, 2007) and higher incidences of
being diagnosed with borderline personality disorder (Widom, Czaja, & Paris, 2009) than individuals without a history of childhood developmental trauma.

When studying the long-term impact of childhood developmental trauma, researchers have examined a variety of populations, such as children in residential settings, adolescents, and college students. One population, in particular, has demonstrated interesting outcomes with regard to the influence such a history has on psychological distress in adulthood. Psychotherapists, like individuals from the general population, appear to have a high incidence of childhood developmental trauma. In fact, some researchers have found childhood developmental trauma to be a more frequent experience for psychotherapists than it is for individuals from the general population (Elliot & Guy, 1993; Follette, Polunsky, & Milbeck, 1994; Radeke & Mahoney, 2000).

Those researchers that have found a higher incidence of childhood developmental trauma among psychotherapists have also found that despite this history, psychotherapists report less distress than individuals from the general population. For example, Elliot and Guy (1993) found that while the psychotherapists they surveyed had significantly higher reports of childhood developmental trauma than other professionals such as lawyers and doctors, they reported less anxiety, depression, sleep problems, and less impairment in interpersonal relationships. In another example, Radeke and Mahoney (2000) found that while the psychotherapists they surveyed had reported more incidents of childhood developmental trauma than did research psychologists, they were more likely to report feeling happy and satisfied with their lives. Finally, Follette, Polunsky, and Milbeck (1994) found that psychotherapists had higher rates of childhood developmental trauma than law enforcement professionals but reported less distress. Based on these findings,
one might conclude that psychotherapists are better capable of handling childhood developmental trauma than are individuals from other populations.

Despite the findings that psychotherapists have higher rates of childhood developmental trauma but report less distress, remarkably few researchers have investigated this population. In spite of a thorough review of the literature, I found few published research articles examining the experience of psychotherapists and childhood developmental trauma. Furthermore, there is a lack of clarity regarding the findings of these previous studies. For example, there is a significant difference in the percentage of endorsed childhood developmental trauma among psychotherapists. For example, Nuttall and Jackson (1994) found only 13% of psychotherapists they studied had experienced childhood developmental trauma, while Racusin, Abramowitz, and Winter (1981) found as many as 50% of their participants endorsed the experience of childhood developmental trauma. It appears that one possible reason for such a range may be that childhood developmental trauma was not consistently or empirically measured. Furthermore, there has been a lack of a theoretical framework explaining the experience of distress among psychotherapists.

**Purpose of Study**

Further investigation is needed into the experiences of psychotherapists. If they do indeed experience more childhood developmental trauma, psychotherapists may have some important lessons to teach us regarding the experience of distress after such experiences. Investigating the reasons that psychotherapists may experience less distress after childhood developmental trauma could help inform researchers and clinicians who work with survivors. Surprisingly, there have been remarkably few investigations of this
population. The first purpose of the current study was to add to the limited literature regarding psychotherapists’ experiences of childhood developmental trauma. In order to have a clearer understanding of the experiences of psychotherapists, I surveyed master’s level psychologists regarding their experience of childhood trauma, their adult attachment orientations, the types of coping strategies they use when faced with stressors, and their experience of psychological distress. Such information offers depth of understanding about this understudied population to the general literature and could potentially impact on the training and supervision of future psychotherapists.

The second purpose of this study was to explore distress among psychotherapists through a theoretical lens. The theoretical view I proposed integrated both attachment and coping theories into the broader research regarding the experiences of childhood developmental trauma and current psychological distress. It was my belief that these theories could potentially offer a fuller understanding of the experience of psychological distress among psychotherapists than has been gained by focusing solely on whether an individual has experienced childhood developmental trauma.

**Need for a Theoretical Framework**

Precious little is known about the reasons that psychotherapists, in some studies (e.g., Elliot & Guy, 1993), appear to experience less psychological distress than individuals in the general population. Some have suggested the training and professional experiences of psychotherapists contribute to their lowered experience of psychological distress. For example, after finding that the psychotherapists in their study were less distressed than their participants from other professions, Elliot and Guy theorized that the personal therapy and the training experienced by psychotherapists may allow them to
form a type of resiliency to the trauma. Similar to this, Radeke and Mahoney (2000) theorized, post hoc, that psychotherapists may have an acceleration and amplification of the developmental process because of the type of work they do with clients. They wondered if the act of working with individuals’ emotional and psychological pain on a daily basis might speed up the developmental trajectory and cause psychotherapists to gain a deeper understanding of and resiliency to their own psychological pain. While these explanations make intuitive sense and offer potential clarification regarding the lack of psychological distress among psychotherapists, a better understanding might be obtained through the use of a theoretical framework.

**Attachment Theory**

Attachment theory offers a useful framework for understanding individual differences in the experience of psychological distress (Obnibene & Collins, 1998; Shapiro & Levendosky, 1999). Attachment scholars (Bowlby, 1988; O'Connor & Elklit, 2008; Shapiro & Levendosky, 1999) have suggested that the long-term impact of childhood developmental trauma may be better understood in the context of attachment orientation. Some scholars have even suggested that an individual’s attachment orientation will influence the long-term functioning of individuals who experienced childhood developmental trauma (e.g., Alexander, 1992; Aspelmeier, Elliot, & Smith, 2007; Higgins, 2003; Muller, Sicoli, & Lemieux, 2000). In the current study, I hope to add to the research examining the role attachment orientation plays in the experience of psychological distress among psychotherapists. I believe that by applying an attachment lens, a deeper understanding can be gained concerning the factors that contribute to psychotherapists’ experience of psychological distress.
According to attachment theory, individuals form internal working models, or mental representations, of attachment figures through repetitive experiences with their primary caregivers during infancy and childhood (Bowlby, 1988). Over time, these internal working models solidify and reflect individuals' general belief about the availability and responsiveness of significant others. Furthermore, these internal working models reflect individuals' sense of self-worth and whether they deserve love. These beliefs about the availability of attachment figures and self as having value become the basis of the development of an attachment orientation. An attachment orientation can be defined as a pattern of expectations, needs, emotions, and behaviors in interpersonal interactions and close relationships (Hazan & Shaver, 1987).

There has been some disagreement among attachment theorists and researchers regarding how to best measure attachment orientation (Obegi & Berant, 2009). Some (e.g., Bartholomew, 1990; Hazan & Shaver, 1987) have viewed attachment orientation as a categorical construct (i.e., secure, fearful-avoidant, preoccupied, and dismissing-avoidant) in which individuals are placed into an attachment category based on their responses on attachment measures. Others suggest that attachment is best conceptualized from a two-dimensional (anxious and avoidant) perspective (e.g., Fraley & Spieker, 2003). When using a dimensional approach, one holds that variation in attachment orientation is largely continuous. Theorists who take a dimensional approach to attachment orientation argue that when people are forced into attachment categories, potentially important information about the way people differ from each other might be lost (Frayley & Phillips, 2009).
For the purposes of this study, I will be using Fraley and Brennan’s (2000) affective-motivational dimensional framework for understanding individual’s attachment orientations. In this model, attachment dimensions are understood as reflecting the variability in functioning of two aspects of the attachment system. The first aspect involves a person’s appraisal of the availability of the attachment figure when feeling vulnerable or threatened. When the person perceives that the attachment figure is not going to be available when the person feels threatened, there is a feeling of anxiety. The amount of variation in a person’s threshold for detecting threats to security is called attachment anxiety (Fraley & Phillips, 2009). The second aspect regulates attachment behavior with regard to the goal individuals have regarding their attachment figures. Thus, an individual may attempt to regulate attachment-related anxiety by orienting his behavior toward his attachment figure or by attempting to withdraw and handle it on his own. The level of difference in this behavioral/motivational aspect is responsible for differences in the attachment related avoidance. An individual’s attachment orientation can be described as the linear combination of the two dimensions of anxiety and avoidance (Fraley & Phillips).

Bowlby (1973, 1988) theorized that an individual’s attachment orientation would influence his experience of distress. There has been some empirical support for this theory, particularly regarding anxiously attached individuals. Multiple researchers have found that anxiously attached individuals report significantly higher levels of psychological distress than do individuals with secure attachment orientations (Bifulco, Moran, Ball, & Bernazzani, 2002; Lopez & Gormley, 2002; Lopez, Mauricio, Gormley, Simko, & Berger, 2001; Vogel & Wei, 2005). Based on these findings one may conclude
that an individual’s attachment orientation would influence the resiliency or ability to cope with adversity.

Researchers have examined the influence of attachment orientation on the functioning of various populations. Psychotherapists, however, remain understudied. The investigation into the attachment orientations of psychotherapists is relatively new. Investigators who have examined this population have focused on how psychotherapists' attachment orientations may influence clinical practice. For example, there has been some investigation into how attachment orientations of psychotherapists impact on therapeutic working alliance (Dinger, Strack, Sachssshe & Schauenburg, 2009; Dunkle & Friedlander 1996; Ligiero & Gelso, 2002; Sauer, Lopez, & Gormley, 2003). In general, these studies have found that psychotherapists’ attachment insecurity seems to hinder the formulation of a good working alliance. For example, Sauer, Lopez, and Gormley found that while anxiously attached psychotherapists initially had significantly positive client-rated working alliance scores, they had significantly negative client working alliance ratings over time. Some researchers have also found that psychotherapists’ attachment orientations may impact the quality of their psychotherapeutic interventions (Dozier, Cue, & Barnett, 1994; Ligiero & Gelso, 2002). For example, Rubino, Barker, Roth, and Fearon (2000) found that anxiously attached psychotherapists were significantly less empathic in their responses to clients, particularly when working with clients who had secure attachment orientations.

When measuring the attachment orientations of psychotherapists, researchers have found that psychotherapists generally rate themselves as “securely attached”. For example Dinger, Strack, Sachssshe and Schauenburg (2009) found that over half of the
participants in their study had secure attachment. Furthermore, 90% of Ligiero and Gelso’s (2002) sample rated themselves as securely attached. Researchers have not examined the attachment orientations of therapists in comparison to non-clinician samples, however.

While researchers have tied attachment orientation to the clinical practices of psychotherapists, they have not examined attachment orientations in relation to psychotherapists’ psychological distress. In the current study, I aimed to extend the research on attachment orientations of psychotherapists. I also intended to offer a theoretical framework for the experience of psychological distress in this population. Psychotherapists’ attachment orientation was one of the elements of that theoretical model.

**Coping Theory**

While attachment theory offers a process framework for understanding how psychotherapists’ interpersonal relationships impact their current psychological distress, it may not fully explain this relationship. The ways in which an individual copes with stressful events may also play an important role in the amount of psychological distress experienced. Coping has been defined as the cognitive and behavioral efforts individuals use to manage negative or stressful situations (Lazarus & Folkman, 1984). Lazarus and Folkman identified two predominant coping strategies: emotion-focused and problem-focused. When an individual uses emotion-focused coping, behaviors are oriented toward changing emotional responses to a situation. Alternatively, when one uses problem-focused coping, behaviors are focused on changing the situation that is causing the distress. Emotion-focused coping has been associated with more psychological
distress while problem-focused coping has been associated with less distress (Ben-Zur, 2005; Brand & Alexander, 2003; Gibson & Leitenberg, 2001; Littleton, Horsley, John & Nelson, 2007).

Other theorists have criticized Lazarus and Folkman's (1984) model of coping as too simplistic. For example, Carver, Scheier, and Weintraub (1989) argued that the problem-focused/emotion-focused distinction is insufficient in describing how individuals deal with stressors and suggested that an overlap exists between the two coping strategies proposed in Lazarus and Folkman's (1984) model. They further noted that different behaviors exist within the problem-focused and emotion-focused factors and that some coping strategies are more functional than others when individuals are faced with stressors. For example, they argued that strategies such as active coping, planning, suppression, restraint, and seeking social support are more adaptive than strategies such as mental and behavioral disengagement, and venting emotions. However, both sets of theorists identified emotion-focused and problem-focused coping strategies. For the purposes of this study, I measured the coping strategies of psychotherapists using both Lazarus and Folkman's and Carver and colleagues' models. I used measures designed by each set of these theorists to describe the coping strategies of psychotherapists.

**Coping and Psychotherapists**

There has been limited investigation into the relationship between the types of coping strategies that psychotherapists use to manage work-related stressors and the level of distress they experience. Those researchers who have investigated this population have found that psychotherapists are more likely to use problem-focused than emotion-focused
strategies (Murtaph & Wollerstheim, 1997). Furthermore, those psychotherapists who use problem-focused coping strategies such as planful problem-solving and strategies that allow them to gain control when working with difficult clients experienced less psychological distress (Murtagh & Wollerstheim, 1997) and more satisfaction with their work (Shapiro, Dorman, Burkey, & Welker, 1999). Conversely, those psychotherapists who engage in more emotion-focused coping such as self-re-evaluation and wishful thinking tend to experience increased stress and their stress lasts longer than psychotherapists who do not engage in these coping strategies (Medeiros & Prochaska, 1988).

**Attachment and Coping**

While theorists have argued that there is a lack of stability in coping over time and across situations (e.g., Lazarus & Folkman, 1984), some have argued that an individual’s attachment orientation impacts on the coping strategy used, providing for some basis of stability (Barker-Collo & Read, 2003; Shapiro & Levendosky, 1999). It is believed that early experiences with attachment figures lead to expectations about future interpersonal interactions which then influences the type of coping strategy used. The type of coping strategy used, in turn, influences how an individual experiences psychological distress (Crittenden, 1992). These scholars have contended that the interactions of attachment orientation and coping strategy may offer a fuller understanding of the experience of psychological distress.

In order to better understand the relationship between these constructs, researchers have examined attachment orientation and type of coping strategy used as they relate to psychological distress (Hawking, Howard, & Oyebode, 2007; Lopez,
Mauricio, Gormley, Simko, & Berger, 2001; Mikulincer & Florian, 1995; Torquati & Vazsonyi, 1999; Wei, Heppner, & Mallinckrodt, 2003). Generally, these researchers have found that individuals who demonstrated anxious or avoidant attachment orientations are more likely than securely attached individuals to use emotion-focused coping strategies when faced with stressors (e.g., Mikulincer & Florian, 1995). Individuals with an anxious or avoidant attachment orientation who used the emotion-focused coping were in turn more likely to report higher levels of psychological distress. Those individuals who used problem-focused coping reported lower levels of distress (Lussier, Sabourin, & Turgeon, 1997).

Taking the research a step further, investigators have approached the constructs of attachment orientation, coping, and current psychological distress using meditational models. Using this approach, researchers have examined how coping may impact on the relationship between attachment orientation and current psychological distress. For example, Wei, Heppner, and Mallinckrodt (2003) found that individual’s perceived use of problem-focused coping strategies fully mediated the relationship between anxious attachment and psychological distress and partially mediated the relationship between avoidant attachment and psychological distress. In another study, Lopez, Mauricio, Gormley, Simko, and Berger, (2001) found that the use of problem-focused coping strategies significantly mediated the relationship between attachment orientation and reported psychological distress. Such findings suggest that both attachment orientation and coping strategies may play important roles in one’s experience of psychological distress.
Formation of Theoretical Framework

Scholars have begun to examine some of the factors that may influence the severity of psychological distress experienced among individuals with a history of childhood developmental trauma (e.g., Barker-Collo & Read, 2003; Crittenden, 1992; Shapiro & Levendosky, 1999; Torquati & Vazsonyi, 1999). These scholars have contended that a fuller understanding of the relationship between childhood developmental trauma and later experience of psychological distress can be gained through the use of a theoretical model. Furthermore, we can potentially gain a richer understanding of those individuals who report less psychological distress despite significant childhood developmental trauma. In this study, I proposed a theoretical model which incorporates attachment orientation and coping strategy. From such a lens, attachment orientation and coping strategies mediate the relationship between childhood developmental trauma and current experience of psychological distress.

Parts of this model have been previously researched. As described earlier, researchers have examined the role attachment orientation plays in the experience of distress (Crittenden, 1992; Lopez & Gormley, 2002; Lopez, Mauricio, Gormley, Simko, & Berger, 2001; Vogel & Wei, 2005). Researchers have also investigated how attachment and coping strategy together may better explain the experience of psychological distress (Hawking, Howard, & Oyebode, 2007; Lopez, Mauricio, Gormley, Simko, & Berger, 2001; Mikulincer & Florian, 1995; Torquati & Vazsonyi, 1999; Wei, Heppner, & Mallinckrodt, 2003). These researchers, however, did not directly examine how attachment and coping may together influence the relationship between childhood developmental trauma and experience of psychological distress.
Finally, other investigators have used both coping and attachment orientations as mediating variables in the relationship between childhood developmental trauma and current psychological distress (Crittenden, 1992; Shapiro & Levendosky, 1999). In this model, the impact of childhood developmental trauma on current psychological distress is influenced by both attachment orientation and coping strategy. For example, Shapiro and Levendosky, when using a structural equation model, found that attachment orientation mediated the relationship between childhood developmental trauma and psychological distress among adolescent females. They also found that the indirect effects of childhood developmental trauma through attachment accounted for most of the effects of coping and psychological distress. Coping strategy also served as mediators in the model. Such findings support the idea that attachment and coping mediate the effects of childhood developmental trauma.

**Hypothesized Psychological Distress Predictor Model**

There were two noteworthy aspects of the current study. First, I developed a predictor model which combined attachment orientation and coping strategy used when stressed. I hoped this model would more fully explain the relationship between childhood developmental trauma and psychological distress than has been gained through solely examining the impact of such a history on adult experience of distress. Second, I examined master's level psychologists, an under-examined set of participants. I intended to expand the knowledge base regarding the prevalence of childhood developmental trauma among this population. As a means of accomplishing this, I studied the experiences of master's level psychologists in the state of Michigan who are currently practicing psychotherapy. This population was selected for several reasons. First,
master's level psychologists were selected instead of doctoral level psychologists because I believed they are more likely to be working primarily as psychotherapists, whereas doctoral level individuals may work in various settings such as academia or research. Second, master's level psychologists were selected because I believed they were less likely to have familiarity with some of the measures used in this study than individuals with a doctoral degree, lowering the likelihood of response bias. Third, psychology professionals were selected over other clinical professionals, such as social workers or counselors, because of their specific, relatively homogeneous training experiences and the universal licensure requirements for master's level psychologists in the state of Michigan.

In order to more fully understand the interrelationship of the experience of childhood developmental trauma, attachment orientation, coping strategy, and current psychological distress, I employed path analysis. Path analysis tests causal models developed from previous research and offers information about the model's adequacy or "fit" related to the data gathered (Klem, 1995). This statistical technique, if used properly, can add valuable information regarding the ways that variables interact (Leclair, 1981). As was proposed in previous studies (e.g., Crittenden, 1992; Shapiro and Levendosky, 1999), the mediator variables included attachment orientation and the types of coping strategies used when faced with a stressor. Attachment orientation was divided into two dimensions: avoidant and anxious. Coping strategy used was divided into two strategies: emotion-focused and problem-focused. The outcome variable in the proposed model was reported psychological distress.
Research Hypotheses/Purpose of Study

In the current study, I examined the following research questions. First, how prevalent is childhood developmental trauma among psychotherapists? Second, what types of coping strategies do psychotherapists use to deal with work-related stressors? Third, what are the average levels of attachment anxiety and attachment avoidance demonstrated among psychotherapists as compared with the norm samples? Fourth, how distressed are psychotherapists in comparison to other individuals? Finally, to what degree do attachment orientation and coping strategy mediate the relationship between childhood developmental trauma and current psychological distress among psychotherapists?

Through the current study, I offered important information for psychotherapists, psychology educators, and supervisors. First, I offered information about an understudied population regarding a sensitive topic. There has been a limited amount of research examining psychotherapists’ experiences with childhood developmental trauma. Such information offers psychology educators and supervisors a better understanding of the experiences of their students and supervisees. It also gives psychotherapists with a history of childhood developmental trauma an understanding that they are not alone in their field.

Second, I added to the limited knowledge base regarding the attachment orientations of psychotherapists. As noted earlier, there has been evidence that psychotherapists’ attachment orientation impacts therapeutic alliance and behaviors in sessions. Yet, there are very few studies examining the attachment orientations of this population. Third, I added to the knowledge base regarding how psychotherapists cope with stressful work situations. As noted earlier, the limited number of studies examining
this construct have found that the type of coping strategy used by psychotherapists impacts the distress they experience. Such information may help educators and supervisors better prepare for the difficulties encountered during professional practice.

Fourth, and most importantly, I offered and evaluated a theoretical framework for the relationship between childhood developmental trauma and current psychological distress among psychotherapists. As previously described, studies (e.g., Elliot & Guy, 1993; Follette, Polunsky, & Milbeck, 1994; Radeke & Mahoney, 2000) have found that psychotherapists experience higher levels of childhood developmental trauma compared to people from the general population. Yet, the psychotherapists in these studies reported less psychological distress. Examining this understudied population through a theoretical lens may offer information regarding protective factors related to childhood developmental trauma. In the current study, I proposed a model in which attachment orientation and coping strategies mediate the relationship between childhood developmental trauma and current psychological distress.

Outline of Hypothesized Interrelationships among Factors

The first broad research question examined the experience of childhood developmental trauma among psychotherapists. Specifically, I was interested in the prevalence of this experience among psychotherapists. In order to gain this information mean scores on a childhood trauma measure were obtained.

Hypothesis 1

It was hypothesized that psychotherapists in the current study would report higher rates of childhood developmental trauma as compared to previously examined non-clinician samples. Previous studies have demonstrated a higher prevalence of childhood
developmental trauma among psychotherapists when compared to non-clinical professionals (Elliot & Guy, 1993; Follette, Polunsy, & Milbeck, 1994; Radeke & Mahoney, 2000).

**Null Hypothesis 1**

Psychotherapists in the current study would not differ in their report of childhood developmental trauma as compared to the existing comparable studies with non-clinician samples.

The second broad question examined the types of coping strategies psychotherapists use when encountering work-related stressors. Specifically, I was interested in whether psychotherapists tend to use more problem-focused or emotion-focused coping strategies when encountering difficult work-related issues.

**Hypothesis 2**

It was hypothesized that psychotherapists in the current study would on average report higher use of problem-focused coping strategies than emotion-focused coping strategies when encountering work-related stressors. Previous studies have demonstrated that psychotherapists tend to use more problem-focused coping strategies when encountering work-related difficulties (e.g., Murtagh & Wollerstheim, 1997).

**Null Hypothesis 2**

Psychotherapists in the current study would report higher or equal rates of the use of emotion-focused over problem-focused coping strategies when encountering work-related stressors.
The third broad question examined the average levels of attachment anxiety and attachment avoidance demonstrated among masters-level psychologists. Specifically, I was interested in the attachment orientations of the psychotherapists in this study.

**Hypothesis 3**

It was hypothesized that the psychotherapists in the current study would, on average, report lower avoidant and anxious dimensions on the attachment measurement when compared to mean responses from previous studies using non-clinicians. Previous studies have demonstrated that psychotherapists, on average, report more “secure” attachment orientations (e.g., Dinger, Strack, Sachsse, & Schauenburg, 2009; Ligiero & Gelso, 2002).

**Null Hypothesis 3a**

Psychotherapists in the current study would, on average, demonstrate higher avoidant or anxious attachment dimensions on the attachment measurement when compared to mean responses from previous studies using non-clinicians.

**Null Hypothesis 3b**

Psychotherapists in the current study would, on average, demonstrate both higher avoidant and higher anxious attachment dimensions on the attachment measurement when compared to mean responses from previous studies using non-clinician samples.

The fourth broad research question examined experience of distress. Specifically, I was interested in the distress levels of psychotherapists in this sample.
Hypothesis 4

It was hypothesized that the psychotherapists in the current study would, on average, report lower levels of distress when compared to mean responses from previous studies using non-clinicians. Previous research indicates that psychotherapists experience less distress than individuals in other professions (e.g., Elliot & Guy, 1993; Follette, Polunsky, & Milbeck, 1994; Radeke & Mahoney, 2000).

Null Hypothesis 4

Psychotherapists in the current study would, on average, report equal to or higher levels of psychological distress when compared to mean responses from previous studies using non-clinician samples.

The fifth research question examined potential factors that may mediate the relationship between childhood developmental trauma and current psychological distress. I was interested specifically in whether attachment orientation and coping strategy mediated the relationship between these two constructs. In order to answer this question, I proposed a theoretical model of the relationships of childhood developmental trauma, attachment orientation, coping strategy, and psychological distress.

As outlined by Klem (1995), path analysis allows researchers to test a theory of causal order among a set of variables. The use of path analysis requires researchers to identify exogenous and endogenous variables. Endogenous variables are affected by one or more variables in the model, while exogenous variables have their values determined by a variable or variables not in the model. In the current model, the exogenous variable is childhood developmental trauma. Childhood developmental trauma was used because of the consistent findings in the literature suggesting that individuals with childhood
developmental trauma are at increased risk of experiencing psychological distress in adulthood (e.g., Anda, et al., 2006; Briere, 1992; Widom, DuMont, & Czaj, 2007).

Endogenous variables included in this model included: (a) anxious attachment orientation, (b) avoidant attachment orientation, (c) emotion-focused coping, (d) problem-focused coping, and (e) current psychological distress. Attachment orientation and coping strategies were included as mediating variables as they have been theorized and empirically found to mediate the relationship between childhood developmental trauma and current psychological distress (e.g., Crittenden, 1992; Shapiro & Levendosky, 1999). Current psychological distress is the outcome variable in this model and is hypothesized to be explained directly and/or indirectly by the predictor variables, anxious attachment orientation, emotion-focused coping strategy, and childhood developmental trauma.

Regarding research question 5, I offer two proposed models. In the first model (Figure 1), childhood developmental trauma was hypothesized to have a direct effect on both types of attachment orientations, both types of coping strategies, and current experience of psychological distress. Childhood trauma was also hypothesized to have an indirect effect on psychological distress through the path of the effects on anxious attachment and emotion-focused coping.

Anxious attachment orientation was hypothesized to have a direct effect on emotion-focused coping and psychological distress. Anxious attachment orientation is also hypothesized to have an indirect effect on psychological distress through its effect on emotion-focused coping. Avoidant attachment orientation is hypothesized to have a direct effect on problem-focused orientation.
In the second proposed model (Figure 2), all of the direct and indirect effects from the first model are also hypothesized. The only difference between the two models is the addition of a hypothesis that childhood developmental trauma directly effects current psychological distress.

Figure 1. Path Analysis Model 1, Hypothesized Indirect Model
Figure 2. Path Analysis Model 2, Hypothesized Direct and Indirect Model

Dissertation Outline

In chapter 1, I offered a broad overview of the theoretical underpinnings that this dissertation draws from, as well as the factors that I hypothesized would influence the current psychological distress of psychotherapists. In order to clarify the possible influences on current psychological distress among psychotherapists, I first examined the proposed theoretical underpinnings used to formulate this study. Specifically, I drew from attachment theory (Bowlby, 1982; Bowlby, 1988) and coping theory (Lazarus & Folkman, 1984). Second, I explored the predictor variables, as well as the outcome variable and described hypotheses for these variables. Third, I outlined the interrelationships among factors for the hypothesized model of current psychological distress among psychotherapists. In Chapter 2, I provide an extended review of the literature regarding the major constructs used in this study. In Chapter 3, I describe the methods that I used in this study, and in Chapter 4, I describe the results of the study.
Finally, in chapter 5, I explore the findings of the current study in relation to the literature, as well as provided implications for the training and supervision of psychotherapists. I conclude this chapter with a description of the limitations of this study.
CHAPTER II

REVIEW OF THE LITERATURE

Introduction

In this chapter I present an investigative review of the relevant literature related to the current study. First, I briefly review the literature regarding the prevalence and impact of childhood developmental trauma for the general population. Second, I explore what is known about the prevalence and impact of childhood developmental trauma among psychotherapists. I, specifically, explore what researchers have found regarding the psychological distress of psychotherapists who have experienced childhood developmental trauma. Third, I review attachment theory. Specifically, I explore how this theory has been used to explain variation in psychological distress. In this section, I also offer an overview of the empirical investigations involving the attachment orientations of psychotherapists. Fourth, I offer a description of coping theory. I describe some of the research findings regarding psychotherapists and coping, as well as the impact of coping strategy on individuals’ psychological distress. Fifth, I briefly discuss the empirical investigations that have used an integrative approach incorporating attachment orientations and coping strategies to understand current levels of psychological distress. Finally, I end this chapter with an argument for an integrative model in which attachment orientation and coping strategies mediate the relationship between psychotherapists’ childhood developmental trauma and their current experience of psychological distress.
Childhood Developmental Trauma

Most individuals will experience some type of traumatic event during their lifetimes. In fact, it has been found that roughly 50-60% of the US population will, at some point, experience some type of trauma (Ozer, Best, Lipsey, & Weiss, 2003). Trauma during childhood development also occurs frequently. For example, Felitti et al. (1998), as part of the Adverse Childhood Experiences (ACE) study based at Kaiser Permanente’s San Diego Health Appraisal Clinic, surveyed over 9500 United States residents regarding their childhood experiences. These researchers found that more than half (52%) of the participants reported some type of adverse childhood exposure and nearly one in four (24.9%) reported having been exposed to multiple types of adverse experiences during childhood development.

Much of the time, trauma experienced in childhood involves abuse within a family in the form of child sexual, physical, and/or emotional abuse or neglect. For example, the U.S. Department of Health and Human Services (2007) estimated having received approximately 3.2 million referrals (para. 10) within a one year period of time. These referrals to Child Protective agencies in the United States involved alleged maltreatment of approximately 5.8 million children by caregivers. Likewise, Briere and Elliot’s (2003) survey of individuals living in the United States found that 14% of males and 32% of females had experienced childhood sexual abuse; 22% of males and 19% of females had experienced childhood physical abuse. These findings emphasize the fact that interpersonal trauma during childhood development occurs to many individuals.
Definition of Childhood Developmental Trauma

Trauma during childhood development can occur in various manners other than abuse and neglect. For example, children are exposed to war, to community violence, and/or the sudden loss of a parent or sibling. While it is believed that all forms of childhood trauma can have a significant impact on individuals, attempting to investigate the multitude of experiences would make studying the prevalence and impact of childhood developmental trauma unwieldy. A myriad of factors are associated with the various types of trauma, making the construct of childhood developmental trauma difficult to define and clearly measure. Therefore, in order to narrow the scope of childhood developmental trauma, in the current study I focus on a particular kind of trauma in childhood. For the purposes of this study, childhood developmental trauma will encompass an individual’s subjective experience of having been sexually, physically, or verbally abused, as well as physically or emotionally neglected, prior to the age of 16. Such an interpersonal definition of childhood developmental trauma was selected because of the documented long-term impact such interpersonal experiences have on individual’s distress levels (e.g., Briere, 1992). I also selected this definition because of the interpersonal nature of psychotherapists’ work.

Impact of Childhood Developmental Trauma

Childhood developmental trauma impacts many individuals long after the negative events have ended. Unlike trauma that occurs during adulthood, when an individual’s personality has already formed, trauma during childhood development has the potential of forming and deforming the personality (Herman, 1992). Childhood developmental trauma, whether it is in the form of physical, emotional, or sexual abuse,
and/or neglect, can potentially leave unchangeable psychological scars because it occurs during the development of the child’s personality. Unlike those exposed to trauma during adulthood, individuals who have traumatic experiences during childhood have no past experience in which to contextualize these traumatic events, and the trauma becomes a part of the fabric of the developing self.

Scholars have theorized about the impact of living in a traumatic environment during one’s childhood. By examining childhood development through a trauma lens, scholars have proposed the potential ways an individual will be changed by such experiences. For example, Herman (1992) posed individuals with trauma during childhood development would likely experience difficulty in a wide variety of areas including self-worth, social relationships, and mood difficulties during adulthood. Furthermore, Van der Kolk, Roth, Pelcovitz, Sunday, and Spinazzola (2005) proposed that trauma during development would influence an individual’s attachment, biology, affect regulation, dissociation, behavioral control, cognition, and self-concept.

The findings of multiple investigators have supported scholars’ assertions that childhood developmental trauma would impact an individual’s well-being in adulthood. For example, Anda, et al. (2006) found that trauma exposure during childhood was correlated to higher incidents of somatic concerns, substance abuse, aggressiveness, memory difficulties, and sexual problems in adulthood. In another example, Joiner, et al. (2006) found that adults with a history of childhood developmental trauma are more likely to attempt suicide than individuals who have no such history. Furthermore, childhood developmental trauma has been found to be positively correlated to adults’ reports of multiple health problems and disabilities due to health concerns (Chartier,
Walker, & Naimark, 2007; Sachs-Ericsson, Kendall-Tackett, & Hernandez, 2007). There has also been evidence of a relationship between childhood developmental trauma and interpersonal functioning in adulthood. Persons with such a history have significantly more difficulties in interpersonal relationships (Colman & Widom, 2004; Crawford & Wright, 2007). Finally, researchers have found that childhood developmental trauma is significantly correlated with affective problems, such as higher rates of depression and anxiety, during adulthood (Anda, et al, 2006; Sachs-Ericsson, et al., 2007; Widom, DuMont, & Czaja, 2007).

**Childhood Developmental Trauma among Psychotherapists**

While scholars have theorized about the impact childhood adversity has on psychotherapists (e.g., Goldberg, 1986; Guy, 1987; Miller, 1997), few researchers have actually examined childhood developmental trauma among this population. Most of the researchers who have studied psychotherapists have found that they generally view their childhoods as highly stressful. Furthermore, psychotherapists are more likely than people from the general population to report trauma during childhood development. Yet, psychotherapists are less likely than individuals from other professions to report psychological distress in adulthood despite this increased report of childhood developmental trauma (e.g., Elliot & Guy, 1993). In this section, I explore what is known about the prevalence of childhood developmental trauma among psychotherapists, as well as explore findings regarding their report of psychological distress.

**Childhood Developmental Trauma, Psychotherapists, and Distress**

It has been said in the scholarly literature that some individuals who choose to become psychotherapists do so because of difficulties in their own childhoods. For
example, Miller (1997) wrote, “The therapist’s sensibility, empathy, responsiveness, and powerful ‘antennae’ indicate that as a child he probably used to fulfill other people’s needs and to repress his own” (p. 19). Other scholars (Rausin, Abramowitz, & Winter, 1981; Sussman, 1992) have suggested psychotherapists may have experienced more psychological pain during childhood than individuals in other professions. These theorists have suggested that such pain during childhood increases the psychotherapists’ awareness of both their own suffering and the suffering of others. The concept of the “wounded healer” has been offered (Goldberg, 1986; Guy, 1987) suggesting that the negative experiences in childhood of some psychotherapists better prepares them to identify with the problems of their clients and to demonstrate a greater degree of empathy. These theorists suggest that there may be a connection between early childhood experiences of trauma and the professional life of psychotherapists.

A few researchers have specifically examined the prevalence of childhood trauma among psychotherapists. These researchers have found that psychotherapists, in fact, do report high levels of childhood developmental trauma (Adams & Riggs, 2008; Elliot & Guy, 1993; Fussell & Bonney, 1990; Nikcevic, Kramolisova-Advani, & Spada, 2007; Nuttall & Jackson, 1994; Plosny & Follette, 1996). For example, Nuttall and Jackson (1994) found that 21% of the 656 psychotherapists who participated in their survey had experienced some type of childhood developmental trauma. In their national survey of 296 psychologists, Pope and Feldman-Summers (1992) found even higher rates (33.1%) of childhood developmental trauma. Furthermore, when compared with individuals from other professions, such as lawyers, physicians, researchers, and individuals in law enforcement, psychotherapists report higher levels of childhood developmental trauma.
Based on the previously noted findings regarding the long-term impacts of childhood developmental trauma, one could hypothesize that psychotherapists would report high levels of psychological distress. Potentially in support of such a hypothesis, some researchers found differences in the relationship statuses of psychotherapists with and without such a history. These researchers found that the psychotherapists in their sample with a history of childhood developmental trauma reported lower rates of marriage and having had fewer children than their non-traumatized counterparts (Nuttall & Jackson, 1994). However, these researchers did not use any formal psychological distress measures when assessing their participants, and thus it is unclear if the difference had more to do with choices about relationships than actual experiences of distress.

Generally, the findings of previous researchers have not supported the hypothesis that because psychotherapists report higher levels of childhood developmental trauma than non-psychotherapists, they would report higher distress. For example, when comparing psychotherapists to non-mental health professionals, researchers have found that psychotherapists report significantly less psychological distress than non-mental health professionals. For example, Elliot and Guy (1993) found that psychotherapists appear to experience less distress than individuals working in other professions despite having reported a higher prevalence of childhood developmental trauma. These researchers compared female psychotherapists to female non-mental health professionals on issues related to the amount of childhood developmental trauma experienced. Elliot and Guy found that the mental health professionals in their study were significantly more
likely than non-mental health professionals to report one or more traumas. They assessed psychological distress using several aspects including hospitalization for a mental health reason, a history of substance abuse, symptoms of psychological distress, and interpersonal difficulties. Surprisingly, there were no significant differences found between psychotherapists and other professionals in the prevalence of a substance abuse history, nor was there a significant difference found in the rate of psychiatric hospitalizations. Regarding the current level of trauma-related psychological distress, post hoc ANOVAs revealed that psychotherapists reported significantly less anxiety, depression, dissociation, sleep disturbance, and interpersonal problems than did other female professionals.

One possible reason for the high report of childhood developmental trauma among Elliot and Guy's (1993) participants may be due the relatively high use of personal counseling that they had received in comparison to the non-psychotherapist participants. The authors theorized that through personal therapy, psychotherapists became more aware of their own abuse history. However, because the authors did not find history effects or interactions on symptomology, the relatively greater personal use of psychotherapy by psychotherapists was not a sufficient explanation for the findings of their study. Another hypothesis considered by the researchers to explain the higher levels of reported trauma was that, through their training, psychotherapists were more aware of abuse than were non-mental health professionals and thus more able to identify the presence of abuse in their own lives. Interestingly, however, log-linear analysis found that psychotherapists were no better at identifying childhood experience of sexual abuse than were other professionals.
Following Elliot and Guy's (1993) findings, a small number of researchers have compared psychotherapists to various other professionals regarding the relationship between childhood developmental trauma and current psychological distress. Nikcevic, Kramolisova-Advani, and Spada (2007), for example, found that psychology students planning to become psychotherapists reported significantly more incidents of childhood developmental trauma than did psychology students planning to focus on research, as well as business students. Yet, despite the higher incidents of childhood developmental trauma among students preparing to be psychotherapists, there was no difference in the levels of current psychological distress among the student groups.

In another example comparing psychotherapists to non-mental health professionals, Follette, Polunsy, and Milbeck (1994) compared psychotherapists and law enforcement professionals on their perspective rates of current and childhood developmental trauma. The psychotherapists in this study reported significantly more physical and sexual abuse experiences in childhood than did law enforcement professionals. Yet, Follette and colleagues found that the law enforcement professionals reported significantly higher levels of trauma symptoms, general levels of psychological distress and PTSD symptoms when compared to the psychotherapists. In contrast to Elliot and Guy's (1993) findings, Follette and colleagues found that both psychotherapists and law enforcement professionals with childhood developmental trauma had significantly higher levels of trauma-specific symptoms than their professional counterparts who did not report childhood developmental trauma. Law enforcement professionals, however, were significantly more distressed than
psychotherapists on all measures whether they had experienced childhood developmental trauma or not.

Also interested in the relationship between childhood developmental trauma and current psychological distress, Radeke and Mahoney (2000) compared psychotherapists to research psychologists in areas which included the experience of childhood developmental trauma, psychological distress, and personal satisfaction with their lives. The sample consisted of 146 research psychologists and 130 psychotherapists. Radeke and Mahoney found that the research psychologists were significantly more likely than psychotherapists to report a happy childhood and significantly less likely to report having experienced childhood developmental trauma. In this study, psychotherapists reported significantly more feelings of emotional exhaustion, anxiety, and depression than did researchers, though psychotherapists and researchers both described themselves as happy and satisfied with their work. Yet, while they reported more childhood developmental trauma, the psychotherapists reported being more satisfied with their adult lives than the researchers. Psychotherapists reported believing their work had impact on their personal lives, mostly in positive ways. The reported positive benefits included feeling their work helped them become better people, increased their self-awareness, and accelerated their own psychological maturity.

As demonstrated in this section, scholars have speculated that experiences of childhood adversity likely impacts on the choice to become a psychotherapist. The few researchers who have examined this population have found, in fact, that many psychotherapists have experienced childhood developmental trauma. Furthermore, some researchers have found that psychotherapists may actually have a higher prevalence of
the experience of childhood developmental trauma than do people from the general population. Yet, these researchers have found that despite this higher prevalence, psychotherapists generally report less psychological distress than people from other professions.

Applying Theory to Psychotherapists and Childhood Developmental Trauma

A major limitation in the research examining the relationship between childhood developmental trauma and psychological distress among psychotherapists has been that much of it has been atheoretical. There has not been a general framework from which to conceptualize the experience of psychological distress among this population. Researchers have suggested theories post hoc when they discover that psychotherapists are doing better than individuals from other professions. For example, Elliot and Guy (1993), after finding that the psychotherapists in their study reported less psychological distress compared to individuals in other professions despite reporting higher incidences of childhood developmental trauma, suggested that personal therapy and training may have lowered their psychological distress. Radeke and Mahoney (2000) also offered potential reasons after they found that the psychotherapists in their study had lower levels of distress. They posited that the act of doing psychotherapy with clients may accelerate the developmental process and allow psychotherapists to grow and heal from their own traumas. While these ideas offer interesting hypotheses about what may be happening for psychotherapists, a fuller understanding might be gained through the use of a theoretical framework. Researchers have proposed attachment theory as a useful framework for understanding differences in psychological distress among individuals who have been traumatized (e.g., Shapiro & Levendosky, 1999).
In the following section, I explore attachment theory. First, I offer a brief overview of the main tenets of attachment theory. Second, I define internal working models of attachment figures and explore them in relationship to how they impact on one’s current view of self and relationships. Third, I describe the research regarding childhood developmental trauma and adult attachment. Finally, I offer a brief overview of research examining the attachment orientations of psychotherapists.

**Attachment Theory**

Bowlby (1973; 1977, 1988), theorized that human beings are innately programmed at birth to make strong emotional bonds to particular others. His attachment theory posited that a person’s propensity to seek out and depend on caregivers, as well as the person’s tendency to strive for some autonomy from the caregiver, has an evolutionary purpose which begins in infancy. As a means of survival, children depend on their caregivers to meet their basic needs and to provide them with safety and support. In order to gain this safety, children seek proximity to their caregivers. On the other hand, as part of their evolutionary process, children also yearn to explore and to gain autonomy from their caregivers. Thus, children both engage in proximity seeking to their caregivers for safety and exploratory behaviors as part of their evolutionary development.

Caregivers may respond to children’s evolutionary behaviors either adequately or inadequately, and their reactions can impact on the quality of children’s attachment bonds. For example, if the caregiver is responsive to the child, providing comfort and security, as well as room to explore the environment, the child will form a “secure” attachment to the caregiver. If, on the other hand, the caregiver is inconsistent with the
child, unresponsive, unavailable, or even abusive, the child will likely form an “insecure” attachment to the caregiver (Ainsworth, Blehar, Waters, & Wall, 1978).

**Internal Working Models**

According to attachment theory, individuals form cognitive and affective representations of their caregivers. These internal working models of their attachment figures become more or less stable over time. Internal working models reflect the individual’s general sense and stored information regarding the availability and responsiveness of attachment figures (Bowlby, 1988). This stored information regarding the availability of caregivers allows the individual to predict the results of future interactions with attachment figures and to adjust proximity-seeking behaviors accordingly (Shaver & Mikulincer, 2009). Bowlby proposed two types of working models that are developed from the stored information individuals have regarding their caregivers. He posited that individuals have internal working models about the availability and responses of their attachment figures (working model of other). Additionally, he theorized that individuals have internal representations of their own lovability and competence (working model of self).

Bowlby (1988) further theorized that variations in an individual’s internal working model depend on the availability, sensitivity, and responsiveness of the attachment figure during times of need. When the attachment figure is available, sensitive, and responsive to the individual’s proximity and support-seeking behaviors, the individual is likely to feel secure. The individual is also likely to have confidence that proximity and support-seeking will lead to relief if distressed. If this repeats itself with enough regularity, the individual will likely form a “secure” internal model and
attachment orientation. If, however, the attachment figure proves to be unavailable, insensitive, and/or unresponsive when the individual seeks proximity and/or support, felt security is not attained and the individual is likely to develop an “insecure” attachment orientation. Thus, in this case, the individual is forced to find alternative strategies to deal with the current insecurity and distress. These alternative strategies are referred to as secondary attachment strategies and are demonstrated through either hyperactivation or deactivation (Main, 1990).

According to Main (1990) individuals use secondary attachment strategies when an unreliable or insufficiently available attachment figure fails to provide the individual’s needed support and security when there is a perceived threat. One secondary strategy, hyperactivation, generally involves an exaggeration of the danger encountered and an intensification of the individual’s needs and emotional reactions to frustrated needs (Shaver & Mikulincer, 2009). Individuals who largely use hyperactivating strategies are said to be demonstrating an anxious attachment orientation. Deactivating strategies, on the other hand, involve efforts to escape, avoid, or minimize the pain experienced because of the behaviors of the attachment figure during periods of perceived threat. Individuals who largely use deactivating strategies are said to be demonstrating an avoidant attachment orientation.

One’s internal working model also impacts on the appraisal and perception of threat (e.g., Berant, Mikulincer, & Florian, 2001; Mikulincer & Florian, 1995; Torquati & Vazsonyi, 1999). Stressful or ominous events are interpreted through the filter of the internal model. For example, Torquati and Vazsonyi found that attachment orientation was significantly related to perceived control and threat during conflicts among dating
partners. When filtered through a secure internal model, such events often appear more manageable and there is lower perceived threat. When filtered through an insecure internal model, however, individuals perceive a greater amount of threat. In another example, Mikulincer and Florian found a significant relationship between Israeli recruits' attachment orientation and their appraisal of threat during a four-month combat training experience. Those recruits with insecure attachment orientations were significantly more likely to appraise the training as threatening.

**Attachment Orientations**

When individuals have consolidated internal working models which they chronically access in response to stress, they can form relatively stable individual differences in attachment orientation. Hazan and Shaver (1987) defined attachment orientations as habitual patterns of expectations, affective responses, needs, and behaviors used in interpersonal interactions and close relationships. Scholars (e.g., Brennan, Clark, & Shaver, 1998; Fraley & Phillips, 2009) have concluded that attachment orientations are best conceptualized from a two-dimensional perspective on which attachment orientations are measured on a continuum of two dimensions (anxious and avoidant). These scholars argue that individuals' attachment varies along a continuum and when researchers place people into attachment categories, they could potentially miss important differences between individuals. From a dimensional perspective on attachment, individuals who are low on the anxious dimension but high on the avoidant dimension are understood as having an avoidant attachment orientation. Avoidantly attached individuals have internalized a positive view of self but a negative model of others. Individuals who are high on the anxious dimension but low on the
avoidant dimension can be understood as having an anxious attachment orientation. Anxiously attached individuals have internalized a positive view of others but a negative self-model.

**Attachment, Psychological Distress, and Childhood Developmental Trauma**

One of the central ideas in Bowlby’s (1973, 1988) theory is that the security of an individual’s bonds developed in childhood affects the psychological adjustment and resiliency in adulthood. He posited that securely attached individuals would demonstrate resiliency when faced with adversity. Those individuals with high attachment anxiety or avoidance would conversely experience higher levels of distress and would not demonstrate the resiliency shown among securely attached individuals. It is believed that where a secure adult attachment orientation functions as an “inner resource” that individuals use when faced with difficulties (Mikulincer, 1998), an insecure attachment orientation reduces the person’s resilience in times of stress.

There has been a growing body of research investigating the link between attachment orientations and current psychological distress among individuals with childhood developmental trauma. Investigators have found significant correlations between attachment orientation and the number of negative symptoms reported among adults who experienced childhood developmental trauma (e.g., Muller, Sicoli, & Lemieux, 2000; O’Connor & Elklit, 2008.) Furthermore, some researchers have found that one’s attachment orientation may influence the relationship between childhood developmental trauma and current experience of psychological distress (Aspelmeier, Elliot, & Smith, 2007; Higgins, 2003; Limke, Showers, Zeigler-Hill, 2010; Roche, Runtz, & Hunter, 1999). For example, Mikulincer, Florian, and Weller (1993) found a
significant relationship between insecure attachment and increased distress symptoms related to participants’ reactions to the impact of the Gulf War in Israel. Furthermore, O’Connor and Elklit (2008) found a significant relationship between attachment orientation and reported distress among participants who had experienced a traumatic event. Those participants with insecure attachment orientations were significantly more likely to report symptoms of posttraumatic stress disorder (PTSD); alternatively, there was a significant negative correlation between secure attachment orientations and PTSD symptoms. Such findings support Bowlby’s (1973, 1988) contention that attachment orientation affects the psychological adjustment and resiliency of an individual when faced with adversity.

**Attachment Theory and Psychotherapists**

To date, few researchers have examined the attachment orientations of psychotherapists. Some of the attachment investigators who have examined this population have looked at how attachment orientation impacts therapeutic efficacy. For example, researchers have investigated the relationship between psychotherapists’ attachment orientations and their ability to develop positive working alliances with their clients (Dinger, Strack, Sachsse, & Schauenburg, 2009; Dunkle & Friedlander, 1996; Ligiero & Gelso, 2002; Mohr, Gelso, & Hill, 2005; Romano, Fitzpatrick, & Janzen, 2008; Sauer, Lopez, & Gormley, 2003). Generally, researchers have found that psychotherapists with avoidant attachment orientations have the most difficulty with developing a positive working alliance with clients. Furthermore, Sauer and his colleagues found that while psychotherapists with anxious attachment orientations were
initially able to form a positive therapeutic alliance, they were unable to maintain it over time.

Other investigators have found significant relationships between psychotherapists' attachment orientation and the types of behaviors they demonstrate during therapy sessions (e.g., Dozier, Cue, & Barnett; 1994; Rubino, Barker, Roth, & Fearon, 2000). These researchers have found that psychotherapists with avoidant or anxious attachment orientations demonstrate negative in-session behaviors such as difficulty with demonstrating empathy. Furthermore, in her dissertation, Nigro (2005) found a significant relationship between insecure attachment orientations and sexual contact with clients among her Canadian psychologist participants. These findings suggest that psychotherapists with high levels of anxious and/or avoidant attachment may have more difficulties in conducting psychotherapy than their more secure counterparts.

However, Trusty, Ng, and Watts (2005) found counselor trainees with high levels of attachment anxiety were better able to demonstrate in-session empathy. They speculated that anxious attachment may have actually helped their participants gain a fuller understanding of client difficulty. These researchers did not specify at what point in the therapy process they measured empathy, however. It is possible, therefore, that the anxiously attached counselors were not able to maintain an empathic stance throughout the therapeutic relationship as was found by Sauer and colleagues (2003).

While the work of these researchers offers interesting information about the relationship between clinical functioning and attachment orientations, such findings do not offer information about the relationship between psychotherapists' attachment orientation and their own experience of psychological distress. Because psychotherapists,
in previous studies, have demonstrated lower than expected negative responses to developmental trauma, assessment of their attachment orientations in relation to childhood developmental trauma and psychological distress may offer valuable information regarding responses to such experiences.

Coping

In this section, I explore the definition of coping and how appraisal influences the type of coping strategy used in response to stress. I report on what is known about the connection between coping and childhood developmental trauma, as well as what is known about how psychotherapists cope with difficulties. I conclude this section with a description of my theory related to the roles attachment orientation and coping strategy play in the relationship between childhood developmental trauma and psychological distress.

Coping, according to the model proposed by Lazarus and Folkman (1984), is defined as all efforts made, both cognitively and behaviorally, in response to a perceived threat. These scholars proposed that the type of coping strategy used depends upon both the appraisal of the threat and the appraisal of one’s available resources to address that threat. Lazarus and Folkman further offered a classification system which distinguishes between problem-focused and emotion-focused coping. When using problem-focused coping strategies, one attempts to change or alter the stressor in some way. An example of problem-focused coping could include defining problems, considering alternative solutions, and following a plan of action. When using an emotion-focused coping strategy, the individual attempts to change or alter their emotional response to the
stressor. Examples of emotion-focused coping include avoidance and trying to change the way one feels about the situation.

Carver, Scheier, and Weintraub (1989) argued that the problem-focused/emotion-focused distinction in Lazarus and Folkman’s (1984) model offered too simplistic a description of how individuals deal with stressors. They further suggested that an overlap exists between the two coping strategies proposed in Lazarus and Folkman’s model. They also believed that different behaviors exist within the problem-focused and emotion-focused factors than were described by Lazarus and Folkman.

Carver, Scheier, and Weintraub (1989) proposed a model that integrated the Lazarus model with a model of behavioral self-regulation, and they developed thirteen distinct scales based on functional and less functional coping strategies. They defined active coping as behaviors that are intended to reduce or remove a stressor. Planning was described as strategies for handling stressors. Suppression of competing activities included behaviors that involve putting other distractors aside in order to attend to the problem or stressor. Restraint coping involves allowing time to think about the stressor. Seeking social support (instrumental type) involves seeking advice or further information about the stressor. These strategies were considered functional in Carver and colleagues’ model. Seeking social support (emotional type), includes getting empathy or understanding from others. Focusing on and venting emotions involves attending to the stressor and expressing one’s emotions. These coping strategies were identified as functional in the short-term, but Carver and colleagues described them as potentially dysfunctional if the strategy increases distress and becomes a long-term coping strategy. Behavioral disengagement and mental disengagement are two strategies that were
identified as dysfunctional. Behavioral disengagement involves an individual giving up on their goal, and mental disengagement involves use of distraction such as daydreaming.

Carver and colleagues (1989) also included four additional scales. Positive reinterpretation and growth is considered a type of emotion-focused coping strategy in which a person focuses on managing the distressing emotion instead of coping with the stressor. Turning to religion could also be considered an emotion-focused strategy or could be considered an active response to the stressor. While denial as a coping strategy could help to minimize distress, it tends to be dysfunctional, according to Carver and colleagues, as it tends to ignore the stressor. Acceptance is considered functional as it accepts the reality of the stressor and suggests a person’s attempt to deal with the stressor.

**Coping and Trauma**

Multiple researchers have found that individuals tend to engage in emotion-focused coping strategies, such as wishful thinking and avoidance, when having memories of childhood developmental trauma (Bal, Van Oost, De Bourdeauhuij, & Crombez, 2003; Gibson & Leitenberg, 2001; Leitenberg, Gibson, & Novy, 2004; Limke, et al., 2010). Researchers have also found that emotion-focused coping has been significantly correlated with increased psychological distress (Banyard, 2003; Glass, Flory, Hankin, Kloos, & Turecki, 2009; Schnider, Elhai, & Gray, 2007; Wright, Crawford, & Sebastian, 2007; Wright, Fopma-Loy, & Fischer, 2005). In one example, Runtz and Schallow (1997) found that the use of avoidance, an emotion-focused coping strategy, when thinking about childhood developmental trauma was significantly related to impairment in functioning. Furthermore, Brand and Alexander (2003), found that individuals with a history of childhood developmental trauma were more likely to use
emotion-focused strategies. They further found that such use of emotion-focused strategies was significantly related to increased psychological distress.

Some researchers have found a negative correlation between the use of problem-focused coping and distress related to trauma (e.g., Ben-Zur, 2005). Other researchers, however, have found mixed results regarding the correlation between problem-focused coping and decreased distress (e.g., Leitenberg, et al., 2002). For example, Littleton, Horsley, John, and Nelson (2007) used meta-analysis when examining the relationship between coping strategies used (both problem-focused and emotion/cognitive focused) following trauma and psychological distress. They evaluated thirty-nine studies where the researchers had examined the type of coping strategy used following two types of traumatic events, interpersonal violence and severe injury. Littleton and colleagues found there was significant association between emotion-focused coping such as use of avoidance and higher levels of distress. They did not, however, find a significant relationship between more problem-focused approach coping and decreased distress.

Coping and Psychotherapists

While researchers have examined the coping strategies of health professionals such as nurses and social workers (e.g., Anderson, 2000), there have been few researchers who have investigated the types of coping strategies that psychotherapists use to manage work-related stressors. Those who have investigated this population have found that psychotherapists tend to use more active or problem-focused coping strategies (Murtagh & Wollersheim, 1997). Those psychotherapists who used such coping strategies reported less distress. When psychotherapists reported more emotion-focused coping strategies,
they experienced more stress and less satisfaction with their careers (Wallace, Lee, & Lee, 2010).

For example, researchers who have investigated psychotherapist reactions to work-related stress have found that problem-focused coping strategies were associated with less burn-out while emotion-focused coping strategies were associated with negative emotion and increased burn-out (Murtagh & Wollersheim, 1997; Wallace, Lee, & Lee, 2010). In fact, while Murtagh and Wollersheim expected that client attributes would impact psychotherapists’ distress, they instead found that the specific types of coping strategies used when dealing with clients had more impact on level of distress. They also found that psychotherapists were significantly more likely to use planful problem-solving and controlling strategies when dealing with work-related stressors.

In another study examining the type of coping strategies used by psychotherapists, Medeiros and Prochaska (1988) surveyed 222 members of Division 29 (Psychotherapy) of the American Psychological Association. They used selected scales of the Ways of Coping Questionnaire, two scales from the Process of Change Scale, and a stress questionnaire. The coping strategies used by psychotherapists when dealing with stressful clients included self-evaluation, humor, optimistic perseverance, seeking social support, seeking inner peace, contingency control, and avoidance. Psychotherapists who used more emotion-focused coping strategies such as self-reevaluation and wishful thinking experienced increased stress and their stress last longer than psychotherapists who relied on more optimistic perseverance coping strategies.

Finally, Shapiro, Dorman, Burkey, and Welker (1999) investigated the relationship between coping strategies, work-related strategies, and personal history of
childhood developmental trauma as predictors of job satisfaction and burnout in child abuse psychotherapists. They surveyed 215 participants who were attending a professional conference on sexual abuse treatment. Shapiro and colleagues found that the use of coping strategies such as planful problem solving, positive reappraisal, and seeking social support were associated with positive work satisfaction. Conversely, the use of confrontive coping, escape/avoidance, and accepting responsibility were associated with negative work satisfaction. Interestingly, job satisfaction was higher in subjects reporting a childhood history of sexual abuse or neglect.

Coping and Appraisal

The type of coping strategy used depends on the individual’s appraisal of the encountered stressor (Lazarus, 1993). If an individual appraises a stressful situation as unchangeable, emotion-focused coping predominates. For example, if one has been told he has terminal cancer and appraises the situation as unchangeable, he will likely engage in emotion-focused coping strategies. If one believes that attempts to alter the stressful situation will be futile or there is a lack of resources available then emotion-focused or avoidant coping strategies are used (Mikulincer & Florian, 1995; Mikulincer, Florian, & Weller, 1993). On the other hand, when individuals believe they have some management over a stressor, they are more likely to use active or problem-focused coping strategies.

Coping strategies change with the context and the appraisal of the situation encountered, potentially making coping a fluid and changeable construct. For example, an individual who has experienced childhood developmental trauma will be more likely to use emotion focused coping if there is a belief that the situation is not changeable. On
the other hand, that same individual will be more likely to use problem-focused coping if there is a belief that the situation can be changed.

**Attachment Orientation Impacts Coping Strategy**

While the type of coping strategy used appears to be dependent on how a stressor is appraised, thus potentially changing according to situation, an individual's attachment orientation can impact on the type of appraisal made. As noted earlier, an individual's internal working model for attachment is activated in the context of a perceived threat and functions as an organizational construct for affect regulation and coping behaviors (Bowlby, 1988). Thus, some researchers have investigated the link between coping and attachment. These researchers (e.g., Hawkins, Howard, & Oyebode, 2007) have found that attachment orientations are related to the type of coping strategies used by individuals.

An individual's internal working model influences how interpersonal events are understood and appraised. Thus, while some theorists (e.g., Lazarus, 1993) have argued that coping is often not stable over time, the influence of attachment orientation may provide a basis for stability (Shapiro & Levendosky, 1999). One objective of the current study is to demonstrate that, by including both attachment orientation and coping strategies in an integrated model, a better understanding regarding the current psychological distress of psychotherapists can be gained than by examining either construct separately. Furthermore, this integrated model can offer a deeper understanding of the relationship between childhood developmental trauma and current psychological distress.
A possible integrated model brings the concepts regarding coping posited by Folkman and Lazarus (1988) together with Bowlby's attachment theory (1973). In this model attachment orientation is understood as an over-arching perspective that influences how individuals appraise stressors and subsequently chose coping strategies when encountering a stressful situation. Other researchers have previously applied similar models when examining other populations, including marital partners, Israeli military recruits, adolescents, and undergraduates from a Midwestern university (e.g., Lussier, Sabourin, & Turgeon, 1997; Mikulincer & Florian, 1995; Seiffge-Krenke, 2006; Wei, Heppner, & Mallinckrodt, 2003).

In an attempt to offer an integrated model which includes attachment orientation, coping strategies, and current psychological distress, some researchers have examined the ways that these constructs interact. A few investigators (e.g., Lopez, Mauricio, Gormley, Simko, & Berger, 2001; Lopez, Mitchell, & Gormley, 2002; Wei, Heppner, & Mallinckrodt, 2003) have proposed theoretical models in which the type of coping strategy used by the individual mediates the relationship between attachment orientation and current psychological distress. Such a model would suggest that attachment orientation would not directly influence psychological distress but would instead be mediated by the type of coping strategy used by the individual. Other researchers (e.g, Mikuliner & Florian, 1995; Seiffge-Krenke, 2006) have suggested that attachment orientation mediates the relationship between coping strategies and current psychological distress. This type of model proposes that coping strategy used would not directly impact on current distress but would instead be mediated by one's attachment orientation.
After reviewing the literature, Barker-Collo and Read (2003) concluded that individual characteristics such as attachment orientations and relational factors such as coping strategies likely combine to mediate the relationship between childhood developmental trauma and current experience of psychological distress. In one of the few studies examining such an integrative approach, Crittenden (1992) found support for such a model when examining children’s experience of distress related to trauma. In her model, children’s coping varied as a function of their internal working model, which developed after their experience of childhood developmental trauma. Crittenden’s model described how a child’s experience with an attachment figure leads to expectations about future situations which in turn impacts coping strategies and subsequently level of distress.

In a similarly designed study, Guelzow, Cornett, and Dougherty (2002) investigated whether perceived relational support (an aspect of attachment) and coping mediated the relationship between childhood developmental trauma in the form of sexual abuse and psychological distress. They found that individuals who had experienced childhood developmental trauma were more likely to perceive that there was less relational support than individuals without this history. They were also more likely to use emotion-focused coping. Emotion-focused coping mediated the relationship between perceived relational support and negative self-worth.

Finally, in another study examining factors that influence the experience of psychological distress after childhood developmental trauma, Shapiro and Levendosky (1999) theorized that attachment and coping would mediate the relationship between abuse and distress. These researchers found interesting interactions between childhood
developmental trauma, coping strategy, and attachment. First, attachment mediated the effects of childhood developmental trauma, accounting for 46% of the variance in psychological distress. In addition, the effects of childhood developmental trauma on the type of coping strategy used was mediated by attachment orientation, which also accounted for almost all of the indirect effects of childhood developmental trauma on psychological distress.

**Summary of Chapter II**

In this chapter I offered a comprehensive review of the current findings regarding the major constructs of this study. First, I described the findings related to the high prevalence and impact of childhood developmental trauma, for the general population. Second, I explored what is known about the prevalence and impact of childhood developmental trauma on psychotherapists. I described how researchers have found that psychotherapists do not report more distress than other professionals despite their higher reported experience of childhood developmental trauma. Interestingly, however, few researchers have investigated this populations' response to such a history. As psychotherapists appear to be responding differently than other populations to childhood developmental trauma, it is surprising that so few investigations have been conducted.

Third, I reviewed attachment theory and described how it has been used as a potential explanation for the variation in psychological distress experienced by psychotherapists. In this section, I offered an overview of the empirical investigations involving the attachment orientations of psychotherapists. I noted that most of the attachment-related investigation of this population has been related to the impact it has on psychotherapy practice. The relationship between attachment and distress has not been
investigated among psychotherapists despite evidence in other populations that attachment is strongly correlated with distress. Fourth, I offered a description of coping theory. I explored the research findings regarding the impact of the type of coping strategy used on individuals' distress levels. As with attachment, researchers investigating psychotherapists' coping strategies have been most interested in how coping impacts on psychotherapy practice and not on psychotherapists' distress levels. Finally, I posited that by integrating knowledge from findings related to attachment orientation's impact on distress with findings related to how coping strategy impacts distress, we may be better able to account for the experience of distress among psychotherapists with a history of childhood developmental trauma. I concluded the chapter with an examination of the empirical investigations that have used such an integrative approach when investigating other populations.
CHAPTER III

METHOD

Introduction

In this chapter, I outline the methodological procedures for the current study. First, I describe the research participants, including the recruitment and selection procedures. Second, I identify the data collection procedures. Third, I describe the measures used for the current study, and I report information regarding the validity and reliability of each measure. Finally, I summarize the statistical analysis that I conducted.

Participants

All participants in the current study held a Psychologist, Limited License-Masters (LLP) credential in the state of Michigan and were practicing psychotherapy. All individuals who held an LLP in the state of Michigan were eligible to receive a research packet. In order to sample individuals currently practicing psychotherapy, only the data from those individuals who indicated on the demographic survey that they were providing psychotherapy were used. If individuals indicated on the demographic questionnaire that they were not currently practicing psychotherapy, their data were not used in the current study. A list of 3515 names and addresses were purchased from the Department of Community Health for the State of Michigan (Appendix B). A computer generated randomized list of numbers was used to select participants from this list. Because response rates in similar studies have ranged from 22-52% (e.g., Elliot & Guy, 1993; Follette, Polusny, & Milbeck, 1994; Polusny & Follette, 1996), a total of 700 individuals were selected from the list of individuals with a LLP in the state of Michigan. Of the 700 packets mailed, 361 were returned. Of the 361 returned, 72 declined
participation, 129 of the returned packets were not qualified to participate because of reasons including the individual was not seeing clients for therapy (98), had a Ph.D. (6), or were working as school counselors (15). Some packets (18) had incorrect mailing information and were returned. There were 138 packets completed and returned. Taking all of these factors into consideration, a 25% response rate was found. Eight packets were unusable due to insufficient data.

**Demographic Description of the Final Sample**

The remaining 130 participants ranged in age from 27 to 78 years old (Mean = 50.46, SD = 12.05). There were 91 (70%) female, 38 (29.2%) male, and 1 (0.8%) gender unidentified participants. As shown in Table 1, the majority of participants described themselves as Euro-American/Caucasian. Furthermore, Table 2 demonstrates that the majority of the participants were in a committed relationship lasting more than 10 years.

Table 1

*Racial/Ethnic Backgrounds of Participants*

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>African-American</td>
<td>3</td>
<td>2.3%</td>
</tr>
<tr>
<td>Asian-American/Pacific Islander</td>
<td>1</td>
<td>0.8%</td>
</tr>
<tr>
<td>Hispanic/Latina</td>
<td>1</td>
<td>0.8%</td>
</tr>
<tr>
<td>Euro-American/Caucasian</td>
<td>116</td>
<td>89.2%</td>
</tr>
<tr>
<td>Native American/American Indian</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Multi-racial</td>
<td>3</td>
<td>2.3%</td>
</tr>
<tr>
<td>Unreported</td>
<td>1</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

Note. *n* = Number of participants; % = percentage of participants
The range of years that the participants had been practicing psychotherapy ranged from 2 years, 5 months to 46 years, 3 months (Mean = 17 years, 4 months, SD = 9 years, 9 months). As demonstrated in Table 3, most of the participants in the current study were seeing, on average, more than 15 clients per week.

Table 2

Description of Participant Relationship Status

<table>
<thead>
<tr>
<th>Relationship Status</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single, Not Dating</td>
<td>11</td>
<td>8.5%</td>
</tr>
<tr>
<td>Single, Dating Multiple Partners</td>
<td>3</td>
<td>2.3%</td>
</tr>
<tr>
<td>Single, Dating One Partner</td>
<td>7</td>
<td>5.4%</td>
</tr>
<tr>
<td>Committed Relationship: &lt; 2 years</td>
<td>1</td>
<td>0.8%</td>
</tr>
<tr>
<td>Committed Relationship: 2-5 years</td>
<td>16</td>
<td>12.3%</td>
</tr>
<tr>
<td>Committed Relationship: 5-10 years</td>
<td>16</td>
<td>12.3%</td>
</tr>
<tr>
<td>Committed Relationship: 10+ years</td>
<td>72</td>
<td>55.4%</td>
</tr>
<tr>
<td>Unreported</td>
<td>4</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

Note. $n =$ Number of participants; % = percentage of participants

There were 99 (76.2%) participants who received their own psychotherapy at some point during their lifetime. Of those participants who had previously been psychotherapy clients, 69 (53.1%) had attended between 1 and 50 sessions, 11 (8.5%) had attended between 51 and 100 sessions, 2 (1.5%) who had attended between 101 and 150 sessions, 1 (.8%) who had attended between 151 and 200 sessions, and 16 (12.3%) who had attended more than 200 sessions during their lifetimes.
Table 3

Description of Participant Caseloads

<table>
<thead>
<tr>
<th>Clients Seen Per Week</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5</td>
<td>17</td>
<td>13.1%</td>
</tr>
<tr>
<td>6-10</td>
<td>22</td>
<td>16.9%</td>
</tr>
<tr>
<td>11-15</td>
<td>16</td>
<td>12.3%</td>
</tr>
<tr>
<td>16-20</td>
<td>27</td>
<td>20.8%</td>
</tr>
<tr>
<td>20+</td>
<td>47</td>
<td>36.2%</td>
</tr>
</tbody>
</table>

Note. n = Number of participants; % = percentage of participants

Procedures

The recruitment and data collection procedures were managed in the following manner. I mailed a survey packet to the 700 randomly selected individuals with an LLP in the state of Michigan requesting their involvement in the project. Two weeks after the initial mailing, a reminder letter (Appendix G) was sent to each potential participant. All packets included an introductory cover letter (Appendix C), an anonymous survey consent form (Appendix E), a demographic survey (Appendix F), and five self-report measures. To control for possible ordering effects, measures were counter-balanced.

Participants were surveyed anonymously as a means of encouraging complete honesty and openness. No records were kept connecting the mailing packets to the names or identifying information of potential participants. Each packet of measures was assigned a code in order to identify and connect all measures for one participant together, but these codes were not linked to any identifying information of the participants.
Given the potential for participants to feel some psychological discomfort while completing the survey packet, a national 24-hour crisis phone number was also included in the packet at the end of the demographic questionnaire (see Appendix F). Participants were instructed to return completed packets to the researcher by mail in a self-addressed, stamped envelope provided by the researcher. As some potential participants opted to not participate in this study, the survey packet also had a form indicating non-participation which could be filled out and returned (Appendix D). Participants that did not wish to complete the surveys were asked to return unused measures with the “decline to participate” form in the provided stamped envelope. This procedure helped track which participants were not interested or did not qualify for participation.

**Instruments**

**Demographic Survey**

A demographic questionnaire (Appendix F) was designed to gather information regarding the participants’ age, ethnic/racial membership, current romantic relationship status, and experience of their own personal psychotherapy. The questionnaire also gathered information about participants’ living arrangements during their childhoods/adolescence and which adults the participants felt close to during this time period.

**Child Abuse and Trauma Scale (CAT)**

The CAT (Sanders & Becker-Lausen, 1995) is a 38-item self-report measure designed to assess an individual’s subjective perceptions of stress or trauma present in childhood. Participants were asked to rate the general atmosphere and the degree to which they experienced distressing events in their childhood home environments using a five
point Likert scale (0 = never; 4 = always). With regard to specific types of perceived adverse childhood experiences, Sanders and Becker-Lausen originally identified three subscales including negative home environment/neglect, sexual abuse, and punishment. They found internal consistencies for those scales to be .86, .76, and .63, respectively. Kent and Waller (1998) developed a fourth scale, Emotional Abuse, from existing CAT questions. They found an internal consistency of .88 for this scale.

The four scales, with internal consistency found with the current sample, are described as follows: The Negative Home Environment/Neglect subscale (14 questions; α = .87) assesses situations in which a child felt ignored, neglected, or unloved by his or her caretakers as well as negative behaviors caretakers used toward each other (e.g., “As a child, did you feel unwanted or emotionally neglected?”). The Sexual Abuse subscale (6 questions; α = .84) assesses sexual contact/conduct between a child and an adult (e.g., “Before age 14, did you engage in any sexual activity with an adult?”). The Punishment subscale (6 questions; α = .78) assesses physical assault on a child that could potentially or actually cause injury, as well as inappropriate punishment (e.g., “Did your parents ever hit you or beat you when you did not expect it?”). The Emotional Abuse subscale (7 questions; α = .90) assesses emotional abuse experiences in childhood (e.g., “Did your parents ever ridicule you?”). Higher scores on these four subscales reflect greater frequency of the respective types of child abuse experiences. An overall score for the CAT can also be calculated. This score assesses the overall childhood trauma experienced in childhood.

Previous researchers have found the internal consistency estimates for the overall CAT to be strong with a Cronbach’s alpha of .90 (Kent & Waller, 1998; Sanders &
Becker-Lausen, 1995). Sanders and Becker-Lausen found test-retest reliability (6-8 weeks) for the measure was strong at .89. The internal consistency estimate for the overall CAT in the current study was found to be .88.

Sanders and Becker-Lausen (1995) validated the CAT using two large samples (n = 834 & 301) of non-clinical college students, as well as with a small sample (n = 17) of individuals diagnosed with Multiple Personality Disorder (MPD). For the two groups of college students, the authors found significant correlations with factors that are generally associated with individuals who have experienced childhood developmental trauma. Furthermore, there were significant positive correlations between the participants' total scores on the CAT and on the Dissociative Experiences Scale, the Beck Depression Inventory, the Life Experiences Survey, and the Object Relations Scale offering further evidence of strong convergent validity. With regard to discriminant validity, participants' scores on the CAT were not found to be significantly correlated to variables that would not be affected by childhood developmental trauma such as the death or illness of close family or friends (Sanders & Becker-Lausen, 1995).

Sanders and Becker-Lausen (1995) noted that the MPD subjects' scores were extremely high in comparison to the non-clinical samples of college students. As MPD has been associated with early and unusually severe abuse, such high scores offer further evidence of validity. The CAT, however, has been normed on adult populations and is intended to be used for research purposes with non-clinical populations (Kent & Waller, 1998; Roy & Perry, 2004; Sanders & Becker-Lausen, 1995). Regarding use with populations similar to the participants in the current study, the CAT has also been used as an assessment of child abuse among college students considering psychology-oriented
professions and found to have strong ($\alpha = .91$) overall internal consistency estimates. Convergent validity was also established as there was a significant correlation with a parentification scale (Nikkovic, Kramolisova-Advani, & Spada, 2007).

In the current study, the CAT was used to offer descriptive information regarding the sample and to address two of the research questions. First, all four subscales were examined individually in order to offer a fuller description of the childhood experiences of the psychotherapist participants. Second, the means for the overall CAT and the subscales were compared to means from previous samples in order to address the first hypothesis which proposed that the participants would experience higher rates of childhood developmental trauma than did previous samples. Third, the overall mean of the CAT was used to define “childhood developmental trauma” in the proposed path analysis.

**Ways of Coping-Revised (WOC-R)**

The WOC-R (Folkman & Lazarus, 1985; Folkman, Lazarus, Denkel-Schetter, DeLongis, & Gruen, 1986) is a 66-item questionnaire designed to assess and identify the coping processes that individuals use when encountering either internal or external demands related to stressful encounters. Individuals are asked to respond to a specific stressor and indicate the degree to which they used each particular coping method to deal with it. In the current study, participants were asked to consider a recent stressful or difficult therapeutic encounter and to then respond to items on the WOC-R. They were asked to indicate the frequency with which they used various coping strategies using a 4-point Likert scale (0 = not used; 3 = used a great deal). Higher scores indicated higher frequency of use of the coping strategies.
Folkman and Lazarus (1985) described that people primarily cope with stress using either emotion-focused or problem-focused strategies and indicated that the scales on the WOC-R measured these constructs. However, there have been some inconsistencies between researchers regarding which scales measure problem-focused coping and which scales measure emotion-focused coping. The current study follows Dunkel-Schetter, Folkman, and Lazarus’ (1987) designations regarding emotion-focused and problem-focused coping. The decision to use Dunkel-Schetter and colleagues’ designations was based on the relative strength of their factor analysis as well as the fact that their designations made intuitive sense. Furthermore, researchers who have examined the coping strategies of psychotherapists using the WOC-R also used Dunkel-Schetter and colleagues’ labels when investigating the coping strategies of psychotherapists who work primarily with survivors of child abuse (Murtagh & Wollersheim, 1997; Shapiro, Dorman, Burkey, & Welker, 1999).

Dunkel-Schetter and colleagues (1987) described four problem-focused coping strategies, three emotion-focused strategies, and one scale that was neither emotion-focused nor problem-focused. These scales, with the internal consistency found with the current sample, are described as follows: Confrontive Coping, a problem-focused strategy, describes aggressive efforts to alter or change the situation and suggests some degree of hostility and risk-taking ($\alpha = .57$). Planful Problem-Solving, a problem-focused strategy, describes deliberate problem-focused efforts to alter the situation, coupled with an analytic approach to solving the problem ($\alpha = .63$). Positive Reappraisal, a problem-focused coping strategy, describes efforts to create positive meaning by focusing on personal growth ($\alpha = .81$). Seeking Social Support, a problem-focused coping strategy,
describes efforts to seek informational, tangible, and emotional support (α = .70). Distancing, an emotion-focused strategy, describes cognitive efforts to detach oneself and to minimize the significance of the situation (α = .64). Accepting Responsibility, an emotion-focused strategy, describes one’s ability to acknowledge one’s own role in the problem (α = .62). Escape-Avoidance, an emotion-focused strategy, describes one’s attempts to escape or avoid the problem (α = .72). Self-Controlling, which is considered neither problem-focused nor emotion-focused, describes efforts to regulate feelings and actions (α = .62).

The initial norming data obtained by Folkman and Lazarus (1985) did not include a review of the validity. Validity for the WOC-R has been based primarily on factor analysis of exploratory models developed by other researchers. For example, Aldwin and Revenson (1987) factor analyzed the revised Ways of Coping Questionnaire and also identified eight factors that largely converged with the factors described above. A high degree of convergence was also found in a sample of middle-aged, non-psychiatric married couples (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). While the normative population for the WOC-R did not target psychotherapists, Murtagh and Wollersheim (1997) as well as Shapiro, Dorman, Burkey, and Welker (1999) used the WOC-R when investigating the effects of practice on psychologists. Internal consistency was not reported in their study, however. The items on the WOC-R also demonstrate face validity, because the strategies described are those that individuals have reported using to cope with the demands of stressful situations.

The current study used the WOC-R to address two research questions. First, for purposes of describing how psychotherapists cope with stressful therapeutic or work-
related difficulties, descriptive statistics were gathered using the subscales. Second, subscales from the WOC-R were combined to make higher order “problem-focused” and “emotion-focused” coping subscales. As indicated by Dunkel-Schetter, Folkman, and Lazarus’ (1987), the scores for the subscales Confrontive Coping, Seeking Social Support, Positive Reappraisal, and Planful Problem-Solving were added together to create a Higher Order subscale: Problem-focused coping ($\alpha = .85$). The scores from the subscales Distancing, Accepting Responsibility, and Escape-Avoidance were combined to form a Higher-order subscale Emotion-focused ($\alpha = .82$). The Higher-order subscales were compared to each other to determine if the masters level psychologists in the current study were more likely to use Problem-Focused or Emotion-Focused coping when encountering a work-related stressor, and they were used in the path analysis calculations.

**Brief COPE**

The Brief COPE is a 28-item questionnaire designed to measure the different ways in which people respond to stress (Carver, 1997). This measure was developed as a shortened form of the 60 item COPE (Carver, Scheier, & Weintraub, 1989). Participants rated their coping actions on the described scale on a 4 point Likert scale ($1 =$ usually do not do this; $4 =$ I do this a lot or often). The Brief COPE was validated against the original COPE inventory (Finset, Steine, Haugli, Steen, & Laerum, 2002). According to Carver, the psychometric properties of the Brief COPE were derived from participants recovering from Hurricane Andrew. Two scales from the full COPE, Restraint Coping and Suppression of Competing Activities, were omitted from the brief form because the scales had not shown usefulness in previous studies (Carver, 1997). Three scales underwent slight changes in order to sharpen their focus (Carver, 1997).
The Brief COPE can be used as either a trait or state measure of how individuals respond to stressors. In the current study, it was used in a state form and participants were asked to consider “a particular work-related stressor” when responding. The Brief COPE consists of 14 scales; each scale has 2 items. Higher scores on the Brief COPE suggest higher use of that coping action. Carver (1997) found that the measure has stronger internal validity when participants are asked to respond based on a specific situation rather than asked to respond in a general manner or a hypothetical situation. For the current study, participants were asked to consider a particularly stressful client or clinical situation when responding to the questionnaire.

Each item represents a specific method of coping with stressful situations. Internal consistency estimates for the current study were: Active Coping ($\alpha = .75$), Planning ($\alpha = .83$), Positive Reframing ($\alpha = .53$), Acceptance ($\alpha = .18$), Humor ($\alpha = .86$), Religion ($\alpha = .91$), Using Emotional Support ($\alpha = .86$), Using Instrumental Support ($\alpha = .86$), Self-Distraction ($\alpha = .57$), Denial ($\alpha = .87$), Venting ($\alpha = .73$), Substance Use ($\alpha = .90$), Behavioral Disengagement ($\alpha = .38$), and Self-Blame ($\alpha = .48$).

Carver, Scheier, and Weintraub (1989) described the dimensions of coping measured with the original COPE as “very similar” (p. 268) to the core of what Lazarus and Folkman (1985) described as problem-focused and emotion-focused coping. They described that the active coping, planning, and using instrumental support scales were processes that are conceptually similar to what Lazarus and Folkman deemed “problem-focused” coping. Similarly, they described the scales of positive reframing, acceptance, using emotional support, self-distraction, denial, and venting as processes that are conceptually similar to what Lazarus and Folkman named “emotion-focused” coping.
Previous researchers (e.g., Horwitz, Hill, & King, 2011; Wilson, Pritchard, & Revalee, 2005) have combined subscales to create 3 higher order subscales: (1) Emotion-Focused Coping ($\alpha = .71$; substance abuse, use of emotional support, venting, humor, positive reframing, acceptance, religion, and self-blame); (2) Problem-Focused Coping ($\alpha = .69$; active coping, use of instrumental support, and planning); (3) Avoidant Coping (distraction, denial, and behavioral disengagement). Only the Problem-Focused and Emotion-Focused higher order subscales were used in the current study.

As with the WOC-R, the current study used the Brief COPE to address two research questions. First, for purposes of describing how psychotherapists cope with stressful work-related difficulties, descriptive statistics were gathered using each of the subscales. Second, subscales from the Brief COPE were combined to make higher order “problem-focused” and “emotion-focused” coping subscales. The Higher-order subscales were compared to each other to determine if the master’s-level psychologists in the current study were more likely to use Problem-Focused or Emotion-Focused coping when encountering a work-related stressor, and they were used in the path analysis calculations.

**Experiences in Close Relationships-Revised Questionnaire (ECR-R)**

The ECR-R (Fraley, Waller, & Brennan, 2000) is a 36-item self-report measure designed to assess adult romantic attachment. The ECR-R was developed using item response theory analysis of the Experiences in Close Relationship (ECR), designed by Brennan, Clark, & Shaver, (1998), the Adult Attachment Scales (Collins & Read, 1990), the Relationship Styles Questionnaire (Griffin & Bartholomew, 1994), and an unnamed attachment questionnaire by Simpson (1990). Questions are grouped into one of two 18-
item subscales, Avoidance and Anxiety. These subscales are generally accepted as the
two principle dimensions of adult attachment (Brennan, Clark, & Shaver, 1998). The
first subscale measures attachment Avoidance (e.g., “I find it difficult to allow myself to
depend on romantic partners.”). The second subscale measures attachment Anxiety (e.g.,
“I often worry that my partner doesn’t really love me.”). Continuous ratings for each
subscale allows for both classification into discrete styles and the assessment of each
underlying dimension (attachment-related Avoidance and attachment-related Anxiety).
Participants were given a set of instructions that explain that they were to answer
questions related to how they generally feel in emotionally intimate relationships, and not
necessarily just what was happening in a current romantic relationship. Each participant
was asked to respond using a seven-point Likert scale (1 = disagree strongly; 7 = agree
strongly).

Internal reliability has been found to be high for the ECR-R in previous studies.
For example, Fairchild and Finney’s (2006) analysis found Cronbach’s coefficients of
0.93 for the Avoidance Subscale and .92 for the Anxiety Subscale. In the current study,
Cronbach’s alphas were .93 for the Avoidance Subscale and .90 for the Anxiety Subscale.

Sibley, Fischer and Liu (2005) found that the ECR-R is preferable in situations in
which one wants to examine subtle attachment effects with limited power or small effect
sizes. This is relevant in the current study as there is a potential that psychotherapists may
report more subtle attachment concerns than individuals in the general population.
Furthermore, Sibley et al. concluded that the “ECR-R provides one of, if not the, most
appropriate self-report measures of adult romantic attachment currently available” (p.
1534).
In previous studies, the ECR-R demonstrated convergent validity as indicated by the high correlation between subscales of the ECR-R and other measures examining similar constructs. For example the ECR-R anxiety subscale corresponds with related measures of anxiety such as the anxiety and jealousy subscales on Brennan and Shaver's (1995) instrument. The ECR-R avoidance subscale corresponds well with related measures of avoidance such as the discomfort with closeness on Carnelley, Pietromonaco, and Jaffé’s (1994) instrument. When investigating the experiences of doctoral level counseling psychology students, Kardatzke (2009) found significant correlations with the Relationship Assessment Scale. The ECR-R also demonstrated convergence with The Social Provisions Scale (SPS). Furthermore, Sibley et al. (2005) examined the ECR-R via three separate investigations. The ECR-R was found to have a stability estimate of .90-.92 over a three week period. Confirmatory factor analysis confirmed that the ECR-R adequately represented the dimensions of anxiety and avoidance.

In the current study, the ECR-R was used to offer descriptive information regarding the sample and to address two of the research questions. First, the ECR-R subscales were used in order to offer a fuller description of the attachment orientations of the participants. Second, the means for the ECR-R subscales were compared to means from previous samples in order to assess the third hypothesis which stated that the participants would experience lower attachment avoidance and anxiety than did individuals from previous samples. Third, the ECR-R was used to define “avoidant attachment” and “anxious attachment” in the proposed path analysis.
Brief Symptom Inventory (BSI)

The BSI (Derogatis & Melisaratos, 1983) is a 53-item questionnaire designed to measure the psychological symptoms of either psychiatric clients or non-clinical individuals. Participants were asked to rate their level of distress on a five-point Likert scale (0 = not at all; 4 = extremely distressed) with regards to the 53 listed symptoms (e.g., “feeling fearful”, “thoughts of ending your life”). The BSI was developed as a shortened form of the Symptom Distress Checklist (SCL-90-R) and uses the same three global indices of distress: the General Severity Index (GSI), the Positive Symptom Distress Index (PSDI), and the Positive Symptom Total (PST).

For the purposes of this study, current psychological distress was measured by the GSI. The GSI is the single best indicator of current distress levels, according to Derogatis and Melisaratos (1983). It combines information on the numbers of symptoms and the intensity of perceived distress. To calculate the GSI, the sums for the nine symptom dimensions and the additional items are added together and then divided by the total number of responses (i.e., 53 when there are no missing items). The higher the score, the higher the overall psychological distress experienced by participants.

The BSI has demonstrated adequate reliability and validity. Derogatis and Melisaratos (1983) reported test-retest reliability (2 weeks) ranging from .68 to .91 across individual subscales. Stability of the BSI was also evaluated using a test retest of 60 non-psychiatric participants (2 weeks). Derogatis and Melisaratos further found internal consistency reliability ranged from .71 (Psychoticism) to .85 (Depression). The BSI also demonstrated convergent validity by showing high correlations between BSI subscales and similar dimensions on the MMPI clinical scales (Derogatis & Melisaratos, 1983).
The BSI has been used to measure distress among a variety of clinical (e.g., Derogatis & Melisaratos, 1983) and non-clinical samples (e.g., Stefanek, Derogatis, & Shaw, 1987). Reliability for the GSI (2 weeks) was found by Derogatis and Melisaratos to be strong at .90. In the present study, Cronbach’s alpha for the GSI was .94.

In the current study, the GSI was used to offer descriptive information regarding the sample and to address two of the research questions. First, the GSI was used in order to offer a fuller description of the distress experiences of the psychotherapist participants. Second, the overall GSI mean was compared to means from previous samples in order to address the fourth research hypothesis which stated that the participants in this study would experience lower levels of psychological distress than experienced by previous samples. Third, the GSI was used to define “psychological distress” in the path analysis.

**Data Analysis**

Descriptive statistics and Pearson r correlations were calculated for the variables investigated in this study. In addition, path analyses were conducted. Because path analysis is based on multiple regression, preliminary analyses were performed to assess that assumptions of multiple regression were met. Furthermore, as a means of better understanding the influence of demographic factors on responses to the various measures, Pearson r correlations and univariate analysis of variance (ANOVAs) were employed. SPSS software (SPSS, Inc. 2005) was used for the calculations of the descriptive statistics and correlations. AMOS, a multivariate software program, was used for the calculations of the path analyses. In order to examine the first research question, “How prevalent is childhood developmental trauma among master’s-level Psychologists?” and to test the null hypothesis 1, means for the CAT were calculated. In order to offer a more
nuanced understanding of the types of childhood developmental trauma experienced by participants, the means for the subscales were also calculated. In order to address the second research question “What types of coping strategies do master’s-level psychologists use to deal with work-related stressors?” and to test null hypothesis 2, means for higher order subscales of Emotion-focused and Problem-focused coping for both the Brief COPE and the Ways of Coping-Revised measures were calculated. In order to address the third research question “What are the average levels of attachment anxiety and attachment avoidance demonstrated among master’s-level psychologists?” and to test null hypotheses 3a and 3b, means for subscales Avoidant and Anxious on the Experiences in Close Relationships-Revised Questionnaire were calculated. In order to address the fourth research question “How distressed are psychotherapists in comparison to other individuals?” and to test null hypothesis 4, means from the GSI were calculated.

In order to address the final research question “To what degree do attachment orientation and coping strategy mediate the relationship between childhood developmental trauma and current psychological distress?” three exploratory path analyses were performed to consider the two proposed models. The first model, the Indirect Model, explored whether childhood developmental trauma has an indirect effect on the variable of current psychological distress (see figure 1). That is, this path analysis examined whether childhood developmental trauma affects current psychological distress through its effect on attachment orientation and coping strategies. The second path analysis model, the Direct & Indirect Model (see figure 2) examined whether childhood developmental trauma had both an indirect and direct effect on current psychological distress. These two models were compared to see which was the “best fit” for the data.
When the first two models were found to be poor fits to the model, a third model was posed. This model was also assessed for goodness of fit.
CHAPTER IV

RESULTS

This chapter is comprised of four sections. In the first section, I provide a description of preliminary analyses including findings related to group differences across age, gender, amount of time in the field, and personal use of psychotherapy. While these participant descriptors were not directly related to research hypotheses, examination of these variables offers a fuller understanding of participant experiences. In the second section, I provide means and standard deviations for each predictor and outcome variable. The third section describes the analyses and results that are connected to primary and secondary hypotheses (i.e., the hypothesized indirect path analysis model and the alternative hypothesized direct and indirect path analysis model; see Figure 3 and Figure 4). The chapter ends with an alternative, trimmed, model (Figure 5).

Preliminary Analyses and Group Differences

Prior to the main analyses, all variables of interest were examined through SPSS 19 program for the normality of distributions and univariate outliers. The skewness and kurtosis of almost all of the measured variables were less than 1, indicating the scores from the sample could be regarded as normally distributed. The only measured variable that revealed kurtosis of greater than 2 was the Global Severity Index (GSI) of the BSI (skewness = 1.66, kurtosis = 3.417). These findings suggested that the GSI deviated from a normal distribution and thus a log transformation was conducted. The variable, GSILOG, demonstrated a normal distribution after transformation (skewness = -.672, kurtosis = .325). However, the correlation between the GSI and GSILOG was high (r = .85, p = .001). Glass, Peckham, & Sanders (1972) noted that there are generally only
slight effects for significance/power. Simulation studies, using a variety of non-normal distributions, have shown that the false positive rate is not affected very much by this violation of the assumption so decided to go with the GSI (Glass et al., 1975). Furthermore, there was no difference in the inferential statistical results when the GSILog was used in the analysis. Thus, the original GSI remained in the subsequent analysis. No cases were found to have univariate outliers.

With regard to the proposed path analyses, there are important assumptions that should be met. First, because path analysis is based on the multiple regression technique, the assumptions of multiple regression apply to path analysis. Most importantly, measurement error and specification error can lead to serious consequences such as incorrect estimates of standardized regression coefficients. The advantage of using a covariance analysis program, such as AMOS, however, is that the assumption that variables are measured without error is not necessary (Klem, 1995). Another assumption when using path analysis is that the causal ordering in the model is correct. Furthermore, path analysis assumes that the model has the correct variables. Decisions made regarding causal ordering and use of variables, therefore, should be made based on sound theoretical conceptualization and previous research findings, a practice employed in the current study.

**Group Differences**

Preliminary analyses also included tests of group differences across demographic variables. Of particular interest were age, gender, amount of time in the field, and personal use of psychotherapy. I speculated that these factors may impact both the participants' experience of childhood developmental trauma and their report of distress.
Pearson correlation coefficients were calculated to examine the relationships between participants’ age and amount of time they had been working in the mental health field across measures. There was a large, positive relationship between the participants’ age and length of time in the mental health field, \((r = .74, n = 128, p = .000)\). Older participants had been in the mental health field for longer periods of time. The findings of Pearson correlation coefficient indicated that there was not a significant linear relationship between length of time in the field and Emotion-focused coping strategy using either the WOC-R \((r = .051, n = 128, p = .571)\) or the Brief COPE \((r = -.07, n = 128, p = .385)\). Also, there was not a significant linear relationship between length of time in the field and Problem-focused Coping using either the WOC-R \((r = .049, n = 128, p = .580)\) or the Brief COPE \((r = .021, n = 128, p = .817)\), level of psychological distress \((r = .031, n = 128, p = .729)\), anxious attachment \((r = -.040, n = 128, p = .651)\), avoidant attachment \((r = -.083, n = 128, p = .353)\), or the experience of childhood developmental trauma \((r = .021, n = 128, p = .813)\). Furthermore, there was not a significant linear relationship between participant age and Emotion-focused coping using either the WOC-R \((r = .033, n = 129, p = .713)\) or the Brief COPE \((r = -.124, n = 129, p = .161)\). Also, there was not a significant linear relationship between participant age and Problem-focused Coping using either the WOC-R \((r = -.016, n = 129, p = .860)\) or the Brief COPE \((r = -.037, n = 129, p = .675)\), level of psychological distress \((r = -.048, n = 129, p = .588)\), anxious attachment \((r = -.029, n = 129, p = .744)\), avoidant attachment \((r = -.072, n = 129, p = .414)\), or the experience of childhood developmental trauma \((r = .019, n = 129, p = .830)\). Table 4 presents the correlational matrix for the variables in this study and the correlations for these variables.
Table 4

Correlation Table for Variables in the Model 1, Model 2, and Model 3

<table>
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<tr>
<th>Measure</th>
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<td>1. Brief COPE</td>
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<td>2. Brief COPE</td>
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<td>3. GSI</td>
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<td>4. WOCR</td>
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<td>5. WOCR</td>
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<td>6. ECR-R</td>
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<td>7. ECR-R</td>
<td>.015</td>
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<td>.251**</td>
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<td>8. CAT</td>
<td>.296**</td>
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<td>.136</td>
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</table>

| M    | 2.53 | 2.09 | .35  | .59  | 1.38 | 2.31 | 2.49 | 1.11 |
| S<sub>D</sub> | .64  | .47  | .30  | .35  | .44  | .91  | .99  | .58  |

p < .001 = ***; p < .01 = **; p < .05 = *; M = Mean of each variable; S<sub>D</sub> = standard deviation (1-tailed)

In order to test for group differences across genders, ANOVAs were employed. Levene statistics were employed to assess whether the homogeneity of variance assumption was met. When this assumption was not met, the obtained Welch's adjusted F ratio was used to determine if significant differences existed. One-way ANOVAs indicated that there was a significant difference between how males and females responded to the CAT Sexual Abuse and Neglect subscales. Males and females did not respond differently to the overall CAT scale, the Punishment subscale, and the Emotional Abuse subscale, as well as all other measures. These finding are represented in Table 5.
Table 5

Participant Responses to Measures Related to Gender

<table>
<thead>
<tr>
<th>Measure</th>
<th>Means</th>
<th>F Statistic</th>
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<tbody>
<tr>
<td>CAT Total</td>
<td>Females: $M = 1.17 (SD = .57)$ Males: $M = .98 (SD = .56)$</td>
<td>$F (.946, 72.370) = 2.969, p = .087$</td>
</tr>
<tr>
<td>CAT: Punishment</td>
<td>Females: $M = 1.42 (SD = .78)$ Males: $M = 1.35 (SD = .64)$</td>
<td>$F (.136, 70.143) = .246, p = .621$</td>
</tr>
<tr>
<td>CAT: Sexual Abuse</td>
<td>Females: $M = .35 (SD = .58)$ Males: $M = .12 (SD = .38)$</td>
<td>$Welch's F(1, 105.24) = 7.3, p = .008, \omega^2 = .05$</td>
</tr>
<tr>
<td>CAT: Emotional</td>
<td>Females: $M = 1.31 (SD = .87)$ Males: $M = 1.06 (SD = .81)$</td>
<td>$F (1.658, 93.116) = 2.261, p = .135$</td>
</tr>
<tr>
<td>CAT: Neglect</td>
<td>Females: $M = 1.25 (SD = .75)$ Males: $M = .98 (SD = .56)$</td>
<td>$F (2.872, 72.370) = 5.04, p = .026, \eta^2 = .0382, d = .39$</td>
</tr>
<tr>
<td>WOC-R: Problem</td>
<td>Females: $M = 1.39 (SD = .45)$ Males: $M = 1.35 (SD = .44)$</td>
<td>$F (0.044, 25.078) = .225, p = .636$</td>
</tr>
<tr>
<td>WOC-R: Emotion</td>
<td>Females: $M = .57 (SD = .34)$ Males: $M = .63 (SD = .39)$</td>
<td>$F (.101, 16.237) = .791, p = .375$</td>
</tr>
<tr>
<td>Brief COPE: Problem</td>
<td>Females: $M = 2.58 (SD = .58)$ Males: $M = 2.39 (SD = .75)$</td>
<td>$F (1.035, 51.527) = 2.550, p = .113$</td>
</tr>
<tr>
<td>Brief COPE: Emotion</td>
<td>Females: $M = 2.08 (SD = .49)$ Males: $M = 1.96 (SD = .54)$</td>
<td>$F (.423, 32.678) = 1.644, p = .202$</td>
</tr>
<tr>
<td>ECR-R: Anxious</td>
<td>Females: $M = 2.31 (SD = .96)$ Males: $M = 2.31 (SD = .80)$</td>
<td>$F (1.000, 107.44) = .000, p = .997$</td>
</tr>
<tr>
<td>ECR-R: Avoidant</td>
<td>Females: $M = 2.58 (SD = .58)$ Males: $M = 2.39 (SD = .75)$</td>
<td>$F (380, 127.11) = .379, p = .539$</td>
</tr>
<tr>
<td>BSI: GSI</td>
<td>Females: $M = .37 (SD = .31)$ Males: $M = .30 (SD = .25)$</td>
<td>$F (.113, 11.262) = 1.271, p = .262$</td>
</tr>
</tbody>
</table>

Note. CAT = Child Abuse and Trauma Scale; WOC-R = Ways of Coping, Revised; ECR-R = Experiences in Close Relationships, Revised; BSI = Brief Symptom Inventory; GSI = Global Symptom Inventory
In order to test for group differences related to whether participants had personally used psychotherapy, ANOVAs were calculated. Levene statistics were employed to assess whether the homogeneity of variance assumption was met. When this assumption was not met, the obtained Welch's adjusted $F$ ratio was used to determine if significant differences existed. One-way ANOVAs indicated that participants who had had their own therapy responded significantly differently than those participants who had not had their own therapy on the overall CAT score and two of the subscales, Neglect and Emotional Abuse, as well as the Anxious subscale of the ECR-R and the GSI. Participants who had personally used psychotherapy did not respond differently on the Punishment and Sexual Abuse subscales for the CAT, Emotion-Focused and Problem-Focused higher order scales on both the WOCR and Brief COPE, as well as the Avoidant subscale on the ECR-R. These findings are demonstrated in Table 6.
Table 6  
Participant Responses to Measures Related to Personal Use of Psychotherapy

<table>
<thead>
<tr>
<th>Measure</th>
<th>Means</th>
<th>F Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAT Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Therapy: $M = 1.18$  ($SD = .57$)</td>
<td>$F (1.946, 37.472) = 6.438, p = .012, \eta^2 = .0497, d = .46$</td>
</tr>
<tr>
<td></td>
<td>No Therapy: $M = .87$  ($SD = .45$)</td>
<td></td>
</tr>
<tr>
<td>CAT: Punishment</td>
<td>Therapy: $M = 1.47$  ($SD = .75$)</td>
<td>$F (2.002, 65.541) = 3.79, p = .054$</td>
</tr>
<tr>
<td></td>
<td>No Therapy: $M = 1.16$  ($SD = .63$)</td>
<td></td>
</tr>
<tr>
<td>CAT: Sexual Abuse</td>
<td>Therapy: $M = .32$  ($SD = .57$)</td>
<td>$F (.950, 33.314) = 3.53, p = .062$</td>
</tr>
<tr>
<td></td>
<td>No Therapy: $M = .10$  ($SD = .22$)</td>
<td></td>
</tr>
<tr>
<td>CAT: Emotional</td>
<td>Therapy: $M = 1.35$  ($SD = .89$)</td>
<td>Welch's $F(1, 68.98) = 17.20, p = .000, \omega^2 = .110$</td>
</tr>
<tr>
<td></td>
<td>No Therapy: $M = .79$  ($SD = .54$)</td>
<td></td>
</tr>
<tr>
<td>CAT: Neglect</td>
<td>Therapy: $M = 1.27$  ($SD = .78$)</td>
<td>Welch's $F(1, 56.93) = 16.67, p = .000, \omega^2 = .107$</td>
</tr>
<tr>
<td></td>
<td>No Therapy: $M = .74$  ($SD = .55$)</td>
<td></td>
</tr>
<tr>
<td>WOC-R: Problem</td>
<td>Therapy: $M = 1.37$  ($SD = .43$)</td>
<td>$F (.001, 24.49) = .003, p = .958$</td>
</tr>
<tr>
<td></td>
<td>No Therapy: $M = 1.37$  ($SD = .50$)</td>
<td></td>
</tr>
<tr>
<td>WOC-R: Emotion</td>
<td>Therapy: $M = .59$  ($SD = .34$)</td>
<td>$F (.069, 15.03) = .563, p = .455$</td>
</tr>
<tr>
<td></td>
<td>No Therapy: $M = .53$  ($SD = .38$)</td>
<td></td>
</tr>
<tr>
<td>Brief COPE: Problem</td>
<td>Therapy: $M = 2.54$  ($SD = .59$)</td>
<td>$F (.332, 50.57) = .815, p = .368$</td>
</tr>
<tr>
<td></td>
<td>No Therapy: $M = 2.41$  ($SD = .78$)</td>
<td></td>
</tr>
<tr>
<td>Brief COPE: Emotion</td>
<td>Therapy: $M = 2.09$  ($SD = .49$)</td>
<td>$F (.863, 31.45) = 3.403, p = .067$</td>
</tr>
<tr>
<td></td>
<td>No Therapy: $M = 1.88$  ($SD = .53$)</td>
<td></td>
</tr>
<tr>
<td>ECR-R: Avoidant</td>
<td>Therapy: $M = 2.52$  ($SD = 1.05$)</td>
<td>$F (.246, 126.35) = .241, p = .624$</td>
</tr>
<tr>
<td></td>
<td>No Therapy: $M = 2.41$  ($SD = .81$)</td>
<td></td>
</tr>
<tr>
<td>ECR-R: Anxious</td>
<td>Therapy: $M = 2.43$  ($SD = .96$)</td>
<td>Welch's $F(1, 69.63) = 16.33, p = .000, \omega^2 = .042$</td>
</tr>
<tr>
<td></td>
<td>No Therapy: $M = 1.84$  ($SD = .57$)</td>
<td></td>
</tr>
<tr>
<td>BSI: GSI</td>
<td>Therapy: $M = .39$  ($SD = .35$)</td>
<td>Welch's $F(1, 87.92) = 16.82, p = .000, \omega^2 = .052$</td>
</tr>
<tr>
<td></td>
<td>No Therapy: $M = .21$  ($SD = .16$)</td>
<td></td>
</tr>
</tbody>
</table>

Note. CAT = Child Abuse and Trauma Scale; WOC-R = Ways of Coping, Revised; ECR-R = Experiences in Close Relationships, Revised; BSI = Brief Symptom Inventory; GSI = Global Symptom Inventory
Research Questions and Null Hypotheses

In this section, I present the means and standard deviations of each variable for the entire sample (N = 130). I assess the first four research questions and null hypotheses. I describe variables are described in the following order: childhood developmental trauma, coping strategy, attachment orientation, and current psychological distress. When I report means for the same instrument that was used in the current study, I compared these means to findings from previous studies to situate current findings in context of the literature. I used one sample t-tests to compare means from the current study to means from previous studies and a level of $p < .05$ was used to test for significance.

Childhood Developmental Trauma

The literature regarding childhood developmental trauma among psychotherapists is limited. Those researchers who have investigated the prevalence of such experiences have found that psychotherapists report having experienced more childhood developmental trauma than non-clinician individuals. In order to add to the literature regarding psychotherapists, the first research question of, "How prevalent is childhood developmental trauma among master's-level psychologists?" was studied. It was hypothesized that participants in the current study would report, on average, more experiences of childhood developmental trauma when compared to sample norms as measured by the CAT. The null hypothesis for this question was that psychotherapists in the current study did not differ, on average, in their report of childhood developmental trauma as compared to the existing studies with non-clinician samples.

To consider the first research question and to test the null hypothesis, I compared the participants' mean responses on the Child Abuse and Trauma Scale (CAT; Sanders &
Becker-Lausen, 1995) with mean scores from non-clinician populations reported from previous studies using the CAT. Table 7 presents the means and standard deviations for the current study and the normed samples. Means from the normed samples for the CAT total score were: .75 (SD = .42, N = 834; Sanders & Becker-Lausen, 1995), .73 (SD = .41, N = 301; Sanders & Becker-Lausen, 1995), and .77 (SD = .66, N = 236; Kent & Waller, 1998). Descriptive statistics revealed that the current sample had a total CAT mean score of 1.1 (SD = .56). The results indicated that the participants in this study endorsed significantly more experience of childhood developmental trauma when compared to first Sanders and Becker-Lausen norm sample, $t (129) = 7.32, p = .000, \eta^2 = .11, d = .71$ and the second Sanders and Becker-Lausen norm sample, $t (129) = 7.72, p = .000, \eta^2 = .13, d = .76$ when responding to questions on the CAT. Furthermore, the results indicated that the current participants endorsed significantly more experience childhood developmental trauma than the Kent and Waller norm sample, $t (129) = 6.92, p = .000, \eta^2 = .07, d = .54$. The participants endorsed experiences of childhood developmental trauma similarly to the clinically focused psychology students in the Nikcevic and colleagues’ study (2007; $M = 1.04, SD = .49), t (129) = 1.49, p = .139.$
Table 7

Summary of Means and Standard Deviations for Current and Norm Samples on the CAT

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CAT Total</td>
<td>$M = 1.1$ (SD = .56)</td>
<td>$M = .75$ (SD = .42)</td>
<td>$M = .77$ (SD = .66)</td>
</tr>
<tr>
<td></td>
<td>$p &lt; .001$</td>
<td>$p &lt; .001$</td>
<td>$p &lt; .001$</td>
</tr>
<tr>
<td>Punishment</td>
<td>$M = 1.4$ (SD = .74)</td>
<td>$M = 1.16$ (SD = .53)</td>
<td>$M = 1.12$ (SD = .82)</td>
</tr>
<tr>
<td></td>
<td>$p = .002$</td>
<td>$p = .002$</td>
<td>$p = .002$</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>$M = .28$ (SD = .54)</td>
<td>$M = .11$ (SD = .29)</td>
<td>$M = .21$ (SD = .45)</td>
</tr>
<tr>
<td></td>
<td>$p &lt; .001$</td>
<td>$p &lt; .001$</td>
<td></td>
</tr>
<tr>
<td>Emotional Abuse</td>
<td>NOT FACTORED</td>
<td>NOT FACTORED</td>
<td>$M = .08$ (SD = .63)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$p = .002$</td>
</tr>
<tr>
<td>Neglect</td>
<td>$M = 1.16$ (SD = .77)</td>
<td>$M = .11$ (SD = .59)</td>
<td>$M = .83$ (SD = .86)</td>
</tr>
<tr>
<td></td>
<td>$p &lt; .001$</td>
<td>$p &lt; .001$</td>
<td>$p &lt; .001$</td>
</tr>
</tbody>
</table>

Note. CAT = Child Abuse and Trauma Scale; $p < .001 = ***$; $p < .01 = **$; $p < .05 = *$; $M = $ Mean of each variable; SD = standard deviation.

Means from the normed samples on the Negative Home Environment/Neglect subscale were: .85 (SD = .63; Sanders & Becker-Lausen, 1995), .80 (SD = .59; Sanders & Becker-Lausen, 1995), and .83 (SD = .86; Kent & Waller, 1998). Descriptive statistics revealed that the current sample had a Negative Home Environment/Neglect mean score of 1.16 (SD = .77). The results indicated that the participants in this study endorsed significantly more experiences of negative home environments/neglect when compared to first Sanders and Becker-Lausen norm sample, $t(129) = 4.65, p = .000, \eta^2 = .0462, d = .44$, and the second Sanders and Becker-Lausen norm sample, $t(129) = 5.39, p = .000, \eta^2 = .0633, d = .52$, when responding to Negative Home Environment/Neglect subscale.
questions on the CAT. Furthermore, the results indicated that the current participants endorsed significantly more experience of negative home environments/neglect than the Kent and Waller norm sample, \( t(129) = 4.94, p = .000, \eta^2 = .0385, d = .40 \). The participants endorsed experiences of neglect similarly to the clinically focused psychology students in the Nikcevic et al study (2007; \( M = 1.22, SD = .67 \), \( t(129) = - .836, p = .405 \).

Means from previous studies on the Sexual Abuse subscale of the CAT were: .08 (SD = .63; Sanders & Becker-Lausen, 1995), .11 (SD = .29; Sanders & Becker-Lausen, 1995), and .21 (SD = .45; Kent & Waller, 1998). Descriptive statistics revealed that the current sample had a Sexual Abuse subscale mean score of .28 (SD = .54). The current participants endorsed significantly higher levels of sexual abuse when compared to first Sanders and Becker-Lausen normed sample \( t(129) = 4.283, p = .000, \eta^2 = .0282, d = .341 \), and the second Sanders and Becker-Lausen norm sample, \( t(129) = 3.647, p = .000, \eta^2 = .0366, d = .39 \). When compared to the Kent and Waller sample, however, there was not a significant difference between them on this subscale, \( t(129) = 1.53, p = .129 \). The participants endorsed experiences of sexual abuse similarly to the clinically focused psychology students in the Nikcevic, and colleagues study (2007; \( M = .26, SD = .36 \), \( t(129) = .467, p = .640 \).

Means from previous studies on the Punishment subscale were: 1.2 (SD = .54; Sanders & Becker-Lausen, 1995), 1.16 (SD = .53; Sanders & Becker-Lausen, 1995), and 1.12 (SD = .82; Kent & Waller, 1998). Descriptive statistics revealed that the current sample had a Punishment subscale mean score of 1.4 (SD = .74). The results indicated that the participants in this study endorsed significantly more experience of punishment.
than the first Sanders and Becker-Lausen normed sample, $t(129) = 3.11, p = .002, \eta^2 = .0233, d = .31$, and the second Sanders and Becker-Lausen normed sample, $t(129) = 3.72, p = .000, \eta^2 = .0336, d = .37$, when responding to Punishment subscale questions on the CAT. Furthermore, the results indicated that the current participants endorsed significantly more experience of punishment than the Kent and Waller norm sample, $t(129) = 4.34, p = .000, \eta^2 = .0312, d = .36$. The participants endorsed experiences of punishment similarly to the clinically focused psychology students in the Nikcevic, Kramolisova-Advani, and Spada study (2007; $M = 1.49, SD = .74$), $t(129) = -1.374, p = .172$.

Means from the normed sample on the Emotional Abuse subscale was .83 ($SD = .86$; Kent & Waller, 1998). Descriptive statistics revealed that the current sample had an Emotional Abuse subscale mean score of 1.2 ($SD = .86$). These results indicated that the participants in this study endorsed significantly more experiences of punishment than the normed sample, $t(129) = 5.34, p = .000, \eta^2 = .0442, d = .43$ when responding to Punishment subscale questions on the CAT.

Based on the significant difference between the means of this sample and the means of the normed sample on the CAT, the null hypothesis for first research question was rejected. This sample reported significantly more childhood developmental trauma than did the non-clinician samples used when developing the CAT.

**Coping**

Previous researchers have found that psychotherapists are more likely to use problem-focused than emotion-focused coping strategies when encountering work-related stressors. Unfortunately, few researchers have studied the coping strategies of this
population. In order to add to the literature related to psychotherapists' use of coping strategies, the second research question of, "What types of coping strategies do master's-level psychologists use to deal with work-related stressors?" was studied. It was hypothesized that the participants in the current study would report higher use of Problem-Focused coping strategies over Emotion-Focused coping strategies. The null hypotheses for this question were that psychotherapists in the current study would report higher or equal rates of emotion-focused over problem-focused of both coping strategies when encountering work-related stressors.

To consider the second research question and to test the null hypotheses, the participants' mean responses on the emotion-focused higher order subscales were compared with the mean responses on the Problem-focused higher order subscales for both the Ways of Coping-Revised (WOC-R; Folkman & Lazarus, 1985) and the Brief COPE (Carver, 1997). With regard to both measures, which were designed to assess and identify individual's coping processes, an overall mean is not calculated. Instead means were found for the subscales. As previously described, certain subscales were then combined in order to create higher order subscales of Emotion-focused and Problem-focused coping.

Means for the subscales on the WOC-R were Planful Problem-Solving ($M = 1.85; SD = .56$), Confrontive Coping ($M = .84; SD = .43$), Self-Controlling ($M = 1.49; SD = .50$), Seeking Social Support ($M = 1.45; SD = .62$), Accepting Responsibility ($M = .63; SD = .53$), Escape-Avoidance ($M = .39; SD = .39$), and Positive Reappraisal ($M = 1.35; SD = .69$). As indicated by Dunkel-Schetter, Folkman, and Lazarus (1987), the scores for the subscales Confrontive Coping, Seeking Social Support, Positive Reappraisal, and Planful
Problem-Solving were combined to create the higher order Problem-Focused subscale. Descriptive statistics revealed that the current sample had a higher order Problem-Focused coping mean score of 1.38 (SD = .44). The scores from the subscales Distancing, Accepting Responsibility, and Escape-Avoidance were combined to form a higher-order subscale Emotion-Focused. Descriptive statistics revealed that the current sample had an Emotion-Focused mean score of .59 (SD = .36). The results indicated that the participants in this study endorsed significantly more use of Problem-Focused coping strategies than Emotion-Focused strategies, \( t(129) = 20.363, p = .000, \eta^2 = .4924, d = 1.965 \), when responding to questions on the Ways of Coping-Revised.

Means for the subscales of the Brief COPE (Carver, 1997) were Active Coping (\( M = 3.01; SD = .80 \)), Self-Distraction (\( M = 2.11; SD = .78 \)), Denial (\( M = 1.03; SD = .21 \)), Substance Use (\( M = 1.16; SD = .44 \)), Use of Emotional Support (\( M = 2.68; SD = .88 \)), Use of Instrumental Support (\( M = 1.73; SD = .74 \)), Behavioral Disengagement (\( M = 1.15; SD = .39 \)), Vventing (\( M = 2.19; SD = .77 \)), Positive Reframing (\( M = 2.25; SD = .80 \)), Planning (\( M = 2.83; SD = .92 \)), Humor (\( M = 1.91; SD = .85 \)), Acceptance (\( M = 2.70; SD = .80 \)), Religion (\( M = 2.30; SD = 1.18 \)), and Self-Blame (\( M = 1.60; SD = .75 \)). Previous researchers (e.g., Horwitz, Hill, & King, 2011; Wilson, Pritchard, & Revalee, 2005) have combined subscales from the Brief COPE to create higher order Problem-Focused and Emotion-Focused subscales. The first higher order subscale, Problem-Focused coping, combines the subscales Active Coping, Use of Instrumental Support, and Planning. Descriptive statistics revealed that the current sample had a higher order Problem-Focused coping mean score of 2.53 (SD = .30). The second higher order subscale, Emotion-focused coping, combines Substance Abuse, Use of Emotional Support,
Venting, Humor, Positive Reframing, Acceptance, Religion, and Self-Blame. Descriptive statistics revealed that the current sample had a higher order Emotion-focused mean score of 2.09 ($SD = .47$). The results indicated that the participants in this study endorsed significantly more use of Problem-focused coping strategies than Emotion-focused strategies, $t (129) = 7.78, p = .000, \eta^2 = .2374, d = 1.12$, when responding to questions on the Brief COPE.

When responding to questions regarding coping with work-related stressors, psychotherapists in the current study indicated, on both the WOC-R and the Brief COPE, significantly more use of Problem-Focused coping than Emotion-Focused coping. Based on these findings, the null hypothesis for the second research question was rejected.

**Attachment**

Previous researchers have found that psychotherapists report more “secure” attachment orientations when compared to non-clinicians. This population remains remarkably understudied with regard to their attachment orientations. In order to add to the literature on the attachment orientations of psychotherapists, the third research question, “What are the average levels of attachment anxiety and attachment avoidance demonstrated among masters-level psychologists?” was asked. Based on past findings, I hypothesized that psychotherapists in the current study would demonstrate lower mean scores on both the Anxious and Avoidant subscales of the ECR-R than the mean scores of the normed samples for this instrument. The null hypothesis was that the participants in this study would demonstrate higher means on both the Anxious and Avoidant subscales than the means from the norming samples.
To consider the third research question and to test the null hypotheses, means from the Anxious and Avoidant subscales of the Experiences in Close Relationships-Revised Questionnaire (ECR-R; Fraley, Waller, & Brennan, 2000) were compared to the means found from the normed samples consisting of undergraduate students. Table 8 presents the means and standard deviations for the current study and the norm samples. Means from previous studies for the ECR-R Anxious subscale were: 2.16 (SD = 1.08; Fraley, et al.) and 2.03 (SD = 1.16; Sibley, Fisher, & Liu, 2005). Descriptive statistics revealed that the current sample had an Anxious subscale mean score of 2.30 (SD = .91). A one-sample t-test was conducted to determine how participants in this study compared to Fraley and colleagues’ normed sample (M = 2.16, SD = 1.08). The results indicated that the participants in this study did not endorse significantly more or less anxious attachment than the normed sample, t (129) = 1.89, p = .061. However, when compared to the Sibley and colleagues’ normed sample (M = 2.03, SD = 1.16), the current sample did endorse significantly more anxious attachment, t (129) = 3.51, p = .001, η2 = .0165, d = .25
**Table 8**

*Summary of Means and Standard Deviations for Current and Norm Samples on the ECR-R*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anxious subscale</strong></td>
<td><strong>M = 2.16 (SD = 1.08)</strong></td>
<td><strong>M = 2.03 (SD = 1.16)</strong></td>
</tr>
<tr>
<td></td>
<td><em>p = .061</em></td>
<td><em>t (129) = 3.51, p = .001</em></td>
</tr>
<tr>
<td><strong>Avoidant subscale</strong></td>
<td><strong>M = 2.06 (SD = 1.13)</strong></td>
<td><strong>M = 1.75 (SD = 1.01)</strong></td>
</tr>
<tr>
<td></td>
<td><em>t (129) = 4.96, p &lt; .001</em></td>
<td><em>t (129) = 8.52, p &lt; .001</em></td>
</tr>
</tbody>
</table>

*Note. ECR-R = Experiences in Close Relationships-Revised; p < .001 = ***; p < .01 = **; p < .05 = *; M = Mean of each variable; SD = standard deviation*

In her dissertation study examining the attachment orientations of Canadian psychologists, Nigro’s (2005) sample had a mean of 2.06 (SD = 1.33; Nigro, 2005) for the Anxious subscale. The current sample endorsed significantly more Anxious attachment, *t (129) = 3.14, p = .002, η2 = .011, d = .211*, than did the Canadian psychologists in Nigro’s sample. Furthermore, when studying the attachment orientations of counseling psychology doctoral students for her dissertation, Kardatzke (2009), found a mean of 2.18 (SD = 1.02) on the Anxious subscale. The current sample also endorsed significantly more Anxious attachment, *t (129) = 3.59, p = .000, η2 = .0038, d = .12*, than was found in Kardatzke’s sample.

Means from sampling norms for the ECR-R Avoidant subscale were: 2.06 (SD = 1.13, N = 1085; Fraley, et al., 2000) and 1.75 (SD = 1.01; Sibley, et al., 2005). Descriptive statistics revealed that the current sample had an Avoidant subscale mean score of 2.50 (SD = .99). A one-sample t-test was conducted to determine how
participants in this study compared to the Fraley and colleagues’ normed sample \( (M = 2.06, SD = 1.13) \). The results indicated that the participants in the current study endorsed significantly more avoidant attachment than the normed sample, \( t (129) = 4.96, p = .000, \eta^2 = .0411, d = .414 \). Similarly, when compared to the Sibley and colleagues’ normed sample, the current sample also endorsed significantly more avoidant attachment than the normed sample, \( t (129) = 8.52, p = .000, \eta^2 = .1233, d = .75 \).

In her dissertation study examining the attachment orientations of psychologists, Nigro (2005) found a mean of 2.24 \((SD = 1.35)\) on the Avoidant subscale. The current sample also endorsed significantly more avoidance attachment \( t (129) = 3.24, p = .002, \eta^2 = .012, d = .22 \), than did the psychologists in her sample. However, when studying the attachment orientations of counseling psychology doctoral students, Kardatzke (2009), found a mean of 2.64 \((SD = .90)\) on the Avoidant subscale. The current sample endorsed significantly less Avoidant attachment, \( t (129) = -4.10, p = .000, \eta^2 = .0054, d = .148 \), than was found in her sample of counseling psychology doctoral students.

The findings for research question three indicates that the psychotherapists in the current sample experience higher levels of both Anxious and Avoidant attachment than did the normed samples. Based on these findings, the null hypothesis is retained.

**Distress**

Those researchers who have investigated this population have found that psychotherapists report less psychological distress when compared to individuals in other professions. Few researchers, however, have examined distress levels of psychotherapists. In order to add to the literature related to psychotherapists’ experience of psychological distress, the question of, “How distressed are psychotherapists in
comparison to other individuals?” was studied. I hypothesized that the psychotherapists in the current study would, on average, report lower levels of distress when compared to mean responses from previous studies using non-clinicians. Previous findings have indicated that psychotherapists experience less distress than individuals in other professions, including lawyers, physicians, and people in law enforcement (e.g., Elliot & Guy, 1993; Follette, Polunsy, & Milbeck, 1994; Radeke & Mahoney, 2000). The null hypothesis for the fourth research question was that psychotherapists in the current study would, on average, report equal to or higher levels of psychological distress when compared to mean responses from previous studies using non-clinician samples.

To consider the fourth research question, the mean score for the current sample on the General Severity Index (GSI), a global index of Brief Symptom Inventory (BSI), was compared to mean score of the non-patient sample and the outpatient normed sample (Derogatis & Melisaratos, 1983). Descriptive statistics revealed that the current sample had a total GSI mean score of .35 (SD = .30). A one-sample t-test was conducted to determine how participants in this study compared to the adult outpatient normed sample (M = 1.32, SD = .72). The results indicated that the participants in this study endorsed significantly less psychological distress than the outpatient normed sample, \(t(129) = -37.36, p = .000, \eta^2 = .0436, d = 1.76\). A one-sample t-test was also conducted to determine how participants in the current study compared to the adult non-patient normed sample (M = .30, SD = .31). The participants in this study did not report significantly more distress than the normed non-patient participants \(t(129) = 1.80, p = .074\). The findings for research question four indicates that the psychotherapists in the current sample experience similar levels of psychological distress when compared to non-patients.
but significantly lower levels when compared to outpatient participants in the normed sample. Based on these findings, the null hypothesis is retained.

**Proposed Theoretical Models**

Researchers have begun to examine mediators and moderators between childhood developmental trauma and current experience of psychological distress among various populations. In order to test a potential theoretical model regarding the experiences of psychotherapists, the question of, “To what degree do attachment orientation and coping strategy mediate the relationship between childhood developmental trauma and current psychological distress?” was studied using path analysis.

In this study, I investigated and compared two possible models concerning the impact of childhood developmental trauma on current experience of psychological distress. To consider research question 5, path analyses were performed using the AMOS statistical software package. Childhood developmental trauma was the lone exogenous variable in both models. Because of the covariance between the Brief COPE and the WOC-R, the residuals for these measures were correlated in order to incorporate the shared variance. In one model the effects of childhood developmental trauma were hypothesized to indirectly effect current psychological distress through the variables of anxious attachment and emotion-focused coping (Figure 3). The model also hypothesized that childhood developmental trauma directly impacted attachment orientation, as well as directly and indirectly effecting coping strategy used. In the direct and indirect model, all hypothesized paths from the indirect model remain the same with the addition of a direct path between childhood developmental trauma and psychological distress (Figure 4).
**Indirect Model**

Model 1, which is presented in Figure 3, represents the Indirect Model. The Indirect Model had a goodness of fit index (GFI) of .722. Wuensch (2006) recommended a GFI exceeding .9 for a model that accurately fits the data. The GFI for this model is therefore below what is considered a good fitting model. Furthermore, the Indirect Model had a normed fix index (NFI) of .350, which again is well below the recommended .9 or higher for good fitting models (Wuensch, 2006). The comparative fit index (CFI), which falls between 0 and 1, with values close to 1 indicating a good fit was .336. This indicates that the Indirect Model was only 33.6% better than the independent or null model, which assumes all variables are uncorrelated to each other. The root mean square error of approximation (RMSEA) compares models to the saturated model. A saturated model is the most general model possible and is guaranteed to perfectly fit any set of data. The RMSEA is used to calculate a lack of fit for the Indirect Model to the saturated model, and RMSEA of .08 or less equals an adequate fit, while RMSEA of .05 or less indicates an overall good fitting model (Wuensch, 2006). The Indirect Model RMSEA was .335, which is well above the indicators for a good or even adequate fitting model. When considered with the other indices indicating poor fit, the Indirect Model is rejected.
Figure 3. Results of Indirect Path Model
Table 9

Model 1 – Indirect Model Maximum Likelihood Estimates

<table>
<thead>
<tr>
<th>Path</th>
<th>Estimate</th>
<th>S.E.</th>
<th>C.R.</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECRANX &lt; --- MCATtotal</td>
<td>.325</td>
<td>.139</td>
<td>2.337</td>
<td>.019</td>
</tr>
<tr>
<td>ECRAVO &lt; --- MCATtotal</td>
<td>.127</td>
<td>.154</td>
<td>.822</td>
<td>.411</td>
</tr>
<tr>
<td>WOCREMO &lt; --- ECRANX</td>
<td>.050</td>
<td>.054</td>
<td>.920</td>
<td>.357</td>
</tr>
<tr>
<td>EMOBRIEF2&lt; --- MCATtotal</td>
<td>.135</td>
<td>.072</td>
<td>1.874</td>
<td>.061</td>
</tr>
<tr>
<td>WOCREMO &lt; --- ECRANX</td>
<td>.111</td>
<td>.033</td>
<td>3.320</td>
<td>.001</td>
</tr>
<tr>
<td>EMOBRIEF2&lt; --- ECRANX</td>
<td>.108</td>
<td>.045</td>
<td>2.407</td>
<td>.016</td>
</tr>
<tr>
<td>WOCRPROB &lt; --- MCATtotal</td>
<td>.217</td>
<td>.066</td>
<td>3.303</td>
<td>.001</td>
</tr>
<tr>
<td>PROBBrief&lt; --- MCATtotal</td>
<td>.334</td>
<td>.095</td>
<td>3.513</td>
<td>.001</td>
</tr>
<tr>
<td>PROBBrief&lt; --- ECRAVO</td>
<td>-.004</td>
<td>.054</td>
<td>.072</td>
<td>.943</td>
</tr>
<tr>
<td>WOCRPROB &lt; --- ECRANX</td>
<td>.027</td>
<td>.037</td>
<td>.712</td>
<td>.476</td>
</tr>
<tr>
<td>GSI &lt; --- ECRANX</td>
<td>.091</td>
<td>.026</td>
<td>3.467</td>
<td>.001</td>
</tr>
<tr>
<td>GSI &lt; --- EMOBRIEF2</td>
<td>.029</td>
<td>.054</td>
<td>.539</td>
<td>.590</td>
</tr>
<tr>
<td>GSI &lt; --- WOCREMO</td>
<td>.279</td>
<td>.066</td>
<td>4.244</td>
<td>.001</td>
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</tbody>
</table>

Note. ECRANX = Anxious Attachment, ECRAVO = Avoidant Attachment, EMOBrief = Emotion-Focused Coping (Brief COPE), WOCREMO = Emotion-Focused Coping (WOC-R), PROBBrief = Problem-Focused Coping (Brief COPE), WOCRPROB = Problem-Focused Coping (WOC-R), MCATtotal = Child Abuse and Trauma scale total, GSI = Global Distress Index

As Table 5 indicates the following standardized path coefficients (See Figure 3) are statistically significant: ECRANX — MCATtotal (.325, p = .019), WOCRPROB — MCATtotal (.217, p < .001), WOCREMO — ECRANX (.111, p < .001), EMOBRIEF2 — ECRANX (.108, p = .016), PROBBrief — MCATtotal (.217, p < .001), GSI — WOCREMO (.279, p < .001), and GSI — ECRANX (.091, p < .001). When taken together the following path was statistically significant: childhood developmental trauma to anxious attachment to emotion-focused coping to current distress.

Direct and Indirect Model

Figure 4 represents the Direct and Indirect Model. This model has a GFI of .727. The GFI for this model is therefore below what is considered a good fitting model (.9 or above; Wuensch, 2006). Furthermore, the Direct and Indirect Model had NFI of .361, which again is well below the recommended .9 or higher for good fitting models.
(Wuensch, 2006). The CFI was .345 indicating that this model was only 35% better than the independent or null model. The RMSEA, which compares models to the saturated model was calculated to be .345 for the Direct and Indirect Model, which is well above the indicators for a good or even adequate fitting model (.05 and .08; Wuensch, 2006). When considered with the other indices indicating poor fit, the Direct and Indirect Model is rejected.

Figure 4. Results of Direct and Indirect Path Model
Table 10

Model 2 – Direct and Indirect Model Maximum Likelihood Estimates

<table>
<thead>
<tr>
<th></th>
<th>Estimate</th>
<th>S.E.</th>
<th>C.R.</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECRANX ← MCATtotal</td>
<td>.325</td>
<td>.139</td>
<td>2.337</td>
<td>.019</td>
</tr>
<tr>
<td>ECRAVO ← MCATtotal</td>
<td>.127</td>
<td>.154</td>
<td>.822</td>
<td>.411</td>
</tr>
<tr>
<td>WOCREMO ← MCATtotal</td>
<td>.050</td>
<td>.054</td>
<td>.920</td>
<td>.357</td>
</tr>
<tr>
<td>EMOBRIEF2 ← MCATtotal</td>
<td>.135</td>
<td>.072</td>
<td>1.874</td>
<td>.061</td>
</tr>
<tr>
<td>WOCREMO ← ECRANX</td>
<td>.111</td>
<td>.033</td>
<td>3.320</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>EMOBRIEF2 ← ECRANX</td>
<td>.108</td>
<td>.045</td>
<td>2.407</td>
<td>.016</td>
</tr>
<tr>
<td>WOCRPROB ← MCATtotal</td>
<td>.217</td>
<td>.066</td>
<td>3.303</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>PROBBrief ← MCATtotal</td>
<td>.334</td>
<td>.095</td>
<td>3.513</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>PROBBrief ← ECRAVO</td>
<td>-.004</td>
<td>.054</td>
<td>-.072</td>
<td>.943</td>
</tr>
<tr>
<td>WOCRPROB ← ECRAVO</td>
<td>.027</td>
<td>.037</td>
<td>.712</td>
<td>.476</td>
</tr>
<tr>
<td>GSI ← MCATtotal</td>
<td>.081</td>
<td>.041</td>
<td>1.997</td>
<td>.046</td>
</tr>
<tr>
<td>GSI ← EMOBRIEF2</td>
<td>.014</td>
<td>.053</td>
<td>.259</td>
<td>.795</td>
</tr>
<tr>
<td>GSI ← WOCREMO</td>
<td>.278</td>
<td>.065</td>
<td>4.285</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>GSI ← ECRANX</td>
<td>.084</td>
<td>.026</td>
<td>3.193</td>
<td>.001</td>
</tr>
</tbody>
</table>

Note. ECRANX = Anxious Attachment, ECRAVO = Avoidant Attachment, EMOBrief = Emotion-Focused Coping (Brief COPE), WOCREMO = Emotion-Focused Coping (WOC-R), PROBBrief = Problem-Focused Coping (Brief COPE), WOCRPROB = Problem-Focused Coping (WOC-R), MCATtotal = Child Abuse and Trauma scale total, GSI = Global Distress Index

As Table 6 indicates the following standardized path coefficients (See Figure 4) are statistically significant: ECRANX ← MCATtotal (.325, p = .019), WOCREMO ← ECRANX (.111, p < .001), EMOBRIEF2 ← ECRANX (.108, p = .016), WOCRPROB ← MCATtotal (.217, p < .001), PROBBrief ← MCATtotal (.334, p < .001) GSI ← MCATtotal (.081, p = .046), GSI ← WOCREMO (.278, p < .001) and GSI ← ECRANX (.084, p = .001). When taken together the following path was statistically significant: childhood developmental trauma to anxious attachment to emotion-focused coping to current distress.

After reviewing both hypothesized path models, it was clear that neither model fit the data well. It was also apparent that the path between childhood developmental trauma and avoidant attachment was not significant in either model. From a theoretical...
perspective, these findings make sense. Individuals with more avoidant attachment orientations do not often endorse distress (e.g., Aspelmeier, Elliott, & Smith, 2007; Mikulincer, Florian, & Weller, 1993; Mikulincer, Shaver, Cassidy, & Berant, 2009). On the other hand, the paths from childhood trauma to anxious attachment, emotional coping, and distress were significant, as were the paths from anxious attachment and emotion-focused coping to distress. Based on these observations and theoretical re-conceptualization, I decided to examine a third, exploratory, model in which childhood developmental trauma was hypothesized to indirectly affect psychological distress through the paths of anxious attachment and emotion-focused coping. Avoidant attachment and problem-focused coping were not included in this exploratory analysis in order to simplify the model and to focus on the primary variables of interest (i.e., childhood developmental trauma, anxious attachment, emotion-focused coping, and psychological distress). The results of this exploratory analysis are presented in Figure 5 and Table 7.

The third model represents the Indirect Effects of Childhood Developmental Trauma. The indices for the model fit for this third proposed model were mixed. For example, the RMSEA was .149. Wuensch (2006) stated that a good fitting model will have a RMSEA of below .05. Furthermore, the chi-square for this model was 3.859 with 1 degree of freedom and a probability level of .049. A significant probability level is indicative that the data significantly varied from the proposed model and suggests that the model should be rejected. While chi-square is a basic test of discrepancy between the matrices, it tends to very sensitive to small differences and be overly conservative. Other model fit indices indicated that the model should be accepted. For example, the GFI was
.988, signifying a good fitting model as it was above the recommended level of .9 (Wuensch, 2006). The NFI was .960, which is again above the recommended .90 or higher for good fitting models (Wuensch, 2006). The CFI was .967, which indicated that the Indirect Effects of Childhood Developmental Trauma was 96.7% better than the independent or null model. Taken all together, this model should be considered a plausible model.

Figure 5. Indirect Effects of Childhood Developmental Trauma
Table 11

**Model 3 — Indirect Effects of Childhood Developmental Trauma**

<table>
<thead>
<tr>
<th>Path Coefficient</th>
<th>Estimate</th>
<th>S.E.</th>
<th>C.R.</th>
<th>( P )</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECRANX &lt; --- MCATtotal</td>
<td>.325</td>
<td>.139</td>
<td>2.337</td>
<td>.019</td>
</tr>
<tr>
<td>WOCREMO &lt; --- MCATtotal</td>
<td>.050</td>
<td>.054</td>
<td>.920</td>
<td>.357</td>
</tr>
<tr>
<td>EMOBRIEF2 &lt; --- MCATtotal</td>
<td>.135</td>
<td>.072</td>
<td>1.874</td>
<td>.061</td>
</tr>
<tr>
<td>WOCREMO &lt; --- ECRANX</td>
<td>.111</td>
<td>.033</td>
<td>3.320</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>EMOBRIEF &lt; --- ECRANX</td>
<td>.108</td>
<td>.045</td>
<td>2.407</td>
<td>.016</td>
</tr>
<tr>
<td>GSI &lt; --- EMOBrief</td>
<td>.018</td>
<td>.051</td>
<td>.361</td>
<td>.718</td>
</tr>
<tr>
<td>GSI &lt; --- WOCREMO</td>
<td>.279</td>
<td>.071</td>
<td>3.916</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>GSI &lt; --- ECRANX</td>
<td>.091</td>
<td>.026</td>
<td>3.525</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

Note. ECRANX = Anxious Attachment, EMOBrief = Emotion-Focused Coping (Brief COPE), WOCREMO = Emotion-Focused Coping (WOC-R), MCATtotal = Child Abuse and Trauma scale total, GSI = Global Distress Index

As Table 7 indicates the following standardized path coefficients (See Figure 6) were statistically significant: ECRANX — MCATtotal (.325, \( p = .019 \)), WOCREMO — ECRANX (.111, \( p < .001 \)), EMOBRIEF2 — ECRANX (.108, \( p = .016 \)), GSI — WOCREMO (.279, \( p < .001 \)), and GSI — ECRANX (.091, \( p < .001 \)). Based on these findings the following path was significant: childhood developmental trauma to anxious attachment to emotion-focused coping to current psychological distress.

Path coefficients are standardized regression coefficients (beta) showing the direct effect of an independent variable on a dependent variable in the path model. Path coefficients measure the extent of effect of one variable on another in the model controlling for other prior variables, using standardized data. The larger the coefficient, the greater the amount of effect demonstrated. One can calculate the total causal effect in this model by multiplying the path coefficients for the paths of childhood trauma to anxious attachment, anxious attachment to emotion-focused coping, and emotion-focused coping to psychological distress. The product of that calculation would then be added to the product of multiplying the path coefficients for childhood developmental trauma to
anxious attachment and anxious attachment to psychological distress. The total indirect
effect of childhood developmental trauma on psychological distress is .058. This
alternative indirect model accounted for 26.3% of the variance in distress.

Summary of Chapter IV

In Chapter IV, I presented the results of this study. I provided preliminary
analyses including demographic comparisons related to variables and correlational
statistics were provided. I used one-sample t-tests to compare the means found in this
sample to the means of other samples. I also performed path analyses for this study. Null
Hypothesis 1 was rejected after a one-sample t-test determined that the mean scores from
the current sample demonstrated significantly more childhood developmental trauma than
the normed samples for the CAT. Null Hypothesis 2 was also rejected when a one-sample
t-test demonstrated that the participants in the current study used significantly more
problem-focused coping over emotion-focused coping. Null Hypothesis 3 was retained.
One sample t-tests revealed that the current sample demonstrated significantly more
anxious and avoidant attachment than did the normed samples. Null Hypothesis 4 was
also retained as there was not a significant difference between the distress levels of the
current sample and the normed non-patient sample.

Neither the indirect (Model 1) nor indirect and direct (Model 2) models proposed
in this study fit the data and therefore were rejected. A third exploratory model was then
investigated to explore a simpler model in which childhood developmental trauma was
hypothesized to be all indirect and through the variables of anxious attachment and
emotion-focused coping. This Indirect Effects of Childhood Developmental Trauma
model was found to be a plausible and good fitting model. Furthermore, the paths
between childhood developmental trauma and anxious attachment, between anxious attachment and emotion-focused coping, and between emotion-focused coping and psychological distress were all significant. In the alternative path model, the paths with the largest path coefficients leading to psychological distress were associated with the use of the WOC-R to measure emotion-focused coping; the indirect effects using the Brief COPE were not as substantial.
CHAPTER V

DISCUSSION

Introduction

In this chapter, I discuss the implications of the results presented in Chapter 4. First, I re-examine the findings of the main and supplemental analyses and explore possible explanations of the findings. I compare and contrast current findings to those of previous researchers. Integrated into this section are suggestions for future counseling psychology research and practice. Next, I discuss the theoretical and research implications of the findings. Finally, I review the limitations of the current study.

Major Findings

Notably, in the current study, I found that master’s-level psychologist participants reported similar levels of distress to non-patient norm samples despite reporting a high prevalence of childhood developmental trauma. Furthermore, I found that these participants were more likely to use problem-focused coping than emotion-focused coping when encountering work-related stressors. In contradiction to my hypothesis, however, the participants in this study reported higher levels of both attachment anxiety and avoidance when compared to norm-samples, as well as samples of other psychotherapists. In an attempt to gain a deeper understanding of the experience of these participants, I offered and assessed two theoretical models representing the relationship between childhood developmental trauma and current psychological distress. While neither proposed model was a good fit to the data, statistically significant path coefficients and theoretical re-conceptualization led to the creation of an alternative third model. This alternative model which posited that childhood developmental trauma had an
indirect effect on distress through the variables of anxious attachment and emotion-focused coping, was a better fit to the data. In the following sections, I will explore these findings in greater depth.

**Childhood Developmental Trauma**

In my first hypothesis, I proposed that the master's level psychologists in the current study would report more childhood developmental trauma when compared to non-clinician sample norms as measured by the CAT. This hypothesis was supported. As expected, the master's level psychologists who participated in this study reported significantly more childhood developmental trauma, in the form of neglect, punishment, and emotional abuse, than the normed samples (Sanders & Becker-Lausen, 1995; Sanders & Becker-Lausen, 1995; Kent & Waller, 1998). The higher incidence of childhood developmental trauma reported by this sample is consistent with previous findings regarding the childhood experiences of psychotherapists (Elliot & Guy, 1993; Follette, Polunsky, & Milbeck, 1994; Nikcevic, Kramolisova-Advani, & Spada, 2007; Radeke & Mahoney, 2000). Unlike in many of the previous studies examining psychotherapists, however, the current study specifically examined the experiences of master's-level psychologists using an empirically validated measure of childhood developmental trauma. Such empirically measured findings add stronger evidence to the existing literature regarding the high prevalence of childhood developmental trauma among psychotherapists.

There are several potential reasons for these findings. For example, the higher rates of neglect, punishment, and emotional abuse reported by this sample could potentially be explained by the type of work in which participants engage. In fact, Radeke
and Mahoney (2000), after finding that the psychotherapists in their study reported higher incidence of childhood developmental trauma, wondered if professional experience influenced their participants' responses. Following such a hypothesis, one could posit that master's-level psychologists would be better able to identify and report their experiences of childhood developmental trauma than individuals from other professions because of their unique training or professional experience. Interestingly, however, Elliot and Guy (1993) found that the psychotherapists in their study were no better able to identify specific types of childhood abuse when compared to non-clinicians. These researchers concluded that occupation and education did not appear to lead to increased ability to report childhood developmental trauma.

Another potential reason for the high levels of reported childhood developmental trauma in the current study could be due to the participants' elevated use of psychotherapy. This sample had a much higher use of personal psychotherapy (76%) compared to use of outpatient psychotherapy found in the general population (ranging from 3.18% to 27%; Olfson & Marcus, 2010; Swindle, Heller, Pescosolido, & Kikuzawa, 2000). The rate of psychotherapy use found in this sample was similar to that found in Elliot and Guy's (1993) sample (78%). One could theorize that through personal use of psychotherapy, participants became better able to identify and report high levels of childhood developmental trauma.

In fact, those participants from the current sample who had engaged in their own psychotherapy did report higher overall childhood developmental trauma and, specifically, higher rates of neglect and emotional abuse. Surprisingly, however, they did not report higher levels of sexual abuse or punishment than the participants who had not
been in their own psychotherapy. Thus, while the argument could be made that the high rates of reported childhood developmental trauma were due to insights gained through personal use of psychotherapy, such experiences did not impact participants’ reporting of sexual or physical abuse.

An alternative explanation for the higher use of personal psychotherapy among participants who also report higher incidents of childhood developmental trauma may be that these participants used psychotherapy as a means of seeking support and treatment for issues related to their trauma. Perhaps this sample was more likely to seek psychotherapy because they experienced more childhood developmental trauma. However, again, participants who had used personal psychotherapy did not report higher levels of childhood sexual abuse or punishment than those who did not seek psychotherapy services. So while this argument makes intuitive sense, it does not account for all of the aspects of the reported levels of childhood developmental trauma. Further research into this phenomenon may help to better understand this population’s experience of childhood developmental trauma. Specifically, researchers may want to consider what type of psychotherapist experiences may lead to their ability to overcome or live beyond childhood developmental trauma.

With regard to demographic differences regarding the report of childhood developmental trauma, it is important to note that there were significant differences in how males and females in this study rated their experiences of childhood sexual abuse and neglect. Female participants reported significantly higher rates of sexual abuse than did male participants. This finding is consistent with previous results regarding gender differences in the rates of reported sexual abuse during childhood (e.g., Briere & Elliot,
Females in the current study also reported more neglect during childhood than did the males. These findings are contrary to previous results that indicate that males are more likely to report neglect. Unlike national surveys demonstrating that males report higher incidence of neglect during childhood, the females in the current sample reported having experienced more neglect during childhood (e.g., Sedlak & Broadhurst, 1996; Straus & Savage, 2005). Perhaps these findings are unique to the current sample and are not representative of all master’s-level psychologists. Alternatively, these findings may be due to the unique experiences of psychotherapists. Perhaps female psychotherapists experience higher levels of neglect when compared to non-clinicians as well as male psychotherapists. Previous investigations into the experiences of psychotherapists have either used only samples of one gender or have not reported specific finding related to neglect. Further research examining the childhood developmental histories of psychotherapists with regard to gender-specific experiences may help to clarify these findings.

Coping

In my second hypothesis, I theorized that the master’s level psychologists in the current study would use more problem-focused than emotion-focused coping when dealing with work-related stressors. The data supported this hypothesis. Participants in this study reported more use of problem-focused coping when measured by both the WOC-R and the Brief COPE. These findings are consistent with the limited number of studies examining the type of coping strategies used by psychotherapists (e.g., Murtagh & Wollersheim, 1997; Shapiro, Dorman, Burkey, & Welker, 1999).
Previous findings indicate that those psychotherapists who use problem-focused coping experience less distress (Murtagh & Wollerstheim, 1997) and more satisfaction with their work (Shapiro, Dorman, Burkey, & Welker, 1999). Other researchers have found that psychotherapists who use emotion-focused coping tend to experience increased stress (Medeiros & Prochaska, 1988; Weaks, 1999) and more symptoms of professional burnout (Wallace, Lee, & Lee, 2010; Weaks). Interestingly, in the current study, there was a significant correlation between problem-focused coping and distress, indicating that the participants who used problem-focused coping were also experiencing psychological distress. However, there was a more substantial significant correlation between emotion-focused coping and distress. Thus, while participants who used problem-focused coping strategies did report psychological distress, those who used emotion-focused coping reported more distress.

There are several possible explanations for the higher use of problem-focused coping strategies among the current sample. For example, one could argue that these findings are related to the high rates of personal use of psychotherapy. Perhaps the participants learned about problem-focused coping strategies while in their own treatment. Past researchers (e.g., Medeiros & Prochaska, 1988; Wallace, Lee, & Lee, 2010; Weaks, 1999) who investigated the coping strategies of psychotherapists did not report data on participant use of psychotherapy, but one might argue that problem-focused coping could have been learned in such a venue. Surprisingly, however, there was no difference between those participants who had had their own therapy and those who had not with regard to responses to either coping measure.
Alternatively, the training and professional experiences of the participants may have influenced their use of problem-focused coping over emotion-focused coping strategies. In fact, Wallace, Lee, and Lee (2010) theorized that clinical supervision can help increase the use of problem-focused coping among abuse-specific clinicians as a means of avoiding burn-out. These researchers postulated that supervisors can help psychotherapists identify and modulate coping strategies in response to work-related stressors. Furthermore, Murtagh and Wollerstheim (1997), after observing that the psychotherapists in their study did not experience higher rates of dysphoric moods despite working with depressed clients, postulated that professional experience may have helped clinicians learn to use problem-focused coping as a means of managing such work-related stress. However, in the current sample, length of time in the field did not significantly influence how participants coped. If professional experience and supervision influence the way participants cope, then those who had been in the field for a longer period should have been significantly more likely to use problem-focused coping. Yet, this was not the case. Further research is needed regarding the impact of personal use of psychotherapy, professional training, and supervision on the types of coping strategies psychotherapists use when coping with work-related stress.

While participants endorsed significantly more use of problem-focused coping when measured by both the WOC-R and the Brief COPE, there appears to be some discrepancy between the measures. The higher order Emotion-focused and Problem-focused subscales do not appear to be measuring the same construct. This was particularly evident in the correlational matrixes and the path coefficients for the theoretical models. For example, while the coefficient for the path between psychological
distress and emotion-focused coping measured by the WOC-R was significant, it was not significant when emotion-focused was measured using the Brief COPE. Furthermore, when emotion-focused coping was measured using the WOC-R, there was a significant correlation between this type of coping and both anxious and avoidant attachment. When emotion-focused coping was measured using the Brief COPE, these correlations were not found to be significant.

This difference between coping measures may be due to the way that the higher order subscales for the WOC-R were conceptualized and designated in this study. There has been inconsistency among researchers with regard to which of the WOC-R subscales should be labeled as emotion-focused and which labeled as problem-focused. I chose to use the Dunkel-Schetter, Folkman, and Lazarus (1987) designations for two main reasons. First, researchers who have studied psychotherapists in the past have used Dunkel-Schetter and colleagues’ designations (e.g., Murtagh & Wollersheim, 1997; Shapiro, Dorman, Burkey & Welker, 1999). Second, Dunkel-Schetter and colleagues’ designations made more intuitive sense. For example, Seeking-Social Support and Positive Reappraisal are both considered problem-focused coping strategies according to Dunkel-Schetter and colleagues, but are considered emotion-focused by other researchers. Because psychotherapists often encourage clients to seek support from others and to consider situations differently as a means of addressing problems, I believed that these strategies would likely be viewed as problem-focused by psychotherapists. It is possible that had I used other researchers’ designations (e.g., Folkman & Lazarus, 1985, 1988) regarding which scales measure problem-focused coping and which emotion-
focused coping, there would have been a higher correlation between the higher order subscales for the two measures.

A larger issue, however, which should be considered by future researchers, has to do with what constitutes problem-focused and emotion-focused coping. It is possible that while various strategies can be loosely designated as into one of these categories, coping can really only be understood as Problem-focused or Emotion-focused within particular contexts. What may be seen as Emotion-focused in one context would be considered Problem-focused in another context. Furthermore, there may be individual differences among people or populations regarding which coping strategies would be considered problem oriented and which strategies oriented toward changing an emotion. Future research may help clarify these issues. Furthermore, there may be a need for the development of stronger coping measures that are better able to capture some of the complexity of how people cope with stressors that has been missing with current measures.

Attachment Orientation

In my third hypothesis, I postulated that psychotherapists would demonstrate lower means on both the anxious and avoidant subscales of the Experiences in Close Relationships-Revised (ECR-R) than the sample norms. This hypothesis was not supported. Participants in the current study endorsed significantly higher anxious and avoidant attachment when compared with non-clinician participants from previous studies. These findings are somewhat surprising. Previous researchers have generally found that psychotherapists tend to report “secure” attachment orientations in that they report low levels of both attachment anxiety and avoidance. For example, Dinger, Strack,
Sachsse, and Schauenburg (2009), found that the majority of psychotherapists in their sample demonstrated a secure attachment orientation when responding to the Adult Attachment Inventory (AAI). Furthermore, Ligiero and Gelso (2002) found that the vast majority of their psychotherapist participants rated themselves on the Relationship Questionnaire as having secure attachment orientations.

It is not clear why the current sample demonstrated higher level of anxious and avoidant attachment when compared with non-clinician samples. I originally hypothesized that the difference between the current findings and those of previous studies had to do with the attachment measure I used. Dinger and colleagues (2009) measured attachment using the AAI; Ligiero and Gelso (2002) used the Relationship Questionnaire (RQ). Perhaps, I argued, the current sample would have demonstrated more secure attachment orientations if they had responded to the measures used in those studies. However, two recent dissertation studies examining attachment orientations of psychotherapists also used the ECR-R and found significantly lower mean scores for anxious attachment than was found in the current sample (Kardatze, 2009; Nigro, 2005). These two researchers found anxious attachment levels more aligned with the normed samples. With regard to avoidant attachment, Kardatze’s sample reported significantly higher levels of avoidant attachment among her sample of counseling graduate students than I found with my sample, while Nigro’s sample reported significantly lower avoidance her sample of Canadian psychologists when compared to the current sample. Nigro’s avoidance levels were in line with the normed samples. Such diversity in findings further indicates the need for more research regarding psychotherapists’ attachment orientation.
There are potential alternative reasons for the higher levels of attachment anxiety and avoidance found in the current sample. For example, it is possible that there were some sampling errors and the current sample was not a true representation of the population of master's level psychologists in the state of Michigan. Individuals interested in childhood developmental trauma and attachment may have been more likely to complete the measures than those psychotherapists less interested in this construct. Alternatively, it is possible that the simultaneous inquiry into childhood developmental trauma in the current study may have stimulated attachment reactions that were not a factor in previous studies investigating psychotherapists’ attachment orientations. While the measures were counterbalanced, thus decreasing the number of participants who completed the CAT prior to the ECR-R, participants may have looked through the measures prior to responding and realized that childhood developmental trauma was being assessed. Few researchers have investigated psychotherapists’ childhood developmental trauma from an attachment perspective. Further investigation may lead to a clearer understanding of how psychotherapists respond differently to attachment measures when also asked questions related to childhood developmental trauma.

**Distress**

In my fourth hypothesis, I theorized that the participants in my study would report less distress when compared to sample means of non-clinicians. The data did not support this hypothesis. While the participants in the current study did report significantly lower distress than sample participants who were receiving outpatient psychotherapy, they were not significantly less distressed than the normed sample of non-patient participants (Derogatis, 1993). These findings are somewhat in contrast to the findings of past
researchers who have investigated the experiences of psychotherapists. For example, Elliot and Guy (1993) found that the psychotherapists in their study reported significantly less distress when compared to non-clinician participants. Furthermore, Follette, Polunsky, and Milbeck's (1994) sample of psychotherapists reported significantly less distress than the law enforcement counterparts despite psychotherapists reporting higher levels of childhood developmental trauma. Alternatively, Nikcevic, Kramolisova-Advani, and Spada (2007) did not find a significant difference in distress levels between their clinically focused and non-clinically focused students. The current findings are more aligned with these findings.

It was interesting, however, that the current sample did not report significantly higher distress when the high levels of reported childhood developmental trauma are taken into consideration. Based on research findings regarding the negative impact of such a history (e.g., Anda, et al., 2006; Joiner, et al., 2006), one would expect that the participants in the current study would report significantly higher levels of distress.

There are several potential reasons for the similarities in levels of distress between the current sample and the normed sample. First, while developmental trauma was measured for the current sample, it was not for the normed sample used when creating the BSI (Derogatis & Melisaratos, 1983). Thus, the norm sample may have experienced different levels of childhood developmental trauma than reported by the current sample. Future research comparing the distress levels of psychotherapists with a history of childhood developmental trauma to non-clinicians with similar histories may help clarify these findings.
An alternative argument could be made that the participants in the current study have had advanced training in psychology and thus are more attuned to psychopathological constructs. Using this argument, one would postulate that participants’ exposure to psychological assessments artificially reduced their report of distress in order to appear more psychologically healthy. However, one would expect that the participants would have also reported lower levels of childhood developmental trauma and decreased attachment avoidance and anxiety if they were attempting to make themselves appear less distressed.

Another potential reason for the relatively low psychological distress when considering the high levels of childhood developmental trauma may have to do with the participants’ experiences. Perhaps the very nature of practicing psychotherapy helped the participants experience less distress. Psychotherapists, by the nature of the work they do, are exposed to traumatic stories, but they are also witness to the strengths and triumphs of their clients. It is possible that through this exposure, the participants in the current study have gained some insight into the universal nature of suffering. As Radeke and Mahoney (2000) theorized, perhaps through clinical work, psychotherapists have accelerated their developmental trajectory. Further research into the experiences of psychotherapists is needed before definitive conclusions can be made.

Participants who had been in their own psychotherapy reported higher levels of distress than those who had not had their own psychotherapy. Intuitively, this makes sense. People seek psychotherapy when distressed. However, one would also wonder if psychotherapy may have helped decrease the amount of distress experienced by the participants. Norcross (2005) when reflecting on the impact of psychotherapy on mental
health clinicians, described finding that personal psychotherapy generally decreases distress among clinicians. Similarly, the psychologists in Coster and Schwebel’s (1997) sample described personal use of psychotherapy as one of the main factors helping them to maintain a positive well-being. The current sample reported significantly less distress than the outpatient normed sample. Perhaps distress levels would have been higher had the majority (76%) of the participants not been in their own psychotherapy. Alternatively, it is also possible that through the process of psychotherapy, the participants were better able to identify, accept, and report their experiences of distress than those participants who had not been in their own psychotherapy. Further research comparing the experiences of psychotherapists in their own psychotherapy with psychotherapists who have not been in psychotherapy may help scholars, as well as educators and supervisors, better understand the role that psychotherapy plays in the experience of distress among psychotherapists.

Finally, the relatively low psychological distress reported by the current and previous samples of psychotherapists despite high report of childhood developmental trauma (e.g., Elliot & Guy, 1993; Radeke & Mahoney, 2000) may be due to a combination of the formerly described reasons. Perhaps, as Miller (1997) and others (e.g., Racusin, Abramowitz, & Winter, 1981; Sussman, 1992) have posited, some individuals who experience significant adversity early in life, as happens with childhood developmental trauma, are attracted to the field of psychotherapy. Once in the field, these people gain insight through training and practice. They may also use personal psychotherapy as a way of coping. These factors, in combination, may lead to lower
distress leads to lower distress. Further examination of these factors may help clarify what is contributing to the relatively low distress in this population.

Theoretical Models

In my fifth research question, I was interested in the degree to which attachment and coping mediated the relationship between childhood developmental trauma and psychological distress. That is, I examined whether childhood developmental trauma had an indirect effect on psychological distress through attachment orientation and coping strategy or whether it had both indirect and direct effects on psychological distress. An alternative exploratory path analysis was also performed to investigate whether removal of problem-focused coping and avoidant attachment might strengthen the model. In the following section, I will first explore the significant path coefficients found in the models. I will conclude this section with a discussion of the proposed and alternative theoretical models.

There were significant path coefficients between many of the factors measured in this study. For example, there was a significant, positive coefficient found for the path between childhood developmental trauma and current levels of psychological distress. This finding was not surprising. As previously described, many researchers have found such a relationship (e.g., Anda, et al., 2006; Joiner, et al., 2006). It is interesting, however, that childhood developmental trauma only accounted for a small portion of variance for current distress. Thus, psychotherapists' experience of distress appears to be related to a variety of other stressors unrelated to their history of childhood developmental trauma. Such findings support the idea that psychotherapists may be
successfully handling childhood developmental trauma. Further research may help clarify the experience of psychotherapists with a history of childhood developmental trauma.

A significant path coefficient was also found between childhood developmental trauma and anxious attachment. These results are consistent with previous findings indicating that individuals who experience childhood developmental trauma are more likely to have insecure attachment orientations in adulthood (e.g., Aspelmeier, Elliot, & Smith, 2005; O’Connor & Elklit, 2008; Gauthier, Stollak, Messe, & Aronoff, 1996). For example, Weinfeld, Sroufe, and Egeland (2000) found a significant relationship between higher levels of childhood developmental trauma and insecure attachment orientations. Furthermore, such results make intuitive sense when one considers Bowlby’s (1973, 1988) position that the availability and responsiveness of one’s attachment figure determines the formation of one’s attachment orientation as either secure or insecure. As was posited by Weinfeld and colleagues regarding the significant relationship they found between high levels of childhood developmental trauma and insecure attachment, it is plausible that the participants in the current study who suffered childhood developmental trauma experienced their attachment figures as unavailable during early threatening or unsafe experiences. Such appraisal of attachment figure unavailability may have contributed to the development of an insecure attachment orientation.

Another important path to consider is between childhood developmental trauma and coping strategies. There was a significant path coefficient between childhood developmental trauma and problem-focused coping when measured by both the WOCR and the Brief COPE, but the coefficient was significant between childhood developmental trauma and emotion-focused coping was not found to be significant using
either measure. These findings are contrary to the findings of some researchers who have found that survivors of childhood developmental trauma are more likely to engage in emotion-focused coping (e.g., Brand & Alexander, 2003; Leitenberg, Gibson, & Novy, 2004). These findings do, however, support the idea that the relationship between childhood developmental trauma and coping is mediated by attachment orientation.

It is conceivable that the current results are due to the fact that the clinicians were asked to consider a work-related stressor when responding to the coping measures. Perhaps had they been asked to think about coping with problems from their childhoods, the participants would have reported higher use of emotion-focused coping. Lazarus (1993) posited that the type of coping strategy used depends on whether the individual views a situation as changeable. It may be that the participants appraised work stress as changeable and thus used problem-focused coping. Had they been considering childhood developmental trauma, an unchangeable stressor, they may have reported use of more emotion-focused coping strategies. Futa, Nack, Hansen, and Garbin (2003), for example, found that there was not a significant difference in coping strategies between individuals with a history of childhood developmental trauma and those without such a history when encountering a stressful event in their adulthood. These researchers posited that everyday coping is likely different from coping with memories of childhood developmental trauma.

Another potential reason for the significant path coefficient between problem-focused coping and childhood developmental trauma may have to do with the participants’ professional knowledge about successful coping. With this theory in mind, Murtagh and Wollersheim (1997) posited that psychotherapists have more knowledge regarding self-care and thus may use more active, problem-focused coping strategies as a
means of protecting themselves from work-related stress. Perhaps the master's level psychologists in the current study use problem-focused coping as a means of protecting themselves from their own memories related to childhood developmental trauma. Further research into how psychotherapists with their own history of childhood developmental trauma cope with both their difficult history and everyday stressors may offer valuable insight.

Another path that warrants exploration is that found between coping strategies and attachment. In the current study, I found a significant path between emotion-focused coping and anxious attachment. This matches the findings of previous researchers who have found that individuals with anxious or avoidant attachment orientations are more likely than securely attached individuals to use emotion-focused coping strategies, but not problem-focused strategies, when faced with stressors (Hawkins, Howard, & Oyebode, 2007; Lopez, Mauricio, Gormley, Simko, & Berger, 2001; Mikulincer, Florian, & Weller 1993; Mikulincer & Florian, 1995; Torquati & Vazsonyi, 1999; Wei, Heppner, & Mallinckrodt, 2003). Attachment orientation influences both the appraisal of threat and the appraisal of one's ability to manage threats (Berant, Mikulincer, & Florian, 2001; Mikulincer & Florian). The decision to use problem-focused versus emotion-focused coping strategy depends upon such an appraisal (Lazarus, 1993). Thus, it makes intuitive sense that individuals who view situations as more threatening and themselves as incapable of managing threat, as is found with anxious attachment orientations, would tend to use more emotion-focused coping strategies when stressed.

While past researchers have found that avoidantly attached individuals tend to use emotion-focused strategies such as distancing (e.g., Berant, Mikulincer, & Florian, 2003;
Lussier, Sabourin, & Turgeon, 1997; Mikulincer, Florian, & Weller 1993; Ognibene & Collins, 1998), there was not a significant path between avoidant attachment and emotion-focused coping in the current study. It is not clear why this was the case. One might postulate that because individuals with avoidant attachment orientations tend to use deactivating attachment strategies, they may have a higher proclivity toward the use of more active types of responses that are found in problem-focused coping strategies. Alternatively, these findings may be related to the way participants with avoidant attachment orientations appraised their own ability to manage stress. Bowlby (1973) described these individuals as “compulsively self-reliant” and as generally appraising themselves as capable of independently managing stressors. Perhaps the avoidantly oriented participants in the current study were more likely to appraise themselves as able to manage work-related stress and this appraisal led to the use of problem-focused coping. Further research into how appraisal impacts attachment and coping for this population may help clarify these findings.

Another significant path was found between anxious attachment and distress. These results align with previous findings demonstrating that individuals with insecure attachment orientations report more distress (e.g., Muller, Sicoli, & Lemieux, 2000; O’Conner & Elklit, 2008; Sauer, Anderson, Gormley, Richmond, & Preacco, 2010). Such findings support Bowlby’s (1973, 1988) position that those individuals with an anxious attachment orientation experience higher levels of distress while individuals with secure adult attachment orientations have developed resiliency that is used in the face of difficulties. Furthermore, scholars have posited that individuals with higher levels of attachment anxiety are thought to pay more attention to and report their own distress
(e.g., Bowlby, 1973; Vogel & Wei, 2005). It may be that the anxiously oriented participants from the current study were more likely to report distress because of this increased attention to distress.

In the two initial hypothesized path analyses, there was a significant path coefficient between childhood developmental trauma and attachment anxiety. There was also a significant path coefficient from anxious attachment to emotion-focused coping. Furthermore, there was a significant path coefficient from emotion-focused coping to current psychological distress, when measured using the WOC-R. There was not a significant path coefficient when coping was measured by the Brief COPE. These findings indicate that individuals who experience childhood developmental trauma are more likely to experience higher levels of attachment anxiety. This, in turn, leads to emotion-focused coping, and finally, increased psychological distress. Also, individuals who have higher levels of attachment anxiety may experience increased psychological distress. Taken all together, each indirect path between childhood developmental trauma and distress, as well as the direct path, were found to be significant. However, goodness of fit indices indicated that neither of the models fit the data well and the models were rejected.

In the third, alternative exploratory model, avoidant attachment and problem-focused coping were not included due to the insignificant path coefficient for the relationship between childhood developmental trauma and avoidant attachment, as well as theoretical re-conceptualization. This model was found to be plausible and childhood developmental trauma was found to have an indirect effect on psychological distress through anxious attachment and emotion-focused coping. All of the paths in this model
were found to have significant path coefficients except the path between emotion-focused coping and psychological distress when coping was measured using the Brief COPE. The path between emotion-focused coping and psychological distress was significant when coping was measured by the WOC-R. While path analysis is not a confirmatory model, the current findings appear to confirm Crittenden's (1992) study demonstrating the impact attachment and coping have on the distress levels of individuals who have experienced childhood developmental trauma. Crittenden theorized that some people who experience trauma in childhood develop an anxious attachment orientation. This attachment orientation leads to increased perception of threat and negative expectations regarding their own ability to manage the threat. Such an appraisal leads to the use of emotion-focused coping strategies. While these coping strategies may have been adaptive when the individual was experiencing the childhood trauma, they are no longer helpful, and the individual experiences increased psychological distress. The findings of the alternative path model appear to support Crittenden's theory. However, there are two cautions related making conclusions based on this model. First, the total indirect effects found in this model were small (.074). The model accounted for 26.3% of the variance for distress. These small effects and limited amount of variance accounted for may be an indication that other factors are involved in the level of distress experienced by psychotherapists. Second, there are some inherent limitations regarding conclusions that can be drawn when using path analysis. While this statistical method allows researchers to diagram a set of hypothesized relationships, path analysis ultimately only examines patterns of correlations found in data. One cannot determine if the path is correct, nor can
one conclude that the paths have causal effects. Thus, further research exploring this theory is needed before causal conclusions can be drawn.

**Implications of the Study**

There are several important implications from the current study. First, I was able to replicate findings from previous researchers related to the childhood experiences and distress levels of psychotherapists. Of particular importance is the fact that despite significantly high levels of childhood developmental trauma, the participants in the current study did not report significantly elevated levels of distress. These findings contradict the overwhelming literature linking childhood developmental trauma with high distress among most populations. Based on the results of this study and previous research, there appears to be something unique about psychotherapists which should be more thoroughly explored in order to better understand potential ways of helping people manage such adverse childhood experiences. Perhaps, through training and practice experiences, psychotherapists have developed some resiliency strategies which can be important in dealing with adversity and perhaps these experiences could be somehow translated for use with other populations. Conversely, however, there may be some intrinsic characteristics which not only attracts individuals to the field of psychotherapy but also helps them deal with difficulties.

Another major implication of the findings regarding master's-level psychologists' elevated experience of childhood developmental trauma involves the future practice of this population. By practicing psychotherapy, clinicians have greater exposure to traumatic material than do other professionals. Further research is needed to evaluate how psychotherapists with a history of childhood developmental trauma experience distress
and how they manage this distress when their focus of treatment is with majority traumatized clients. There does appear to be higher risk of personal and professional distress for psychotherapists with their own history of childhood developmental trauma when they work primarily with trauma-related patients (Adams & Riggs, 2008; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995). While the current study did not examine these psychotherapists, they may need to pay particular attention to their experience of personal and professional distress. One way to do this could be through limiting the number of traumatized clients they see for treatment and to make as much effort as possible to create diversity in their caseloads. Furthermore, it is likely important for these psychotherapists to seek support through supervision and/or personal psychotherapy.

The findings regarding levels of childhood developmental trauma also have important implications for training programs and supervisors. It is important that training programs and supervisors be aware of the high likelihood that the psychology students they work with have had some type of childhood developmental trauma. Researchers have found that training and supervision experiences may help inoculate psychotherapy students with trauma histories from some of the distress inherent in working with patients (e.g., Adams & Riggs, 2008; Baird & Kracen, 2006; Coster & Schwebel, 1997). Faculty and supervisors may help trainees learn ways of managing distress associated with such a history. Such training experiences may, in turn, help them develop into better psychotherapists.

With respect to the participants’ self-reported attachment orientations, there are implications for the training and supervision of psychotherapists. The current sample demonstrated higher levels of both attachment anxiety and avoidance than the normed
samples. Furthermore, they demonstrated higher levels of attachment anxiety than other samples of psychotherapists and higher levels of attachment avoidance than one sample of psychotherapists. Such findings may be unique to the current sample, but it does indicate that psychotherapists may not be any more “secure” in their adult attachments than non-clinicians. It may be helpful for training programs to educate potential clinicians on their own attachment orientations. Such self-awareness may help new psychotherapists understand their own risk factors for distress, as well as potentially encourage them to seek out continued supervision and/or their own psychotherapy.

Another major implication of the current study relates to my proposed theoretical model. The fact that the alternative path model was found to be plausible with significant path coefficients for all paths has several possible implications. First, this model offers a theoretical lens from which the experience of psychological distress among psychotherapists who experienced childhood developmental trauma can be understood. This theoretical framework incorporates attachment theory and coping strategy as a useful context for understanding differences in psychological distress among psychotherapists who have been traumatized during childhood. Second, this model offers potential areas for intervention. When one only focuses on the relationship between childhood developmental trauma and distress, intervention is limited. One cannot go back and un-do trauma already experienced as a means of treating distress. But if distress is a function of attachment and coping, there are points where therapeutic interventions may be helpful. For example, treatment could focus on helping psychotherapists explore and understand their attachment orientation and its impacts on their choice of coping strategy. If there is some change in attachment orientation, there may be change in appraisal and
subsequent coping and distress. In order to make such an intervention successful, anxiously attached psychotherapists would likely benefit from a consistent counseling or supervisory relationship as a secure base from which to explore these new coping strategies and to re-examine their problematic internal working models. Another point of intervention may be with regard to use of coping strategies. Helping psychotherapists gain more effective coping strategies may help decrease their experience of distress (Wei, Heppner, & Mallinckrodt, 2003). Finally, if such a model and interventions are helpful in understanding psychotherapists, it may also help our understanding and treatment of other populations.

**Limitations of the Study**

Several factors limit the external validity of these findings. First, although I had hoped to recruit participants from a range of racial/ethnic backgrounds and ages, the respondents were overwhelmingly white and middle aged. With respect to race and ethnicity, out of the 130 respondents, the vast majority were Euro-American/white. There were very few participants who described themselves as African-American, Asian-American or Pacific Islander, Hispanic/Latina, or bi-racial/multi-racial. Second, the mean age for this sample was 50-years-old, and they had been practicing psychotherapy for 17 years, on average. Thus, it is reasonable to assume that the sample used in this study is more representative of the experiences of professionally seasoned, middle-aged, white female master’s level psychologists. The results found in this study may not represent younger, less experienced, and/or ethnically/racially diverse psychotherapists. Third, most of the participants were female (70%), which limits the knowledge gained from the results regarding the experiences of male master’s level psychologists. As gender did
influence responses on at least one of the measures, future researchers may want to consider either using homo-gendered samples or an equal number of each gender. A major flaw in the design of the demographic questionnaire was the lack of inquiry regarding participants' sexual orientation. Thus, information related to the experiences of participants with various sexual identities remains unknown.

A fourth limitation related to external validity is the 25% response rate in the current study. With such a small percentage of respondents, there is no way to determine if the results are representative of the general body of master’s level psychologists in the state of Michigan. Fifth, there is also potential self-selection bias. Furthermore, the use of such a specific group of participants may have resulted in findings specific to individuals in that group and may not generalize to populations of psychotherapists from different educational or geographic backgrounds. In future research, samples of participants from a more diverse educational background and/or geographical region might be obtained. Finally, while I sampled only master’s level psychologists because of their specific, relatively homogenous educational experiences and universal licensing requirements, the results of this study may not generalize to the experiences of psychotherapists from other disciplines such as social work, counseling or doctoral-level psychologists.

Other limitations of this study concern construct validity. First, all data was obtained through self-report. Such reliance on self-report measures potentially introduces mono-method bias. Thus if a participant responds in a highly distressed way to all self-report instruments, then consistent bias is introduced. Another limitation of the use of such instruments is the assumption that it is measuring what they are intended to measure. Although the participants were told that the study was anonymous and names
were not connected in any way with the data, another limitation when using self-report measures is the potential that participants may attempt to appear more socially-desirable. Furthermore, participants were asked to respond to questions of a highly personal nature which may have impacted on whether participants fully disclosed their experiences. Furthermore, due to the nature of self-report measures, I could not assess the manner in which participants responded or whether they were reducing their actual scores on either the childhood developmental trauma measure or the attachment measure. Future research might benefit from the use of observational data such as the use of the diagnostic interviewing or the Adult Attachment Interview. Second, both of the coping measures had subscales with low to moderate internal consistency. This may be due to limited number of items on each subscale. The coping measures also did not appear to be measuring the same constructs in correlational relationships as well as in the path models. Future research examining the coping constructs, in general, may be helpful.

**Conclusion**

In Chapter 5, I discussed the findings of the current study in the context of the literature, explored the implications and limitations of the current study, and proposed future areas of research. I made several important findings in this study. Of particular importance, I first found that the master’s level psychologists in the current study were significantly more likely to report experiences of childhood developmental trauma than norm-samples from other populations. These findings support previous researchers’ findings regarding the relatively high experience of childhood developmental trauma by psychotherapists. Surprisingly, however, despite these high rates of childhood developmental trauma, the participants in this study did not report higher levels of
distress than non-clinician normed samples. Furthermore, while there was a significant relationship between childhood developmental trauma and distress, the amount of variance accounted for was small. This indicates that the distress experienced by the participants was mostly likely due to various other factors. Unexpectedly, the participants in this study reported elevated levels of both anxious and avoidant attachment. These findings contradict previous findings related to the attachment strategies of psychotherapists. I offered some speculations as to why participants responded as they did and implications of these findings.

In this chapter, I also explored the findings related to the two proposed theoretical path analysis models and subsequent alternative model. The alternative model outlining the indirect effect of childhood developmental trauma on distress through anxious attachment and emotion-focused coping was found to be plausible. This is particularly important as it offers some potential understanding of other factors that influence the distress related to childhood developmental trauma on psychotherapists. Such knowledge may impact interventions for psychotherapists with such a history, as well as other populations.
REFERENCES


http://www.psych.ucsb.edu/research/crl/articles/Collins%20and%20Read,%201999.0.pdf


Glass, K., Flory, K., Hankin, B. L., Kloos, B., & Turecki, G. (2009). Are coping strategies, social support, and hope associated with psychological distress among
http://search.proquest.com/docview/224860314?accountid=15099


Weaks, K. A. *Effects of treating trauma survivors: Vicarious traumatization and style of coping. Dissertation Abstracts International: Section B: The Sciences and*


Appendix A

Human Subjects Institutional Review Board Approval Letter

Date: March 18, 2011

To: Eric Sauer, Principal Investigator
    Rebecca Klott, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number: 11-03-12

This letter will serve as confirmation that your research project titled "Distress among Psychotherapists: The Role of Attachment Orientations and Coping Strategies" has been approved under the exempt category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: March 18, 2012
Appendix B

Letter to Department of Community Health

Department of Community Health
PO Box 30189
Lansing MI 48909
ATTN: ISP

RE: Label request, Review of survey materials

March 4, 2011

Dear ISP:

For my dissertation, I am studying designed to examine the relationships among a combination of variables that have not been widely studied in psychotherapists. I am sending this letter to request the entire list of individuals who currently hold a Psychologist, Limited License-Masters in the state of Michigan. From this list I will randomly select individuals to participate in this study.

We understand that there is a standard reviewer fee and computer service charge in addition to the cost of the labels. Our mailing and billing address are one in the same.

If there are any questions concerning this request, please contact Rebecca Klott via phone: (616) 204-5828, email: rebecca.a.klott@wmich.edu.

Sincerely,

Rebecca Klott, MA LLP
4th year, doctoral student, Counseling Psychology
WMU Graduate Center
200 Ionia St. SW
Grand Rapids, MI 49503

Eric M. Sauer, Ph.D., Associate Professor, Training Director
WMU Graduate Center
200 Ionia St. SW
Grand Rapids, MI 49503
Appendix C

Introductory Letter

Dear Potential Participant:

Hello, my name is Rebecca Klott, and I am a student in Western Michigan University’s Counseling Psychology doctoral program. I am currently completing the final phases of my graduate studies and my dissertation research. My dissertation chair is Dr. Eric Sauer, Associate Professor at Western Michigan University and Director of the Center for Counseling and Psychological Services in Grand Rapids, Michigan.

You have been randomly selected as a potential participant in my dissertation research. The goal of this research is to investigate the experiences of MA-level psychotherapists. I chose to investigate people like you as I believe MA-level psychotherapists have a unique experience that has not been fully understood by the profession. Some of the questions that I would like to ask you may feel very personal. By participating in this study, however, you can help to contribute to our understanding of the experiences of psychotherapists currently working in the field. This information can better inform the ways that psychotherapists are trained and supervised. I am specifically interested in the experiences of psychotherapists currently working with clients. If you are not currently seeing clients for psychotherapy, please return these materials in the provided self-addressed envelope.

If you agree to participate in this study, you will be asked to complete a brief demographic information form, and five psychological measures. As this survey is anonymous, none of your answers can be connected to you in any way. The study has been designed in this way as a means of helping you feel comfortable with being completely honest about your experiences without concern for your professional or personal safety. You should find these forms as part of the packet mailed to you. If you are willing to participate in this research, please review the anonymous survey document, and complete all of the survey forms. Please complete all surveys in one sitting. Once you have completed these forms, please return them to me using the provided stamped, self-addressed envelope. If you are not willing to participate in this research, please indicate this on the “decline to participate” form and return all forms in the provided stamped, self-addressed envelope.

If you have any questions or concerns about this study, please do not hesitate to contact me at (616) 204-5828.

Sincerely,

Rebecca Klott, MA LLP
4th year, doctoral student, Counseling Psychology
Western Michigan University
Appendix D

Decline to Participate Form

Code #

Date

I am not interested in participating in this study. Please make an X mark here: _____
Appendix E

Anonymous Consent

Western Michigan University
Counselor Education and Counseling Psychology
Anonymous survey consent

Dear Potential Participant:

You are invited to participate in a research project entitled “Distress among Psychotherapists: The Role of Attachment Orientation and Coping Strategies.” This study has been designed to examine the relationships among a combination of variables that have not been widely studied in psychotherapists. These variables include adult attachment, coping strategies, and psychological distress. The study is being conducted by Eric Sauer, PhD (principal investigator) and Rebecca Klott, MA (student investigator) from Western Michigan University, Department of Counselor Education and Counseling Psychology. This research is being conducted as part of the dissertation requirements for Rebecca Klott, MA (student investigator).

There are five surveys, each will take about 10-15 minutes for you to complete. In total, it should take you approximately one hour to complete the entire packet. Your replies will be completely anonymous, so do not put your name anywhere on the forms. You may choose to not answer any question and simply leave it blank. If you choose to not participate in this survey, you may either return the blank surveys or you may discard it. Returning the survey indicates your consent for use of the answers you supply. If you have any questions, you may contact Eric Sauer, PhD at (616-771-4171), Rebecca Klott, MA at (616-455-9283), the Human Subjects Institutional Review Board (269-387-8293) or the vice president for research (269-387-8298).

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. You should not participate in this project if the stamped date is more than one year old.
Appendix F

Demographic Survey

Thank you for deciding to participate in this project. The following questions ask about your background. Please circle the appropriate number under each of the items below or enter the correct information in the blank spaces provided.

1. Your gender: ________________________

2. Your age: ______

3. Your ethnic/racial background: (please circle all that apply)
   (1.) African-American
   (2.) Asian-American or Pacific Islander
   (3.) Hispanic/Latina
   (4.) Euro-American/Caucasian
   (5.) Native-American/American Indian
   (6.) Multiracial
   (7.) Other: ________________________
   (please specify)

4. Please circle the number that best indicates the average number of clients you see per week for psychotherapy/counseling:
   (1.) 1-5
   (2.) 6-10
   (3.) 11-15
   (4.) 16-20
   (5.) 21 +
   (6.) None: PLEASE DISCONTINUE AND RETURN SURVEYS TO RESEARCHER.

5. Please circle number that best indicates the average number of other psychotherapists you supervise during a normal week:
   (1.) 1-5
   (2.) 6-10
   (3.) 11-15
   (4.) 16-20
   (5.) 21 +
6. How long have you been practicing psychotherapy? ___(years) ___(months)

7. Are you currently or have you ever been a psychotherapy client?
   (1.) yes
   (2.) no

8. If you answered yes to number 7, how many sessions would you estimate you have attended during your lifetime? _________

9. Please circle the number that best represents your current relationship status:
   (1.) Single, not currently dating
   (2.) Single, currently dating multiple partners
   (3.) Single, currently dating one partner
   (4.) In a committed relationship that has lasted less than 2 years.
   (5.) In a committed relationship that has lasted 2-5 years
   (6.) In a committed relationship that has lasted 5-10 years
   (7.) In a committed relationship that has lasted 10+ years.

10. What adult(s) did you live with during most of your childhood/adolescence? (Circle all that apply)
    (1.) Two parents (biological or adoptive)
    (2.) mother only
    (3.) father only
    (4.) mother and stepparent
    (5.) father and stepparent
    (6.) other extended family members (Please specify: ______________________)
    (7.) Other (Please specify: ______________________)

11. Besides your parents, was/were there any other adult figure(s) that you felt especially close to or who cared for you and supported you consistently during your childhood?
    (1.) yes
    (2.) no

12. If you answered yes to number 11, please specify your relation to him/her. Please indicate the role of the person played in your life and not the name of the individual.

NATIONAL HELP LINE: 1-800-273-TALK (1-800-273-8255)
Appendix G
Reminder Letter

Dear Potential Participant:

A few weeks ago, we sent a survey packet to you in the mail that invites you to participate in a dissertation study concerning the experiences of MA-level psychotherapists. If you have already completed and returned your survey, please disregard this reminder. If you have decided to participate, but have not yet had an opportunity to complete and return the survey packet, we would like to remind you to do so as soon as it is convenient for you. We anticipate that responding to the survey would take approximately one and one-half hours of your time. We would like to reiterate that your responses to survey questions cannot be connected to you.

If you have any questions or concerns related to this study, please contact Rebecca Klott (rebecca.a.klott@wmich.edu) or Dr. Eric Sauer (616-771-4171). If you would like another packet of materials, please email Rebecca Klott.

Sincerely,

Rebecca Klott, MA LLP
4th year, doctoral student, Counseling Psychology
WMU Graduate Center
200 Ionia St. SW
Grand Rapids, MI 49503

Eric M. Sauer, Ph.D., Associate Professor, Training Director
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