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**THE PREVALENCE AND PERCEIVED EFFECTS ON PSYCHOLOGICAL  
PRACTICE OF PRIOR EXPOSURE TO MENTAL ILLNESS AND/OR  
PSYCHOLOGICAL TRAUMA IN PSYCHOLOGISTS**

A thesis presented in partial fulfilment of the requirements  
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‘... if we can look at ourselves in a forthright fashion, then most assuredly the anguish and despair of our present colleagues and our future generations of young therapists ... will be significantly diminished.’

Herbert J. Freudenberger (1987)

## ABSTRACT

One hundred and fifty-six participants comprising registered psychologists and postgraduate psychology students responded to a mail survey requesting information on their experiences prior to undertaking their postgraduate study in psychology.

Clinical and counselling psychologists/students were compared with psychologists and students specialising in other areas of psychology. The clinical/counselling group differed significantly from the comparison group in a number of ways. Clinical/counselling participants were more likely to report prior exposure to mental illness and some types of psychological trauma, as well as a greater number of these experiences.

The influence of prior exposure to mental illness and/or traumatic events on the decision to study psychology, and the perceived effects of these experiences on future psychological practice, were investigated with mixed results. Motivators to enter the field of psychology were also investigated and clinical/counselling participants were more likely to have been motivated by dysfunctional reasons than the comparison participants.

Additionally, the findings of this study suggest that psychology students with psychological problems may be fearful of disclosing these for fear of negative consequences. It is also suggested that, in general, psychologists and postgraduate psychology students in New Zealand may not be entirely satisfied with their education with regard self-care and self-reflection issues.



The results are discussed in terms of effects on psychological practice, and specific issues regarding the education of postgraduate psychology students are raised. Recommendations for further research are suggested.

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## **CHAPTER 1**

### **INTRODUCTION**

#### **1.1 PROFESSIONAL IMPAIRMENT DUE TO MENTAL HEALTH PROBLEMS IN PSYCHOTHERAPISTS**

The impairment of psychologists is of critical concern due to the impact that impairment has on therapeutic effectiveness and on the professional reputation of psychologists in general (Sherman, 1996). The aetiology of professional impairment due to mental health problems in psychotherapists has been outlined within a framework of three areas of possible causal factors: predisposition to mental illness, work factors, and current personal life events (Guy, 1987).

This research focused on the area of predisposition to mental illness. Specifically, the current research addressed exposure to mental illness and/or traumatic psychological experiences in psychologists and postgraduate students, prior to undertaking postgraduate study in psychology, and the perceived effects of this on future psychological practice. It is suggested this investigation was relevant to the domain of impairment because these types of early stressors, faced by some of those who choose to enter the field of psychology, may have the effect of acting as factors that may predispose a person to mental health problems. A predisposition may later interact with work or future life stressors and result in psychopathology (Sherman, 1996). The resultant psychopathology may impair the psychologist's effectiveness (Sherman, 1996).

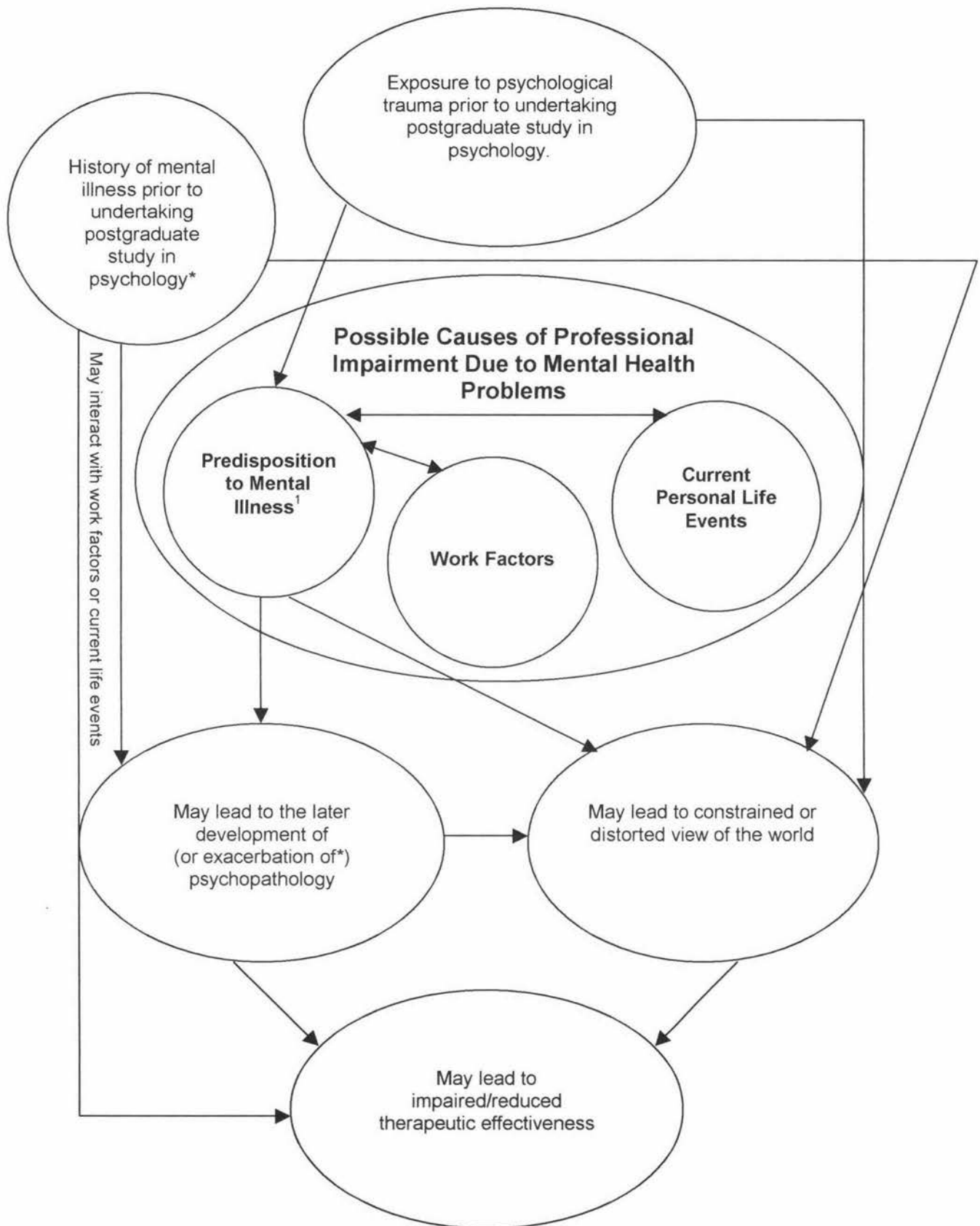
In addition, early stressors, even if they do not lead to the later development of psychopathology, may constrain or distort psychologists' views of the world resulting in clients not receiving the best possible therapy. An example may be found among therapists who have a history of childhood sexual abuse. Although these therapists may be able to empathise extremely well with clients who have similar stories, these therapists may have problems with boundary issues, that is difficulty in separating their own experiences from those of their clients (Little & Hamby, 1996). Additionally, therapists' views may also become distorted through other negative countertransference issues (Little & Hamby, 1996).

Furthermore, the consensus of reviewers of literature on the well-being and adjustment of therapists, where well-being and adjustment include degree of personal distress, symptom severity, self confidence, and aspects of self-concept, suggest that therapists' levels of adjustment are related to therapeutic effectiveness (Beutler, Machado, & Neufeldt, 1994). Some research in this field has also indicated that high levels of personal distress or mental disturbance in therapists may not only be related to preventing client growth, but also to inducing negative changes in clients (Beutler et al., 1994). However, as Beutler et al. (1994) point out, there are some studies that have not replicated these findings, they do suggest, however, that it is possible to conservatively conclude that therapist well-being, although not a necessary condition, may be an important factor in therapeutic effectiveness.

The initial focus of this research was to gain some insight into the prevalence of exposure to mental illness and traumatic psychological experiences, prior to undertaking postgraduate study, in practicing psychologists and postgraduate psychology students.

In addition, an attempt was made to gain an understanding of the type and extent of the perceived effects of these experiences on the future psychological practice of these participants. Finally, an investigation of the motivations psychologists had for entering the field of psychology, taking into account the influence of early exposure to mental illness and/or traumatic psychological experiences, was undertaken.

A model underlying this research was constructed by the present author and is presented in Figure 1. The model suggests that early exposure to psychological trauma may lead to a predisposition to mental illness that may, either directly or through interaction with work factors and/or current life events, may further lead to the development of psychopathology and/or a constrained view of the world. It is further suggested that either of these two consequences may in turn lead to the impaired or reduced therapeutic effectiveness of a psychologist. Additionally, it is also suggested that a prior history of mental illness may possibly lead to this same outcome.



*Figure 1. Model Underlying Present Author's Research*

<sup>1</sup> This research is focused on the factor 'Predisposition to Mental Illness'. The other two factors, 'Work Factors' and 'Current Personal Life Events' may have other outcomes that have not been considered in this research.

This study examined the responses of psychologists/psychology students from different areas of psychology. However, the main interest was in the comparison of clinical or counselling psychologists/psychology students with psychologists/psychology students of other specialties. It is hypothesised that there will be a distinct difference between these two groups. The differentiating variable being that clinical and counselling psychologists/psychology students have a focus, to some degree, on either wanting to learn about or wanting to practice psychotherapy. This variable does not appear to be a focus of psychologists who specialise in other areas.

## **1.2 RATIONALE**

The reason for this investigation was to bring about awareness in the psychological community of the need for further research into self-care and self-reflective educational programs for trainee psychologists. It is hoped that further research generated from this study can bring about specific recommendations for the training and/or self-care of student and practicing psychologists. These recommendations should emphasise both the positive and negative aspects that prior experiences may bring to the practice of psychology.

Although prevalence statistics of the type being investigated have been determined to some degree overseas, they do not appear to have been collected in New Zealand. Therefore, this study may provide some valuable data about psychologists practicing in New Zealand.

It would appear that perceptions of psychologists with regards to how they perceive their own histories may affect their practice of psychology has not been focused on in research. Therefore, by extending this study into this area it was hoped that possible training and self-care issues might be highlighted.

Additionally, an attempt was made to gain insight into the prevalence and degree of dysfunctional reasons psychologists in New Zealand may have for entering the field. These motivators were considered relevant within the scope of this research as they are hypothesised to arise, even if only in part, from early exposure to the experiences being investigated.

### **1.3 HYPOTHESES AND ADDITIONAL AIMS**

#### **1.31 Hypotheses**

1. Clinical/counselling psychologists and postgraduate students will have a significantly greater prevalence of exposure to mental illness, prior to undertaking postgraduate study in psychology, than psychologists and postgraduate students of other specialties.
2. Clinical/counselling psychologists and postgraduate students will have a significantly greater prevalence of exposure to psychological trauma, prior to undertaking postgraduate study in psychology, than psychologists and postgraduate students of other specialties.



3. Clinical/counselling psychologists and postgraduate students will have been influenced by a significantly greater extent to study psychology, at the postgraduate level, by prior exposure to mental illness or psychological trauma than psychologists and postgraduate students of other specialties.
  
4. Clinical/counselling psychologists and postgraduate students who report exposure to mental illness and/or psychological trauma, prior to undertaking postgraduate study in psychology, and **do** report having received psychotherapy or counselling prior to or during their postgraduate study in psychology will:
  - tend to have perceived that their experiences would have either a negative effect or both positive and negative effects on their future practice of psychology, while

Clinical/counselling psychologists and postgraduate students who report exposure to mental illness and/or psychological trauma, prior to undertaking postgraduate study in psychology, and **do not** report having received psychotherapy or counselling prior to or during their postgraduate study in psychology will:

  - tend to have perceived that their experiences would have either no effect or a positive effect on their future practice of psychology.
  
5. Clinical/counselling psychologists and postgraduate students who report exposure to mental illness and/or psychological trauma, prior to undertaking postgraduate study in psychology, and who **do** report having received psychotherapy or counselling, prior to or during their postgraduate study in psychology, will tend to report a greater effect (due to their experiences) on their

future practice of psychology. In comparison, clinical/counselling psychologists and postgraduate students who report exposure to mental illness and/or psychological trauma, prior to undertaking postgraduate study in psychology, and **do not** report having received psychotherapy or counselling, prior to or during their postgraduate study in psychology, will tend to report a lesser effect (due to their experiences) on their future practice of psychology.

6. Clinical/counselling psychologists and postgraduate students will report a significantly greater number and extent of possible or potentially dysfunctional motivators to enter their profession than psychologists and postgraduate students of other specialties.

### **1.32 Additional Aims**

1. To determine the degree of perceived stigma attached to psychology students with psychological problems.
  - It is hypothesised that psychologists/psychology students will be more likely to agree than disagree that psychology students are fearful of disclosing psychological problems for fear of negative consequences.
2. To determine the level of satisfaction of psychologists/psychology students with their postgraduate training in the areas of self-care and self-reflection.
  - It is hypothesised that psychologists/psychology students will be more likely to be dissatisfied than satisfied with the emphasis, during their postgraduate training, placed on issues of self-care and self-reflection.

## **CHAPTER 2**

### **THE LITERATURE**

#### **2.1 PREVALENCE RATES**

There is limited research available on the prevalence of prior exposure to psychological trauma or mental illness in psychologists. The research that does exist falls predominantly into the area of abuse experiences. Existing research tends to indicate that mental health workers, in general, endure at least as much, if not more, psychological distress in their formative years as the general population. The variability found in the statistics produced is probably due to differences in definitions of the trauma under investigation and in the differing methodologies used in various studies (Little & Hamby, 1996).

#### **2.11 Prior History of Psychological Trauma in Therapists**

In a survey of therapists composed of psychologists, mental health counsellors, social workers, psychiatric nurses, and psychiatrists, Little and Hamby (1996) found 32% of their sample, being 33% of the females and 20% of the males, reported a history of childhood sexual abuse.

In a sample of self-identified trauma therapists, 60% answered 'yes' when asked if they had a trauma history (Pearlman & Mac Ian, 1995). Hilton, Jennings, Drugge, and Stephens (1995) surveyed a sample predominantly composed of social workers and psychologists working with sex offenders. They found 36.9 % of the women and 27.3% of the men, overall 32.7% of the sample, reported a history of childhood sexual abuse.

These authors suggested that these statistics were higher than those found within the general population.

When a sample of women psychologists and sexual violence counsellors were investigated, Schauben and Frazier (1995) found that 70% of the psychologists and 83% of the counsellors reported at least one experience of sexual victimisation. Additionally, 37% of the total sample reported more than one type of sexual victimisation.

In their study, Follette, Polusny, and Milbeck (1994) found that 29.8% of the psychologists and marriage and family therapists surveyed, 36.1% of the females and 23.1% of the males, reported a history of either physical or sexual abuse in their childhood. In comparison, a group of law enforcement professionals reported a prevalence rate of childhood abuse of 19.6%, being 40% of the females and 17.1% of the males.

Within a group of social workers, paediatricians, psychologists, and psychiatrists responsible for evaluating alleged childhood sexual abuse, 13% of the men and 20% of the women reported a personal history of childhood sexual abuse. In the same sample 7.3% of the men and 6.9% of the women reported they had been physically abused in their childhood (Nuttall & Jackson, 1994).

Elliott and Guy (1993) surveyed female therapists comprising social workers, psychologists, psychiatric nurses, and psychiatrists. They found that the prevalence rates of reported physical abuse, sexual molestation, parental alcoholism, hospitalisation

of a parent for mental illness, and death of a parent or sibling among this group were significantly higher than those reported by a group of women who were non-mental-health professionals. They also found that the surveyed female therapists reported significantly higher rates of family dysfunction in their families of origin than the women from other professions.

Pope and Feldman-Summers (1992) carried out a national survey of psychologists belonging to the clinical psychology, psychotherapy, and independent practice divisions of the American Psychological Association. The results revealed 26.28% of the male respondents and 39.22% of the female respondents reported either sexual or physical abuse during childhood or adolescence. These prevalence figures increased to 32.85% and 69.93% for males and females respectively if abuse during adulthood was also included. A significant gender difference was found with women being more likely than men to report an incident of abuse.

## **2.12 Prior History of Mental Illness in Therapists**

Empirical research on the prevalence of mental illness in therapists, or more broadly mental health workers in general, prior to undertaking training in their particular fields, appears to be non-existent. A literature search revealed a small number of descriptive accounts detailing: autobiographical experiences of practitioners with pre-existing mental illnesses working in the field of mental health (eg. Deegan, 1993; Frese, 2000; Jamison, 1997; Rippere & Williams, 1985); consumer/provider models (eg. Bassman, 1997; Frese & Davis, 1997); and qualitative studies reporting the perceptions of a very small number of participants (eg. Cain, 2000).

As detailed in the previous section, studies in this area have focused on collecting data on mental health workers of varying fields who have reported early experiences of sexual abuse. These studies have indicated that these experiences may be at least as high as those found in the general population. These studies have not documented the psychological problems or mental disorders often associated with this type of early trauma. Long-term effects of child sexual abuse, however, have been empirically investigated and include the possibility, though not the inevitability, of the development of clinical depression and/or anxiety disorders (Browne & Finkelhor, 1986; Weiss, Longhurst & Mazure, 1999), posttraumatic stress disorder (Melchert, 2000), and eating disorders (Wonderlich, Crosby, Mitchell, Thompson, Redlin, Demuth, Smyth, & Haseltine, 2001). It is reasonable, therefore, to suggest that if the prevalence of early sexual abuse in mental health workers is comparable with that found in the general population, it is also possible that the psychological problems and mental illnesses associated with this trauma may also exist to a comparable extent in mental health workers.

It is not only the experience of childhood sexual abuse that can lead to the development of psychopathology. It has also been suggested that any significant adverse event experienced in childhood may contribute to a later depressive, or other, mental illness by means of biological effects that have been shown to be related to these (Weiss, Longhurst & Mazure, 1999). A recent investigation, for example, has suggested that parental emotional abuse and neglect may contribute to later psychological distress to a greater extent than other factors such as child sexual abuse (Melchert, 2000).

Additionally, there are other mental illnesses that have their roots in any of a number of other causes that have not been considered. It is important not to ignore base rate statistics, which may occur when the base-rate fallacy is in operation (Myers, 1994). It remains reasonable to suggest that the presence of mental illness in some proportion of mental health workers including psychologists, prior to their training, does exist even though there is not yet any research on the extent to which this occurs.

If mental illness has not developed prior to training, it is possible that a predisposition to mental illness may be present if the individual has suffered from some early psychological trauma. It has been suggested that early trauma may sensitise individuals to later trauma (Wonderlich et al., 2001). Therefore, it is possible that the experience of an early trauma that did not lead to the initial development of psychopathology may lead to the development of psychopathology at a later time.

### **2.13 Prior History of Exposure to Family Members with Mental Illness or Psychological Trauma**

In their investigation of the family characteristics of therapists, Racusin, Abramowitz, and Winter (1981) found that at least one family member of each of the fourteen therapists they interviewed had physical or psychological difficulties. The origins of the physical problems could all be associated with psychogenic factors.

Black and Jeffreys (1993) conducted a study where they gathered information on the early life of social work and business students in connection with their personal exposure to psychosocial trauma. It was found that the social work students reported a significantly greater exposure than the business students to alcoholism, as well as to

physical, sexual, and emotional abuse within their families of origin. In addition the social work students were more likely than the business students to report incidents of physical illness, mental illness, death in the family of origin, and suicide occurring.

Graduate clinical psychology students have been shown to have ~~reported~~ significantly greater dysfunction in their family of origin, prior to their 18<sup>th</sup> birthday, than graduate students of business, education, engineering, and health science (Brems, Tryck, Garlock, Freemon, & Bernzott, 1995). This finding may not directly indicate prior exposure to family members suffering a mental illness and/or psychological trauma, however, a significantly greater level of emotional abuse, and higher (but not significant) levels of both sexual and physical abuse were reported by the clinical psychology students than the comparison students. Therefore, the present author suggests that findings of greater dysfunction within the family of origin may be consistent with a likelihood of a greater exposure to family members suffering psychological problems.

It may be that members of helping professions in general may be more likely to have been exposed to a family member with a mental illness or other psychological problems than those who do not work in this area. Phillips (1997) found that a group of nursing students was significantly more likely than a group of business studies students to report having had, in their childhood or adolescent years, a family member with a long-term physical or mental illness.



## **2.2 POSSIBLE EFFECTS FOR THERAPISTS WITH A HISTORY OF EXPOSURE TO MENTAL ILLNESS AND/OR PSYCHOLOGICAL TRAUMA**

### **2.21 Possible Positive Effects**

#### *Increased Therapeutic Effectiveness*

The literature revealed one study where therapeutic effectiveness was suggested to have increased due to therapists' own histories of childhood problems. Poal and Weisz (1989) found that the number of childhood problems reported by therapists was positively correlated with improvement in their child clients' externalising problems as measured by pre-therapy and post-therapy completion of the Child Behavior Checklist (Achenbach & Edelbrock, 1983), which was completed by the children's parents. Poal and Weisz (1989) suggested this might be indicative of therapists with numerous childhood problems being especially effective in helping children cope with their problems.

Therapeutic effectiveness was suggested in a small study where eight particularly effective therapists were identified and interviewed in-depth (Wolgien & Coady, 1997). These authors found that these therapists primarily attributed their effectiveness to difficult experiences in childhood and adulthood. These experiences were primarily related to stressors within the family of origin including death of a parent, problems with parent or sibling, marital problems, mental illness of parents, alcoholism of parents, and foster placements. Other personal experiences mentioned were those of oppression brought about through the early influence of exposure to various types of

diversity. Professional experiences were also mentioned as contributors to therapeutic effectiveness, particularly ‘learning from clients’.

Wolgien and Coady’s (1997) study supports the clinical opinion that the wounded healer paradigm may contribute to therapeutic effectiveness. However, these authors suggest therapeutic effectiveness may only develop in the presence of protective factors that cushion the negative experiences and facilitate the healing processes of wounded therapists. It has also been suggested that wounded healers’ beliefs in recovery may have a positive effect on therapeutic effectiveness (Cain, 2000).

### *Empathy*

Negative experiences in childhood may enable therapists to acquire enhanced empathy through the ability to identify with clients’ experiences (Cain, 2000; Guy, 1987). One study found that women’s perceived competence was higher than men’s in treating abuse victims (Pope & Feldman-Summers, 1992). Pope and Feldman-Summers (1992) propose that this finding may have resulted because women, being more likely to have had experienced abuse in their past, may find it easier to empathise with victims of abuse and therefore feel more competent. Alternatively, Pope and Feldman-Summers (1992) suggested that the women may have had more experience in treating these types of clients, or they may have prepared themselves to a greater extent to treat abuse victims out of interest in this client group or because of their own traumatic histories.

### *Positive Attitudes*

Personal exposure to mental illness may lead to more favourable attitudes towards those with mental health problems. Roth, Antony, Kerr, and Downie (2000) surveyed mental

health professionals, non-psychiatric physicians, and support staff at a large American university medical centre. They found individuals who had either professional or personal exposure to mental illness, through either having had a mental illness themselves or having a family member or friend with such a disorder, had more favourable attitudes to medical students with mental illnesses than individuals without these experiences.

### *Positive Coping Behaviours*

Mental health professionals with childhood abuse histories may use more positive coping behaviours when dealing with their sexually abused clients than those without such histories (Follette, Polusny, Milbeck, 1994; Little & Hamby, 1996). Significant positive coping strategies found by Little and Hamby (1996) were: clinicians getting involved with community prevention, furthering their education, doing their own personal therapy, seeking ongoing supervision/consultation, and seeking discussion with colleagues on cases.

## **2.22 Possible Negative Effects**

### *Reduced Therapeutic Effectiveness*

Guy (1987) suggests that if therapists enter the field with a conscious intent to resolve personal conflicts this may lessen therapeutic effectiveness and may even be detrimental to clients. He suggests this may occur if therapists are unable to focus adequately on their clients' problems due to a focus on, or the internal pressure of, their own unresolved personal problems. It may even arise that therapists may use the therapeutic relationship, intentionally or unintentionally, to meet their own emotional needs.

Lambert (1989) emphasises the importance of individual therapists when assessing therapeutic effectiveness. He suggests clients' changes after psychotherapy may be due to therapists' attitudes and characteristics rather than merely therapeutic techniques. In his review, Lambert (1989) identifies one case in which it appeared a harmful therapeutic environment was created as a result of a therapist who was struggling to cope with his own personal problems. The therapy that was offered by this therapist was unintentionally very unhelpful and produced, in many cases, negative effects for his vulnerable clients.

In a second example described by Lambert (1989) a callous approach taken by a group of therapists proved to impact negatively on their predominantly well functioning clients. The reasons for the callous approach were described only in terms of leadership style, however, the present author suggests the differing leadership styles presented in the study may have been partially influenced by the personal histories of the therapists.

#### *Reduced Therapeutic Effectiveness Due to Problematic Interpersonal Processes*

Investigating the early traumatic psychological experiences of psychologists, particularly if they are derived from within the interpersonal relationships of the family of origin, may be an important task when therapeutic effectiveness is being addressed.

In their investigation Hilliard, Henry, and Strupp (2000) found that early parental relationships directly affected the therapy process, which in turn had an effect on therapy outcome. The implication drawn by these researchers was that the extensive training in psychodynamic therapy, being the therapy used in this study, was not enough to counter the impact of the therapists' interpersonal histories on their therapeutic work.

In addition, other researchers have found that although manualised time limited dynamic psychotherapy was sufficient to correct therapeutic technique, it was insufficient to correct underlying problematic interpersonal processes resulting from interpersonal histories (Henry, Schacht, Strupp, Butler, & Binder, 1993; Henry, Strupp, Butler, Schacht, & Binder, 1993; Strupp, 1993).

Henry, Schacht, and Strupp (1990) found that psychotherapists' introjects, that is their internal representation of early interpersonal influences, were related to the degree to which the interpersonal relationships within the therapy process were problematic. Problematic interpersonal processes, in turn, were found to have a tendency to lead to a poor therapeutic outcome. However, although the absence of difficult interpersonal processes may not be sufficient to produce therapeutic effectiveness, the presence of even low levels of negative therapist behaviour may be detrimental to the outcome of therapy.

Introjects comprise conscious and unconscious ways of treating the self, and include both hostile, which are self-critical, self-destructive, and/or self-neglectful, and friendly introjects, which are self-accepting, self-nurturing, and self-helping (Henry et al., 1990). Considering the effects of early trauma on the formation of introjects is important because introjects are claimed to be important in the shaping of interpersonal behaviour. Introject theory suggests therapists will treat clients in accordance with their own introjects ( Henry et al., 1990).

Further suggestion that interpersonal relationships may be affected through having had a history of childhood sexual abuse may be construed from Nuttall and Jackson's (1994)

study. They found that among their sample of clinicians, respondents with a personal history of childhood sexual abuse were less likely to be married, more likely to be in a non-marital significant relationship, and more likely to be childless than respondents not reporting childhood sexual abuse. However, Pearlman and Mac Ian (1995) found that in their sample of trauma therapists, those with a personal trauma history were significantly more likely to be married than trauma therapists who did not report a personal trauma history.

In their review of the research on the impact of child sexual abuse, Browne and Finkelhor (1986) suggest the effects on interpersonal relating include poor relationships with both men and women, poor parenting, difficulty in trusting others, and vulnerability to revictimisation. If some therapists have a history of this type of trauma, it is then reasonable to suggest that these effects may also exist in some of these individuals and if not addressed may affect therapeutic effectiveness.

### *Trauma Symptoms*

It has been shown that, in general, mental health professionals who work with child sexual abuse survivors may report low levels of trauma symptoms, post traumatic stress disorder (PTSD) symptoms, and general psychological distress, in conjunction with moderate levels of personal stress (Follette, Polusny, & Milbeck, 1994). However, Follette et al. (1994) found significantly higher levels of current trauma specific symptoms in therapists with a personal history of childhood physical or sexual abuse than in those professionals who did not report this type of childhood trauma.

In contrast to the previous study, Elliot and Guy (1993) found that although their surveyed female therapists reported significantly greater childhood trauma than a comparison group of non-mental health professionals, they reported a significantly less degree of current psychological distress than the women working in other fields.

### *Secondary Traumatization*

Kassam-Adams's (1995, cited in Brady, Guy, Poelstra & Brokaw, 1999) unpublished doctoral dissertation reported the finding that in a sample of outpatient therapists, intrusion and avoidance symptoms were significantly correlated with current and cumulative exposure to sexual trauma survivors. In addition it was found that therapists' gender and personal history of childhood trauma were significant predictors of these types of PTSD like symptoms.

Follette, Polusny, & Milbeck, (1994) identified secondary traumatization in their participants by investigating predictors of PTSD symptoms. They found that mental health professionals use of negative coping strategies to deal with sexual abuse victims, level of personal stress, and negative clinical responses to abuse survivors were predictive of secondary trauma symptoms. However, in contradiction to the previous study, having a personal trauma history did not significantly predict trauma symptoms.

### *Vicarious Traumatization*

Vicarious traumatization is purported to be similar to secondary traumatization in that symptoms, resulting from indirect exposure to traumatic material, similar in nature to those of post traumatic stress disorder (PTSD) are evident (Figley, 1995), for example: intrusive thoughts, nightmares and generalised anxiety may be experienced (Cerny,

1995). However, vicarious traumatisation is thought to differ from secondary traumatic stress with the scope of the former concept encompassing disruption to basic cognitive schemas and belief systems (Pearlman & Saakvitne, 1995).

In a survey of women psychotherapists, Brady, Guy, Poelstra, & Brokaw (1999) found that therapists with higher levels of exposure to trauma material evidenced significantly greater levels of trauma symptoms but not greater disruption to cognitive schemas. It is notable that these symptoms were mild. Although this investigation reported that 33% of the therapists themselves reported a personal history of sexual trauma, no findings were reported as to the effects of these histories.

Pearlman and Mac Ian (1995) collected data on a sample of self-identified trauma therapists. Therapists with a personal history of trauma showed a significantly greater disruption in their cognitive schemas, greater general distress, and more intrusive symptoms of PTSD than therapists who did not report a history of personal trauma. Pearlman and Mac Ian (1995) also found that the length of time trauma therapists with a personal history of trauma had worked with this client base was predictive of symptoms. The newer therapists were more greatly affected. In addition, they found, to a lesser extent, percentage of survivors in their caseloads was also predictive for this group.

Schauben & Frazier (1995) conducted a study on a sample of women psychologists and counsellors working with sexual violence survivors. They found that those with a higher percentage of sexual violence survivors in their caseloads reported more disruptions to basic schemas about themselves and others, more PTSD symptoms, and



more self reported vicarious trauma than those therapists with fewer of these types of clients in their caseloads. Participants prior history was not found to be a significant factor, that is therapists with a history of prior victimisation were no more distressed at seeing these clients than those without this history.

### *Burnout*

Burnout is a syndrome that is frequently found among those who work as human service providers and is characterised by feelings of emotional exhaustion, cynical attitudes and feelings towards clients, and negative self-evaluations (Maslach & Jackson, 1981). If burnout is to occur, this has been found likely to happen within the early years of commencing a career in this area (Maslach & Jackson, 1981).

It has been generally suggested that burnout may be caused through one of three mechanisms: environmental/organisational factors; unresolved personal/career factors; or, by a combination of these factors (Suran & Sheridan, 1985).

Justice, Gold, and Klein (1981) found that burnout may be exacerbated by negative life events and that factors other than on the job factors may be related to burnout.

Although this study only tested for life events in the previous six months, the present author suggests it is possible that life events that occurred earlier than this time frame may also have some impact on burnout.

However, positive life events (Justice, Gold, & Klein, 1981), controllability and predicability of life events, and levels of social support (Landsbergis, 1988) may have buffering or modifying effects on burnout.

For those who have experienced an early history of psychological trauma, whether or not it manifests later as a mental illness, the present author suggests that according to an existential-psychoanalytic perspective it is possible that burnout may occur. The psychoanalytic aspect of this perspective suggests that most people choose a career influenced by their positive and negative childhood experiences, burnout may then occur through the existential aspect through an individual's sense of failure in attempting to find meaning in their work (Pines, 2000). For example, an individual may enter the profession of psychology motivated by a need for reparation, ie. a need to make good for others a wrongdoing done to them. If this individual also has high expectations to succeed in the profession, burnout may result if, in combination with the high stress of the job, these goals, ie. reparation and success, are not met.

#### *Countertransference Issues*

Dalenberg (2000) describes various definitions of countertransference that move from the broad, encompassing therapists' total reactions to their clients, to the more particular where specific classes of emotional responses are isolated. The more specific definitions outlined by Dalenberg (2000) include determining the usefulness of the response, where if it is a hindrance it may be considered countertransference and if it has a positive use, merely an aid to therapy. A further definition includes classifying all objective responses outside the realm of countertransference and placing all subjective responses within this rubric. Alternatively, responses that are counter to clients' transferences may be considered by some as countertransference with all independent reactions of therapists being excluded from this definition. Specific classification of therapists' reactions may not prove to be an easy task as reactions will often contain elements of both sides of any dichotomous definition (Dalenberg, 2000).

It is a common belief among psychotherapists that if therapists have similar unresolved issues as their clients, there will be a greater chance of encountering negative countertransference issues (Little & Hamby, 1996).

In general, countertransference is considered to have a useful role within the therapeutic relationship if acted on in an appropriate way. Therapists' reactions to clients may reflect the unspoken or unconscious needs and/or deficits inherent within the inner worlds of clients, thus when countertransference is accurately recognised by therapists the therapeutic encounter may be greatly enhanced (Guy & Brady, 2001).

Countertransference reactions, however, may not be recognised in this way and may instead be acted out by therapists after stimulation of therapists' own needs and issues. Treatment may then be influenced in irrelevant and possibly harmful ways (Guy & Brady, 2001).

Guy (2000) suggests that therapists, as all people, need respect and nurturance, if this is not being obtained from a network of close friends and family, then therapists may look to clients to fulfil these needs. This may in turn reduce therapeutic effectiveness thus clients are adversely affected.

In a survey conducted by Little and Hamby (1996), seventeen countertransference items were tested. Three of the items: 'crying with their clients', 'making boundary mistakes in therapy', and 'sharing own experiences of sexual abuse with clients' were reported significantly more often by therapists with a sexual abuse history than by therapists

without a history of childhood sexual abuse. In the same study a fourth countertransference item, 'feel angry with the perpetrator', approached significance.

Cain (2000) identified some negative aspects of countertransference in mental health workers with a psychiatric history that included feelings of anxiety, frustration, and discomfort. Participants in this study were also prompted to remember difficult times, experienced isolation and vulnerability, and internalised the stigma associated with mental illness. Some participants reported their countertransference reactions might have negatively affected their clients. Over-identification with clients was a problem for some participants, however, all participants believed that their reactions and personal histories inspired and informed their therapeutic work. Whether this was of benefit or not to clients, the clinical work of these participants was affected.

### *Stigmatisation*

Therapists with a personal traumatic history may fear disclosing their past to co-workers for fear of being thought of as a victim or being thought of as not being suitable for their job (Hilton, Jennings, Drugge, & Stephens, 1995). This may be particularly so for those with a history of childhood sexual abuse where feelings of isolation and stigmatisation accompanied by poor self-esteem have been empirically evidenced (Browne & Finkelhor, 1986).

Additionally, a prior history of psychiatric hospitalisation has been reported by 'wounded healers' to lead to the experience of the painful effects of stigmatisation, which appears to be freely perpetuated within the mental health system (Cain, 2000).

However, Cain (2000) did acknowledge varying degrees of this experience and found some participants were hired because of their prior experiences.

### **2.23 Additional Possible Effects on Clinical Practice**

Some additional effects resulting from therapists' prior histories have been found that may prove to be either positive or negative, depending on their degree of influence.

Hilton, Jennings, Drugge, and Stephens's (1995) sample of social workers and psychologists working with sex offenders and reporting a personal history of childhood sexual abuse generally perceived the effects of their histories on their clinical practice as being positive or non-existent. These effects related to influences on their ability, motivation, and content of work with sex offenders.

Clinicians who have a childhood history of sexual or physical abuse may be more likely to believe allegations of sexual abuse than clinicians without personal experience of this type of abuse (Nuttall & Jackson, 1994). Consistent with these findings, Gore-Felton, Arnow, Koopman, Thoresen, and Spiegel (1999) found that clinicians with a prior history of sexual abuse were more likely to believe that the prevalence of childhood sexual abuse is greater than those clinicians without this history. A gender effect was also indicated in this study with female clinicians more likely to believe in a greater prevalence of childhood sexual abuse than their male colleagues.

Polusny and Follette (1996) also investigated the effects of therapists' own personal histories of childhood sexual abuse on their clinical practice and beliefs. They concluded that, in general, clinical practice and beliefs did not significantly differ

between abused therapists and non-abused therapists. However, they did find that abused therapists were more likely than their non-abused counterparts to assign bibliotherapy to clients who reported having no memory of childhood sexual abuse, and to rate this exposure as being less suggestible. Abused therapists were also found to believe more strongly than non-abused therapists in the importance of clients remembering their own childhood sexual abuse experiences in order to alleviate present distress.

Some therapists with histories of childhood sexual abuse may be very influenced by a belief in the importance of clients remembering sexual abuse in their childhoods that they may find it difficult to recognise the possibility that some clients may come to believe falsely in its occurrence. Alternatively, abused therapists may be more likely to appreciate the importance of addressing these issues (Polusny & Follette, 1996).

Having experienced a history of sexual or physical abuse may increase the likelihood of a clinician serving on a family violence team (Nuttall & Jackson, 1994).

### **2.3 MOTIVATIONS**

Among the possible benefits of entering the profession of psychotherapy are professional autonomy, satisfactory financial rewards, variety in the scope of work, recognition of accomplishments and prestige, intellectual stimulation and growth, emotional growth and satisfaction, and personal enrichment and fulfilment (Guy, 1987). However, Guy (1987) suggests there are conscious and unconscious motivations that go beyond merely seeking to enjoy the benefits associated with becoming a

psychotherapist. Furthermore, he proposes there are motivators that are predominantly functional, and others that are possibly or potentially dysfunctional.

2.31 Functional Motivators

Motivators for entering the profession of psychotherapy are proposed to be functional if they enhance the effectiveness and competence of the clinical services provided while promoting personal growth and development in the therapist (Guy, 1987).

As motivations for career choice may be unconscious it is important that therapists bring these into their awareness and that they promote personal growth and maximise therapeutic effectiveness (Racusin, Abramowitz, & Winter, 1981).

Personal characteristics that have been identified as functional motivators are noted in Table 1.

Table 1.

*Functional Motivators for Entering the Profession of Psychotherapy - as Identified by Guy (1987)*

Predominantly Functional Motivators
Deep interest in human behaviour
Able to and enjoys listening to others
Comfortable with verbal interactions
Capacity for empathy and understanding
Tolerance for and comfort with a range of expressed emotions
Tendency to introspection
Ability to deny personal gratification and put others first
Comfortable with ambiguity and patience
Capacity to be extremely warm and caring
Tolerance for intimacy, contact and closeness * <sup>†</sup>
Comfortable with the idea of being in a position of great influence and power in the lives of others* <sup>!!</sup>
Sense of humour

\* These motivators, if extreme, also have the potential to be dysfunctional

<sup>†</sup> A tolerance for intimacy is considered by some to be a common characteristic of psychotherapists and if moderate, a functional motivator. However, if therapists enter the profession to gain the intimacy missing in their own lives they may find this need is detrimental to their professional and personal relationships (Guy, 1987).

<sup>‡</sup> It is possible that being in a position of great power in the lives of others may become dysfunctional and adversely affect clients if therapists' needs for power are not met outside the therapeutic relationship. This need for power may also become dysfunctional if the associated need to influence is great and is used unethically, eg. to convert clients to therapists' own political or religious views (Guy, 1987).

**2.32    Dysfunctional Motivators**

In contrast with functional motivators to entering the profession of psychotherapy, motivators can be dysfunctional if they hinder therapeutic effectiveness and negatively impact on the personal development of the therapist (Guy, 1987). Table 2 lists a number of possible or potentially dysfunctional motivators

Table 2.

*Possible or Potentially Dysfunctional Motivators for Entering the Profession of Psychotherapy - as Identified by Guy (1987)*

Possible or Potentially Dysfunctional Motivators
Emotional distress characterised by an underlying desire to gain self-understanding
A means of vicariously coping with on-going problems
Loneliness and social isolation
Desire for power derived from a sense of powerlessness in one's own life
Search for an outlet to express the need to love
A source of vicarious rebellion



### **2.33 Psychoanalytic Theory of Career Choice**

Psychoanalytic theory proposes that career choice may be made at an unconscious level, and that unconscious determinants reflect meaningful childhood experiences, family dynamics, and familial career choice and emphasises the importance of individuals' relationships with, and the career choices of, key people in childhood (Pines & Yanai 2001). In effect, unconscious career choices reflect a combination of internalised 'objects' and 'object relations' (Pines & Yanai, 1999).

In addition, psychological determinism is a classic tenet of the psychoanalytic theory of career choice. The assumption is made that all work carried out by an individual, excluding the extremes of slavery and imprisonment, is to some extent a personal choice, although this choice may be made at several different levels of consciousness (Pruyser, 1980).

Within psychoanalytic theory occupational choices are thought to be greatly influenced by both positive and negative childhood experiences, and people are assumed to choose a vocation where it will be possible to replicate important childhood experiences, satisfy unfulfilled childhood needs, or realise family expectations (Pines & Yanai, 1999). The partly conscious, but largely unconscious, drive to bring about atonement is considered to be at the root of all work activities (Roberts, 1994).

Dartington (1994) suggests that a general observation can be made that people are drawn to one of the caring professions from their own desire to put something right. She further asserts that this need may only be partially conscious and that it stems from guilt or concern, and is accompanied by the desire to heal the emotional wounds of the

individual and the damaged figures of their internal world. This reparative motivation may appear initially healthy, however, problems may arise if reparation is compulsively sought.

Pines (2000) offers that the greatest career passion can be typically located in an area where some unresolved childhood issue can be found, and that professional success helps heal the childhood wound. However, in cases where individuals feel they have failed they have invariably repeated the childhood trauma rather than healed it, typically resulting in burnout. Pines and Yanai (2001) conclude in their investigation that uncovering the unconscious determinants of career choice is very important in the selection and development of a career, and additionally in the combating of burnout. Unconscious determinants of career choice may be related to job satisfaction and sense of significance of the work being carried out (Pines & Yanai, 1999).

Unconscious unresolved childhood issues are not only considered to influence choice of career but also, particularly within the caring professions, the type of clients to be worked with and the type of work setting (Roberts, 1994). It is further suggested that particular work settings attract individuals with similar internal needs and a similar propensity to exhibit similar defences, this may in turn give rise to collective defences that may obstruct job performance (Roberts, 1994).

Within psychoanalytic theory it is considered imperative that individuals within helping professions have at least some insight into their reasons for choosing such a career, their potential blind spots, their tendency for certain types of defences, and their vulnerability towards particular types of projective identification (Roberts, 1994).

### **2.34 Motivators pertaining to the Family of Origin**

Early experiences within the family of origin may dispose some people to choose a career in psychotherapy (Guy, 1987). Some may choose this path in order to meet a need for closeness and intimacy that was lacking in childhood and that can be met through safe, controlled relationships with clients (Racusin, Abromowitz & Winter, 1981).

Racusin, et al. (1981) found a pattern of upward social mobility among psychotherapists. Perhaps this represents an unconscious movement away from a lower socio-economic and, perhaps, more troubled family of origin.

Racusin et al. (1981) describes parents of psychotherapists as being only moderately, emotionally and physically, close. Although the marriages investigated were characterised by poor communication, work pressures, financial problems, and high stress, divorce rates were surprisingly low due to the enmeshed nature of the parental relationship.

The future therapist was described by Racusin et al. (1981) as often being thrown into the middle of parental strife and assigned, most likely unconsciously, the role of peacemaker/caretaker. The therapists interviewed also actively identified themselves in this role.

In an unpublished American national survey of psychotherapists' attitudes and beliefs, Guy, Stark and Poelstra (1987, cited in Guy, 1987) found that nearly 50 % of the therapists surveyed were either first born or only children. They suggested this would

increase the probability of the future therapist being assigned the role of caretaker.

Being drawn into the role of caretaker early in life may motivate those individuals into taking up this role within the profession of psychotherapy (McCarley, 1975).

### **2.35 Research in the Area of Motivation**

Guy, Stark and Poelstra (1987, cited in Guy, 1987) found that psychotherapists identified the desire to help other people as the primary motivating reason for entering the profession of psychotherapy. This fits with the common suggestion that many of the conscious choices for entering one of the helping professions stem from idealism (Roberts, 1994).

In a study conducted by Youniss, Lorr, and Stefic (1985), three subgroups of psychologists were investigated in terms of their motivational patterns. These three groups comprised clinical practitioners, academic clinical psychologists, and academic non-clinical psychologists.

The clinical practitioners were found to be significantly higher on the motivational dimensions of altruism, person orientation, and material orientation, and significantly lower on the motivational dimensions of theoretical and achievement directed, than the two academic groups combined. On all of the above dimensions, excluding achievement directed, the mean score of the academic clinical group was midway between the clinical practitioners and academic non-clinical psychologists (Youniss, et al., 1985). This study did not investigate or differentiate dysfunctional motivators.

Wilczenski (1997) investigated motivations in relation to choosing school psychology as a career. She found intrinsic motivators such as: interest in the content of the field; desire to work with children; challenge of the position; and desire to influence policy; were highly ranked by respondents. Extrinsic motivators such as: availability of jobs; encouragement from others; status; and examples shown by others in the profession; were found to be ranked at a lower level. This study did not, however, attempt to differentiate or even appear to include dysfunctional motivational options.

Murphy and Halgin (1995) developed a questionnaire in which they derived, after their review of the literature, four factors relating to the concept of motivations for career choice: 1. professional altruism; 2. vocational achievement and opportunity; 3. personal growth and inquisitiveness; and 4. personal problem resolution. In addition, these researchers also derived a further three factors relating to influential past experiences: 1. experiences of personal problems; 2. troubled family experiences; and 3. experiences of strong interpersonal alliances.

Murphy and Halgin (1995) compared the responses of 56 clinical psychologists with 53 social psychologists. Significant differences were found between the groups on the factors vocational achievement and opportunity, and personal problem resolution. It was found that vocational achievement was more important to the clinical psychologists than the social psychologists, and that clinical psychologists were more likely, than the social psychologists, to choose their career in order to resolve personal problems. However, the motivation to resolve personal problems was rarely cited as the most influential factor on career choice.

Two further significant findings in the Murphy and Halgin (1995) study were that the clinical psychologists were more likely than the social psychologists to view experiences of personal problems and troubled family environments as influential in their choice of career. These motivations, however, were not found to be of primary importance. Gender differences were not found in this investigation which led the researchers to suggest that any motivational differences found might apply to the professions as a whole.

## **2.4 PSYCHOTHERAPISTS WHO UNDERGO THEIR OWN PERSONAL PSYCHOTHERAPY**

Guy (1987) suggests trainee psychotherapists who undergo therapy during training may achieve greater levels of functioning and therefore become effective therapists. There is relatively general agreement among therapists that personal therapy is useful and important (Macran, Stiles, & Smith, 1999). Personal therapy is thought to be useful in learning about the therapeutic process because it models clinical methods; provides awareness of the interpersonal dynamics involved in therapy; and promotes greater awareness and personal development (Williams, Coyle & Lyons, 1999).

In Norcross, Dryden, and DeMichele's (1992) literature review six recurring components of personal therapy thought to increase the effectiveness of therapists were identified. These commonalities were: 1. the improvement of emotional and mental functioning of psychotherapists; 2. provision of a greater understanding of personal dynamics, behaviours elicited through interpersonal transactions, and issues derived from conflicts; 3. contribution to the alleviation of issues specific to the profession; 4.

provision of an experience of socialisation where the power of psychotherapy could be grasped first hand; 5. provision of the experience of being in the position of the client; and 6. allowing for the first hand observation of clinical methods. These mechanisms were re-affirmed in a later review by Macran & Shapiro (1998).

However, research has not satisfactorily shown that personal therapy is related to therapists' mental health, or leads directly to increased therapeutic effectiveness (Beutler, Machado, & Neufeldt 1994; Macran & Shapiro, 1998). Although, it has been indicated that therapist well-being and adjustment is related to positive therapeutic outcome (Beutler et al., 1994), and that therapists maladjustment may be harmful to clients (Beutler et al., 1994; Greenberg & Staller, 1981). As therapy has been found to lower disturbance, it remains reasonable to suggest personal therapy to disturbed therapists as, theoretically, this may indirectly benefit therapeutic effectiveness (Greenberg & Staller, 1981).

Personal therapy has also been associated with therapists' increased empathy, warmth and genuineness (Macaskill & Macaskill, 1992; Norcross, Strausser-Kirtland, & Missar, 1988; Peebles, 1980 ), and an increased focus on therapeutic relationships with clients (Wogan & Norcross, 1985). These findings support the value of personal therapy for therapists, as beneficial to clients, since it has been found that these factors are facilitative of therapy (Lambert & Bergin 1994). In addition, one of the conditions suggested to result in harmful treatment is the presence of a distant, rigid and uninvolved therapeutic relationship (Grunebaum, 1986).

Herron (1988) suggested, in his review of the literature, that it appears personal therapy does produce effects on the practice of psychotherapy, but due to the complex nature of these effects and the unexpected results found in some studies, it is difficult to predict what these effects may be. He acknowledged that some therapists are effective without having had personal therapy but that the literature has not shown whether these therapists would be more or less effective if they had received therapy. Herron (1988) also suggests the possibility of interactions between personal therapy and other therapist variables such as experience and theoretical orientation. Finally, he came to the conclusion that it is not possible to come to any definitive judgement as to the merit of personal therapy, however, it is suggested that there is probable benefit of the selective inclusion of personal therapy in conjunction with training in psychotherapy.

A survey of counselling psychologists in the United Kingdom found 88% of the respondents in favour of personal therapy as a mandatory requirement of training (Williams, Coyle & Lyons, 1999). Undertaking personal therapy is the standard in Britain for training courses in psychotherapy or counselling, although it is not for trainee clinical psychologists (Macran & Shapiro, 1998). Williams, Coyle & Lyons, 1999) noted that, in general, participants rated their personal therapy as positive, although 27.6% of the sample reported negative effects. Most of those reporting negative effects, however, were still in favour of mandatory personal therapy as a training requirement. The reporting of negative effects is consistent with other studies (Macaskill, 1988; Macaskill Macaskill, 1992). It appears that, despite its benefits, personal therapy does place a burden on therapists, particularly those completing their training (Macran & Shapiro, 1998).



Macran, Stiles, and Smith (1999), who also acknowledge the possible negative effects of personal therapy, found that negative effects sometimes facilitated therapists as therapists were able to learn from these. An additional finding was that the learning about therapy that took place was more than just a cognitive understanding it was also described as "...learning that had not been put into words and perhaps could not be completely verbalized but that powerfully affected the participants' clinical attitudes and behaviors...". These authors suggested that their participants were better able to provide a more therapeutic environment for their clients due to the mechanisms of personal growth and reciprocal role learning, which provided the opportunity for the therapists to experience these conditions themselves when receiving personal therapy.

In their interpretative phenomenological analysis of personal therapy, Macran, Stiles, and Smith (1999), derived twelve salient themes that could be grouped within three broad domains. The first domain related to therapists' understanding of the importance of their own presence in therapy and successfully managing and fostering that presence. The second domain was client orientated, and related to the importance of allowing clients their own space to work through issues. The remaining domain revealed gaining the ability to work with clients on a more unconscious or deeper level.

A factor analysis carried out by Williams, Coyle & Lyons (1999) revealed three important components to the positive benefits of personal therapy. Most important was the factor pertaining to learning about therapy itself. The other two factors were dealing with issues arising out of training, and dealing with personal issues.

Within the psychoanalytic perspective, personal therapy can be useful in differentiating the past and present and in finding alternative ways to resolve individuals' unconscious conflicts rather than having to effect this primarily through the work role (Roberts, 1994).

## CHAPTER 3

### METHOD

#### 3.1 PARTICIPANTS

##### 3.11 Sample Characteristics

There were 156 participants who were divided into two groups, clinical/counselling psychologists and postgraduate students ( $N = 108$ ), and psychologists and postgraduate students specialising in other areas of psychology ( $N = 47$ ). One participant did not identify her area of specialty and was omitted from analysis based on these two groups.

The clinical/counselling group comprised 93 participants who classified themselves as specialising in clinical psychology and 15 participants who classified themselves as specialising in counselling psychology. The other specialties participants were from the specialty areas of industrial/organisational psychology ( $N = 17$ ), educational psychology ( $N = 24$ ), health psychology ( $N = 3$ ), and areas other than clinical or counselling psychology ( $N = 3$ ). The clinical/counselling participants had commenced their postgraduate psychology training on average 15.72 years ago ( $N = 105$ ,  $SD = 10.322$ ), while the participants specialising in other areas of psychology had commenced their training on average 12.18 years ago ( $N = 45$ ,  $SD = 9.316$ ). Further demographic information for the two groups is shown in Table 3.

Table 3.

*Comparison of Groups on Demographic Variables*

Variable	Clinical/Counselling Group ( <i>N</i> = 108)	Other Specialties Group ( <i>N</i> = 47)
Sex		
Male	<i>N</i> = 39 (36%)	<i>N</i> = 17 (36%)
Female	<i>N</i> = 69 (64%)	<i>N</i> = 30 (64%)
Age		
20-29 years	<i>N</i> = 12 (11%)	<i>N</i> = 3 (6%)
30-39 years	<i>N</i> = 31 (29%)	<i>N</i> = 14 (30%)
40-49 years	<i>N</i> = 30 (28%)	<i>N</i> = 11 (24%)
50-59 years	<i>N</i> = 27 (25%)	<i>N</i> = 18 (38%)
60 years plus	<i>N</i> = 8 (7%)	<i>N</i> = 1 (2%)
Primary Status		
Student	<i>N</i> = 11 (10%)	<i>N</i> = 6 (13%)
Practitioner	<i>N</i> = 91 (84%)	<i>N</i> = 40 (85%)
Academic	<i>N</i> = 6 (6%)	<i>N</i> = 1 (2%)
Highest Completed Qualification		
Bachelors/Honours Degree	<i>N</i> = 7 (7%)	<i>N</i> = 9 (19%)
Postgraduate Diploma	<i>N</i> = 10 (9%)	<i>N</i> = 6 (13%)
Masters Degree	<i>N</i> = 14 (13%)	<i>N</i> = 16 (34%)
PG Dip in Clin. Psychology	<i>N</i> = 50 (46%)	<i>N</i> = 2 (4%)
PG Dip in Ed. Psychology	<i>N</i> = 1 (1%)	<i>N</i> = 10 (21%)
Doctorate	<i>N</i> = 22 (20%)	<i>N</i> = 4 (9%)
Other	<i>N</i> = 4 (4%)	<i>N</i> = 0 (0%)
Theoretical Orientation		
Psychodynamic	<i>N</i> = 8 (7%)	<i>N</i> = 0 (0%)
Behavioural	<i>N</i> = 3 (3%)	<i>N</i> = 5 (11%)
Cognitive-Behavioural	<i>N</i> = 45 (42%)	<i>N</i> = 13 (28%)
Eclectic	<i>N</i> = 26 (24%)	<i>N</i> = 12 (25%)
Mixed	<i>N</i> = 17 (16%)	<i>N</i> = 6 (13%)
Other	<i>N</i> = 7 (6%)	<i>N</i> = 4 (8%)
Not Applicable	<i>N</i> = 2 (2%)	<i>N</i> = 7 (15%)

Comparisons between the two groups were made on the relevant demographic variables. The Pearson chi-square test was used to compare the variable sex ( $\chi^2 < .0005$ ,  $df = 1$ ,  $p = .994$ , two tailed) and primary status ( $\chi^2 = 2.514$ ,  $df = 2$ ,  $p = .285$ , two tailed), the Mann-Whitney test was used for age ( $U = 2374.0000$ ,  $N_1 = 108$ ,  $N_2 = 47$ ,  $p = .508$ , two tailed), and the independent t-test for length of time elapsed since postgraduate training was commenced ( $t = 1.984$ ,  $df = 148$ ,  $p = .049$ , two tailed). These demographic characteristics were evaluated using an alpha of .05 resulting in the finding that the two groups did not differ significantly on the variables of sex, primary status, and age. However, they did differ significantly, although significance was only just attained, in terms of length of time elapsed since postgraduate training was commenced (descriptive statistics for this variable are reported on page 41).

Statistical analysis of the variable 'highest completed qualification' was not undertaken due to all participants having either attained or currently working towards a postgraduate qualification in psychology. The two groups were also not statistically compared on the variable 'theoretical orientation' as not all psychologists in all fields of psychology identified a particular theoretical orientation. It is suggested this variable is more relevant to the clinical/counselling participants than the participants from other psychological specialties.

### **3.12 Coding of Demographics**

#### *Primary Status*

Participants were asked to select among the options of 'student', 'practitioner', 'academic', or 'other'. Participants who selected the category 'other' specified their status as one of the following: practitioner in another field, manager, consultant, HR professional, rehabilitation worker with sex offenders, or police officer. For the purposes of analysis these participants were included in the practitioner category.

#### *Highest, fully completed, qualification*

When coding participants' highest, fully completed, qualifications, those who specified they had earned an honours degree under the option of 'other' were included with those

who had selected 'bachelors degree'. In addition, a sufficient number of participants indicated having obtained a postgraduate diploma in educational psychology for this qualification to be afforded its own category. The four clinical/counselling participants who selected the option of 'other' specified their highest qualifications as being one of the following: a post doctoral diploma in analytical psychology (Jungian Analysis), a postgraduate diploma in community psychology, a postgraduate diploma in a psychological area not specified, and a licence en sciences psychologique and pedagogiques (an overseas qualification).

### *Area of Specialty*

It was anticipated that in completing the demographics section of the questionnaire participants would select only one item under each question. However, in some cases participants chose more than one item. When this occurred the following rules were applied when classifying participants.

When asked the question 'What is, or will be, your area of specialty?' participants had a choice of six items but were ultimately classified for analysis under one of two categories being either 'clinical/counselling group' or 'other specialties group'. Some participants selected more than one category. When this occurred participants were classified in the following way:

1. If 'clinical psychology' was selected among other choices the participant was coded in the area of 'clinical psychology' and ultimately categorised in the 'clinical/counselling group'.

2. If 'counselling psychology' was selected among other choices, excluding clinical psychology, the participant was coded in the area of 'counselling psychology' and ultimately categorised in the 'clinical/counselling group'.
3. If more than one area of specialty was selected excluding both 'clinical psychology' and 'counselling psychology' the participant was coded as 'mixed' and ultimately included in the 'other specialities group'.

Two participants described themselves as specialising solely in neuropsychology, these respondents were classified as clinical psychologists.

### *Theoretical Orientation*

In cases where participants chose more than one theoretical orientation, if one of their choices was 'eclectic' then participants were coded as 'eclectic'. If more than one theoretical orientation was selected excluding 'eclectic' then participants were coded as 'mixed'. Some participants specified under 'other' that they were of a psychoanalytic theoretical orientation, these cases were coded as 'psychodynamic'.

### **3.13 Missing Data**

Some of the questionnaires were returned with some items incomplete. All questionnaires, whether fully or partially completed, were deemed to be useable due to the number of hypotheses in this study, not all of which required all items to be answered. Therefore, all completed items were coded for analysis and data that was incomplete was entered as missing. For each statistical test, if the relevant item was missing then that case was omitted from the analysis, however, if applicable, that case

was still used in other statistical tests relating to other sections of the same or other hypotheses.

### **3.2 MEASURE**

The present author designed an original questionnaire primarily intended to explore areas relating to psychologists' experiences and perceptions prior to their undertaking postgraduate study in psychology.

Questions 1 to 3 were designed to elicit information regarding early personal experiences of psychological trauma and mental illness. The following three questions aimed to gather information on the perceived influence of these experiences in the choice to study psychology, and the perceived effects of these experiences on the practice of psychology in the future. Question 7 was designed to extend the information gathered in questions 1 to 3 by obtaining data on vicarious exposure to psychological trauma or disorder, ie. through having had a family member or close friend who had directly experienced certain experiences. The perceived influence and effects of these experiences were examined in three further questions. Questions 11 and 12 ascertained whether the students or psychologists had received any psychotherapy or counselling as a client prior to or during their postgraduate study.

The questionnaire also devoted a section to determining the extent of influence of various factors in the decisions of participants to become psychologists. A further section was designed to collect information regarding the extent of perceived stigmatisation attached to postgraduate students with psychological problems and also



the degree of satisfaction of students and psychologists with their postgraduate study in relation to self-care and self-reflective issues. A final section gathered demographic data that included sex, age, status, qualifications held, year postgraduate study commenced, area of specialty, and theoretical orientation. A copy of the questionnaire can be found in Appendix A.

### **3.21 Survey Development**

The development of the questionnaire proceeded in line with the recommendations of Leong and Austin (1996).

#### *Step One: Table of specifications*

A table of specifications determining the domains of interest and the specific details of information the present author wanted to capture was drawn up. Table 4 presents the initial table of specifications set down for this study.

Table 4.

*Table of Specifications for Research Questionnaire*

Domain		Specific Information Required	
1.	Demographics	1.	Gender
		2.	Age
		3.	Status
		4.	Qualifications
		5.	Area of Specialty
		6.	Theoretical Orientation
2.	Prevalence	1.	Prevalence of pre-training* exposure to mental illness in: self family member close friend
		2.	Prevalence of pre-training* exposure to psychological trauma, e.g. physical abuse, sexual abuse, parental alcoholism, death of a parent or sibling.
3.	Psychologists' perceptions	1.	Perceptions of extent of influence of pre-training* exposure to mental illness and/or psychological trauma on decision to study psychology.
		2.	Perceptions of how pre-training* exposure to mental illness and/or psychological trauma would affect ability to practice as a psychologist once training had been completed.
4.	Motivations for entering field of psychology	1.	Extent to which motivated by potentially dysfunctional motivators.
5.	Satisfaction with training	1.	Perceived stigma attached to students with psychological problems.
		2.	Satisfaction with emphasis on self-care.
		3.	Satisfaction with emphasis on self-reflection.

\* pre-training exposure refers to exposure prior to undertaking postgraduate study in psychology.

*Step Two: The representativeness of the sample was considered.*

It was anticipated that questionnaires would be made available to a randomly selected sample of registered psychologists, drawn from the register of psychologists, and also to a broad selection of postgraduate psychology students from one university. However, due to the voluntary nature of recruitment and the nature of this study, it was expected that participants who chose to respond would differ from non-respondents in a variety of meaningful ways. For example, it was thought that participants who had experienced prior exposure to psychological trauma and/or mental illness would be either more or less likely to respond on a volunteer basis than those who had not had these experiences.

*Step Three: The specific questionnaire items were written and the most appropriate response formats were considered.*

For each of the five areas listed in the table of specifications outlined in Table 4, specific questions were generated and appropriate response formats selected. The demographics section of the questionnaire was designed to collect categorical data that would provide the means for separating the data into the groups required for analysis.

The aim of Question 1 was to elicit information regarding participants' prior exposure to traumatic psychological experiences. A literature review was undertaken and revealed that childhood sexual and physical abuse were commonly investigated with regards to this type of study, therefore the items 'childhood sexual abuse', 'other sexual abuse', and 'physical abuse' were included. The items 'death of a family member', 'death of a close friend', and 'rape' were included after perusing various life stress inventories and discovering the high ratings given to items of these types on these scales (Renner & Mackin, 1998; Holmes & Rahe, 1967). The item 'traumatic brain injury'

was added to balance out the items by adding a seemingly innocuous item. The items 'emotional abuse', 'feelings of being neglected in childhood', and 'problems associated with your own alcohol or substance abuse' were added because they made intuitive sense to the present author. Finally an open option 'other psychological trauma' was added because the present author suggests that the nature of psychological trauma is subjective and believed it necessary to allow participants to include a description of any prior psychological experience they perceived as being traumatic.

Question 13 was designed to elicit information regarding the degree to which certain motivators influenced participants in their decisions to become psychologists. The decision to include specific items in this subsection was initially derived from the work of Guy (1987). Guy (1987) outlines his views on the functional or dysfunctional needs behind certain motivators and this information was used in the creation of items presented in this scale. In addition, research carried out by Murphy and Halgin (1995), where seven factors were derived relating to motivations for career choice and influential past experiences was also taken into consideration when designing this scale.

Among the listed motivators in question 13 were some factors that were included in an attempt to gather information regarding the extent of influence due to dysfunctional motivation. The factors specifically addressing this task can be found in the items: 'a desire to resolve your own problems or conflicts'; a desire to learn to cope with life stresses through seeing others cope'; 'a wish to better cope with a sense of loneliness/isolation experienced in childhood'; 'a desire to express caring and warmth'; and 'a wish to be a positive force for those less capable than oneself'.

*Step Four: The structure of the questionnaire was considered.*

The ordering and grouping of the questions was considered along with how much information would be provided to the participants with regards to the nature of the research.

*Step Five: Questionnaire pre-test.*

Prior to the distribution of the questionnaire it was pre-tested in two ways. The thesis supervisor distributed the questionnaire to a number of his colleagues for their completion and comments. In addition, the present author distributed the questionnaire to members of her thesis support group for their feedback. Suggestions were received from both these avenues and modifications to the questionnaire were made accordingly.

### **3.3 PROCEDURE**

Questionnaires were distributed in two distinct ways. In the first distribution questionnaires, information sheets, and freepost return envelopes were mailed to 298 registered psychologists who were randomly selected through selecting every fourth name from the alphabetically listed New Zealand Register of Psychologists current as at 10 May 2002. The information sheets stated that the information provided by the participants was anonymous and that the final research reports would present only aggregated data so that confidentiality could be preserved. The participants were also warned that the questionnaire would contain sensitive questions regarding personal psychological disorder and trauma (see Appendix B). By 17 July 2002, 133 useable questionnaires were returned and a further 8 questionnaires had been returned undeliverable yielding a response rate of 45.9%.

In the second distribution permission was sought from the course co-ordinator of the Massey University 175-738 Psychological Research: Principles of Design postgraduate psychology course for distribution by e-mail of the questionnaire and suitably modified information sheet (see Appendix C). This particular course was chosen because it comprised postgraduate psychology students from a spread of areas of psychology. This would facilitate the analysis of responses across differences in psychological specialties. Permission was granted from the course co-ordinator and 108 postgraduate students were e-mailed questionnaires and information sheets. By 17 July 2002, 23 useable questionnaires were returned giving a response rate of 21.1%. Combining useable returns from both distributions yielded a total response rate of 39.2%.

## CHAPTER 4

### RESULTS

In the analysis that follows, the term ‘prior to training’ has been used interchangeably with the term ‘prior to undertaking postgraduate study in psychology’.

#### 4.1 HYPOTHESIS ONE

Clinical/counselling participants were significantly more likely than the other specialties participants to have reported having suffered, prior to training, from a psychological disorder ( $\chi^2 = 2.832$ ,  $df = 1$ ,  $p < .05$ , one tailed). This experience was reported by 32.4% of the participants in the clinical/counselling group and 19.1% of the participants in the other specialties group.

Psychological disorders voluntarily disclosed by participants included: anxiety ( $N = 7$ ), obsessive compulsive disorder ( $N = 2$ ), social phobia ( $N = 1$ ), agoraphobia ( $N = 1$ ), panic attacks ( $N = 7$ ), post-traumatic stress disorder ( $N = 2$ ), depression ( $N = 24$ ), dysthymia ( $N = 1$ ), pre-natal depression ( $N = 1$ ), bulimia nervosa ( $N = 3$ ), anorexia nervosa ( $N = 5$ ), hyperkinesis ( $N = 1$ ), gender identity disorder ( $N = 1$ ), and substance abuse ( $N = 2$ ). Some participants specified more than one psychological disorder and some disorders were specified as being sub-clinical.

Clinical/counselling participants were also significantly more likely than participants of the other specialties group to have reported having had the experience, prior to training, of having a family member or close friend with a psychological disorder ( $\chi^2 = 3.516$ ,  $df$

= 1,  $p < .05$ , one tailed). This exposure was reported by 48.1 % of the clinical/counselling participants and 31.9% of the other specialties participants.

## 4.2 HYPOTHESIS TWO

The prevalence rates for exposure to particular traumatic experiences, prior to training, were calculated for the total sample and for each of the comparison groups. The rates for the clinical/counselling group were all greater than the rates for the total sample and other specialties group.

The clinical/counselling participants were significantly more likely than the other specialties participants to have experienced, prior to training, the death of a family member ( $\chi^2 = 3.916$ ,  $df = 1$ ,  $p < .025$ , one tailed), physical abuse ( $\chi^2 = 3.558$ ,  $df = 1$ ,  $p < .05$ , one tailed), and emotional abuse ( $\chi^2 = 3.312$ ,  $df = 1$ ,  $p < .05$ , one tailed). It was found that the clinical/counselling participants were also more likely than the other specialties participants to have had experienced, prior to training, rape ( $\chi^2 = 3.190$ ,  $df = 1$ ,  $p < .05$ , one tailed). However, this result must be interpreted cautiously as two cells (50%) had an expected count of less than 5, with a minimum expected count of 2.12.

Table 5 shows the prevalence rates obtained for the total sample and the comparison groups.



Table 5.

*Prevalence Rates for Exposure to Different Types of Psychological Trauma Prior to Undertaking Postgraduate Study in Psychology*

Trauma	Total Sample (N = 156)	Clinical/Counselling Group (N = 108)	Other Specialties Group (N=47)
Death of a Family Member	44.2%	49.1%**	31.9%**
Death of a Close Friend	19.2%	20.4%	17.0%
Traumatic Brain Injury	1.3%	1.9%	0.0%
Childhood Sexual Abuse	12.8%	14.8%	8.5%
Other Sexual Abuse	5.1%	5.6%	4.3%
Rape	4.5%	6.5%*	0.0%*
Physical Abuse	11.5%	14.8%*	4.3%*
Emotional Abuse	21.8%	25.9%*	12.8%*
Feelings of Being Neglected in Childhood	16.7%	17.6%	14.9%
Problems Associated with Own Alcohol or Substance Abuse	5.8%	7.4%	2.1%
Other Psychological Trauma	12.8%	14.8%	8.5%

\*\* Difference between groups significant at  $p < .025$

\* Difference between groups significant at  $p < .05$

Types of psychological trauma specified by participants under the 'other psychological trauma' category were classified under themes suggested by the present author and are shown in Table 6.

Table 6.

*Trauma Specified by Participants Under the 'Other Psychological Trauma Category'.*

Theme	Specified Trauma
Family Trauma	Attachment issues Parental divorce Father stating he wanted nothing to do with participant ever again and behaving like he didn't have a daughter (age 13) Values clash Near death of younger brother
School Trauma	School teasing/bullying Teacher bullying Learning disability Rejection by peer group due to physical illness Trauma associated with changing schools mid-adolescence
Pregnancy	Teenage pregnancy and sent away to have the baby adopted Abortion
Violence	Attempted rape at gunpoint Threatened with a loaded weapon
Illness/Accident	Potentially life threatening illness in childhood Anaphylactic shock almost leading to own death Accident with multiple injuries and multiple surgeries including amputation Suicide attempt Undergoing ECT following depression
Relationship Trauma	Marriage problems Marriage breakup and custody case in court Husband became gay
Cultural Discrimination	Alienation because of immigrant status

Exposure to certain traumatic experiences, prior to training, via a family member or close friend were investigated. The clinical/counselling participants were significantly more likely than the other specialties participants to have reported having a family member or close friend with a life threatening illness ( $\chi^2 = 4.070$ ,  $df = 1$ ,  $p < .025$ , one tailed).

Table 7 shows the prevalence rates obtained for the comparison groups for exposure to different psychological traumas in a family member or close friend.

Table 7.

*Prevalence Rates for Exposure to Psychological Trauma in a Family Member or Close Friend Prior to Undertaking Postgraduate Study in Psychology*

Trauma	Total Sample (N = 156)	Clinical/Counselling Group (N = 108)	Other Specialties Group (N=47)
Life Threatening Illness in a Family Member or Close Friend	37.8%	42.6%**	25.5%**
Psychological Trauma in a Family Member or Close Friend	35.9%	36.1%	36.2%
Alcohol/Substance Abuse in a Family Member	26.9%	30.6%	19.1%

\*\* Difference between groups significant at  $p < .025$

A score for each participant was derived for the total number of different types of traumatic psychological experiences reported. This calculation was based on the number of items selected in question one of the questionnaire, ie. it specifically related to direct personal exposure excluding those items in question seven that related to exposure through a family member or close friend. On initial analysis, it was found that the clinical/counselling participants reported a significantly greater number of these experiences, prior to training, than the participants of the other specialties group ( $t = 2.496$ ,  $df = 153$ ,  $p < .01$ , one tailed). This result, however, must be regarded with care as the data was found to be both positively skewed and kurtoic, to a highly significant extent.

On further screening of the data, it was found that five outliers were present. There were four outliers in the clinical/counselling data, with one participant reporting nine different items, another reporting eight items, and two participants reporting six items. One outlier was found in the other specialties data with one participant reporting six

items. Although these items were reviewed and considered valid, the present author decided to drop them from the analysis and repeat the statistical test. A significant difference was confirmed with the clinical/counselling group still more likely to have had experienced a greater number of different types of psychological trauma, prior to training, than the other specialties group ( $t = 2.605$ ,  $df = 148$ ,  $p < .005$ , one tailed).

Although removing the outliers reduced kurtosis to a non-significant level, the data remained positively skewed at a highly significant level and included values of 0. Therefore, a transformation of the data using the formula  $\log_{10}(X + C)$  was undertaken. This transformation reduced the positive skewness to a non-significant level and the statistical procedure was repeated. The existing significant finding was again confirmed ( $t = 2.807$ ,  $df = 148$ ,  $p < .005$ , one tailed).

Table 8 reports the descriptive statistics relating to the total number of different types of traumatic experiences reported by each group under the different data manipulations.

Table 8.

*Descriptive Statistics relating to the Total Number of Different Types of Traumatic Experiences Reported by the Total Sample and the Two Comparison Groups*

Data Manipulation	Total Sample	Clinical/Counselling Group	Other Specialties Group
Untransformed Data			
<i>N</i>	156	108	47
<i>M</i>	1.55	1.78	1.04
<i>Mdn</i>	1	1	0
<i>SD</i>	1.71	1.78	1.43
<i>Min</i>	0	0	0
<i>Max</i>	9	9	6
Untransformed Data Excluding Outliers			
<i>N</i>	151	104	46
<i>M</i>	1.37	1.57	0.93
<i>Mdn</i>	1	1	0
<i>SD</i>	1.39	1.43	1.24
<i>Min</i>	0	0	0
<i>Max</i>	5	5	4
Transformed Data Excluding Outliers			
<i>N</i>	151	104	46
<i>M</i>	0.30	0.34	0.21
<i>Mdn</i>	0.30	0.30	0.00
<i>SD</i>	0.26	0.26	0.25
<i>Min</i>	0	0	0
<i>Max</i>	0.78	0.78	0.70

*N* = number of participants, *M* = mean, *Mdn* = median, *SD* = standard deviation, *Min* = minimum, *Max* = maximum

### 4.3 HYPOTHESIS THREE

Participants who reported having themselves suffered from a psychological disorder, and/or who had directly experienced at least one traumatic psychological experience prior to training were selected for analysis. Clinical/counselling participants ( $N = 78$ ,  $M = 2.22$ ,  $SD = 1.03$ ) were no more influenced to study psychology by this exposure than other specialties participants were ( $N = 25$ ,  $M = 1.96$ ,  $SD = 1.27$ ). A similar finding was obtained when considering only participants who reported having experienced, prior to training, a family member or close friend with a psychological disorder, and/or life

threatening illness, and/or psychological trauma, and/or alcohol or substance abuse.

These events did not influence participants of the clinical/counselling group ( $N = 86$ ,  $M = 2.29$ ,  $SD = .94$ ) to a significantly greater extent than the other specialties group ( $N = 25$ ,  $M = 2.16$ ,  $SD = 1.03$ ).

However, when the analysis was repeated including all participants and re-classifying in the 'no influence' category those participants who responded 'not applicable' due to not experiencing the events, significant differences between the groups were obtained. The clinical/counselling group ( $N = 108$ ) was influenced by a greater extent to study psychology than the other specialties group ( $N = 47$ ) by both their personal experiences (clinical/counselling  $M = 1.88$ ,  $SD = 1.03$ ; other specialties  $M = 1.51$ ,  $SD = 1.04$ ), ( $t = 2.045$ ,  $df = 153$ ,  $p < .025$ , one tailed) and their experiences via a family member or close friend (clinical/counselling  $M = 1.98$ ,  $SD = .94$ ; other specialties  $M = 1.57$ ,  $SD = 1.04$ ), ( $t = 2.405$ ,  $df = 153$ ,  $p < .01$ , one tailed).

The significant results above were obtained using data that was substantially positively skewed. A transformation of the data using the calculation  $\log_{10}(X)$  was undertaken and the significant results for both personal experiences ( $t = 2.608$ ,  $df = 92.696$ ,  $p < .01$ , one tailed, equal variances not assumed) and experiences via a family member or close friend ( $t = 2.990$ ,  $df = 153$ ,  $p < .0025$ , one tailed) were confirmed.

Tables 9 and 10 show the reported extent of influence for the two groups as reported by the participants prior to reclassifying 'not applicable' responses as 'no influence'.

Table 9.

*Percentage of Participants Indicating Extent of Influence of Personal Exposure to Mental Illness or Traumatic Psychological Experience, Prior to Undertaking Postgraduate Study in Psychology, in their Decision to Study Psychology*

Extent of Influence	Clinical/Counselling Group (N = 108)	Other Specialties Group (N = 47)
Not Applicable – did not experience these events	26.9%	46.8%
No Influence	22.2%	27.7%
Little Influence	22.2%	12.8%
Moderate Influence	22.2%	2.1%
Great Influence	4.6%	8.5%
Extreme Influence	1.9%	2.1%

Table 10.

*Percentage of Participants Indicating Extent of Influence of Personal Exposure to Mental Illness or Traumatic Psychological Experience **Via a Family Member or Close Friend**, Prior to Undertaking Postgraduate Study in Psychology, in their Decision to Study Psychology.*

Extent of Influence	Clinical/Counselling Group (N = 108)	Other Specialties Group (N = 47)
Not Applicable – did not experience these events	18.5%	44.7%
No Influence	20.4%	23.4%
Little Influence	29.6%	17.0%
Moderate Influence	25.9%	8.5%
Great Influence	5.6%	2.1%
Extreme Influence	0.0%	4.3%

#### 4.4 HYPOTHESIS FOUR

This hypothesis involved analysing two subgroups of the total sample. The first subgroup comprised clinical/counselling participants who reported exposure to mental

illness and/or at least one instance of psychological trauma prior to training. This subgroup was considered in terms of the type of effect participants believed, prior to training, these experiences would have on their future practice of psychology. The variable of interest in this analysis was whether or not participants had received psychotherapy or counselling either prior to or during their training.

The second subgroup comprised clinical/counselling participants who reported exposure to mental illness and/or psychological trauma via a family member or close friend prior to training. This subgroup was also considered in terms of the type of effect participants believed, prior to training, these experiences would have on their future practice of psychology. Again the variable of interest was whether or not participants had received psychotherapy or counselling either prior to or during their training.

There was no relationship found, in the hypothesised direction, in the first subgroup of participants between receiving psychotherapy or counselling and the type of effect participants believed their experiences would have on their practice of psychology in the future. However, whether or not participants had received psychotherapy or counselling, participants tended to respond that they believed, prior to commencing their training, that their prior experiences would have a positive effect on their practice of psychology. A greater percentage of those who did not receive psychotherapy or counselling than those who did indicated they believed their experiences would have no effect on their future practice of psychology. Table 11 specifies the actual percentages of participants reporting different perceived future effects.



Table 11.

*Perceived Effects on Future Practice of Psychology in Clinical/Counselling Participants Who Experienced Personal Exposure to Mental Illness or Psychological Trauma, Prior to Undertaking Postgraduate Study in Psychology, and Did or Did Not Receive Psychotherapy or Counselling Prior to or During Their Training.*

Type of Effect	Clinical/Counselling Participants Receiving Psychotherapy/ Counselling <b>Prior</b> to Postgraduate Study		Clinical/Counselling Participants Receiving Psychotherapy/ Counselling <b>During</b> Postgraduate Study	
	YES (N = 34 )	NO (N = 46)	YES (N =28)	NO (N =51)
No Effect	8.8%	30.4%	10.7%	27.4%
Positive Effect	55.9%	41.3%	60.7%	41.2%
Negative Effect	0.0%	0.0%	0.0%	0.0%
Both Positive and Negative Effects	35.3%	28.3%	28.6%	31.4%

With regards to the perceived effects on their practice of psychology in the future for those participants who experienced exposure to mental illness or psychological trauma, prior to training, via a family member or close friend, a relationship in the hypothesised direction was not found. Whether or not they had received psychotherapy or counselling prior to or during postgraduate study in psychology, participants tended to believe their experiences would have a positive effect on their practice of psychology. Around 22% of this subgroup of participants, whether or not they received psychotherapy or counselling, believed their experiences would have no effect on their practice of psychology in the future. A greater percentage of those receiving psychotherapy or counselling than those not receiving psychotherapy or counselling believed that their experiences would have both positive and negative effects on their future practice of psychology. Table 12 specifies the actual percentages of participants reporting different perceived future effects.

Table 12

*Perceived Effects on Future Practice of Psychology in Clinical/Counselling Participants Who Experienced Personal Exposure to Mental Illness or Psychological Trauma Via a Family Member or Close Friend, Prior to Undertaking Postgraduate Study in Psychology, and Did or Did Not Receive Psychotherapy or Counselling Prior to or During Their Training.*

Type of Effect	Clinical/Counselling Participants Receiving Psychotherapy/ Counselling <b>Prior</b> to Postgraduate Study		Clinical/Counselling Participants Receiving Psychotherapy/ Counselling <b>During</b> Postgraduate Study	
	YES (N = 33)	NO (N = 54)	YES (N = 28)	NO (N = 59)
No Effect	21.2%	22.2%	21.4%	22.0%
Positive Effect	57.6%	63.0%	57.2%	62.7%
Negative Effect	0.0%	0.0%	0.0%	0.0%
Both Positive and Negative Effects	21.2%	14.8%	21.4%	15.3%

4.5 HYPOTHESIS FIVE

This hypothesis involved the same subgroups of participants analysed in hypothesis four. Clinical/counselling participants who reported exposure to mental illness and/or at least one instance of psychological trauma, prior to training, were analysed in terms of the extent of effect these experiences were believed, prior to training, to have on their future practice of psychology. The variable of interest was whether or not participants had received psychotherapy or counselling prior to or during their training.

Additionally, clinical/counselling participants who had reported exposure to mental illness and/or psychological trauma via a family member or close friend prior to training were also analysed in terms of the extent of effect these experiences were believed, prior to training, to have on their future practice of psychology. Again, the variable of

interest was whether or not participants had received psychotherapy or counselling prior to or during their training

Participants who reported receiving psychotherapy or counselling prior to training believed, prior to training, their personal experiences would have a significantly greater effect on their future practice of psychology ( $N = 34$ ,  $M = 2.76$ ,  $SD = .86$ ) than those who did not receive psychotherapy or counselling prior to training ( $N = 45$ ,  $M = 2.16$ ,  $SD = .98$ ), ( $t = 2.895$ ,  $df = 77$ ,  $p < .0025$ , one tailed). A significantly greater effect on their future practice of psychology was also found for participants who reported having received psychotherapy or counselling during their training ( $N = 27$ ,  $M = 2.96$ ,  $SD = 1.02$ ) than those who did not receive psychotherapy or counselling during their training ( $N = 51$ ,  $M = 2.12$ ,  $SD = .82$ ), ( $t = 3.989$ ,  $df = 76$ ,  $p < .00025$ , one tailed).

Significant results were also obtained for participants who reported having experienced mental illness or psychological trauma via a family member or close friend.

Participants who reported receiving psychotherapy or counselling prior to training were more likely to report a greater effect, prior to training, on their future practice of psychology ( $N = 33$ ,  $M = 2.67$ ,  $SD = 1.02$ ) than those who did not report receiving psychotherapy or counselling prior to training ( $N = 53$ ,  $M = 2.06$ ,  $SD = .82$ ), ( $t = 3.054$ ,  $df = 84$ ,  $p < .0025$ , one tailed). Participants who reported having received psychotherapy or counselling during their training were also more likely to report this greater effect ( $N = 27$ ,  $M = 2.67$ ,  $SD = 1.14$ ) than those who did not report receiving psychotherapy or counselling during their training ( $N = 59$ ,  $M = 2.12$ ,  $SD = .79$ ), ( $t = 2.256$ ,  $df = 37.780$ ,  $p < .025$ , one tailed, equal variances not assumed).

#### 4.6 HYPOTHESIS SIX

Eleven motivators to become a psychologist were presented to participants in a scale in question 13 of the questionnaire. Five of the items were included because of their possible or potential dysfunctional nature. A reliability analysis was conducted on these five items yielding a Cronbach's alpha internal consistency coefficient of .6451.

Ratings given by each of the respondents for each of the five dysfunctional motivators were added together to give a score of dysfunctional motivation for each participant. Cumulative dysfunctional motivation scores for clinical/counselling participants were more likely to be greater ( $N = 102$ ,  $M = 11.17$ ,  $SD = 3.15$ ) than those of the other specialties participants ( $N = 45$ ,  $M = 9.87$ ,  $SD = 3.06$ ), ( $t = 2.327$ ,  $df = 145$ ,  $p < .025$ , one tailed).

When the dysfunctional motivators were analysed as separate items, only the motivator 'a wish to better cope with a sense of loneliness/isolation experienced in childhood' produced a significant result ( $t = 3.312$ ,  $df = 146.374$ ,  $p < .0005$ , one tailed, equal variances not assumed). Clinical/counselling participants were more likely to score this item higher ( $N = 104$ ,  $M = 1.41$ ,  $SD = .796$ ) than the other specialties participants ( $N = 45$ ,  $M = 1.11$ ,  $SD = .318$ ). However, the validity of this item as a single indicator of dysfunctional motivation must be discounted due to the highly skewed and highly kurtotic nature of the distribution of the scores on this item that remained evident even after an attempted transformation of the data. It should be noted, however, that the cumulative scores, with and without this item included, did meet the criteria required for a normal distribution and parametric testing.

In order to determine the effect of the item ‘a wish to better cope with a sense of loneliness/isolation experienced in childhood’ on the cumulative dysfunctional motivation score it was dropped from the scale and analysis of the cumulative scores of the four remaining items was undertaken. A significant difference was again obtained ( $t = 1.972$ ,  $df = 145$ ,  $p < .025$ , one tailed). Clinical/counselling participants remained more likely to report a greater score of dysfunctional motivation ( $N = 102$ ,  $M = 9.75$ ,  $SD = 2.72$ ) than the other specialties participants ( $N = 45$ ,  $M = 8.76$ ,  $SD = 2.98$ ).

The ratings for the remaining items of question 13, chosen for their functional nature, were added together to give a score of functional motivation for each participant. No significant differences were found between the two comparison groups on this cumulative score or for any of these six functional items individually.

#### **4.7 ADDITIONAL AIMS**

Participants were asked whether they ‘strongly disagreed’, ‘disagreed’, were ‘uncertain’, ‘agreed’, or ‘strongly agreed’ with the following statement: ‘In general, psychology students do not disclose psychological problems for fear of negative consequences, eg. not being selected into a training program of their choice, or being thought incompetent’. The chi goodness-of-fit-test was applied. It was found that participants were significantly more likely to ‘agree’ with this statement than make any other response ( $\chi^2 = 58.471$ ,  $df = 4$ ,  $p < .0005$ ). The categories were then collapsed, the ‘strongly disagree’ and ‘disagree’ categories were combined, the ‘uncertain’ category was left unchanged, and the ‘agree’ and ‘strongly agree’ categories combined. The expected values of the new three categories were entered as equal. On repeating the chi

goodness-of-fit-test a significant result remained with participants more likely to either ‘strongly agree’ or ‘agree’ with the statement than report one of the other two categories ( $\chi^2 = 34.039$ ,  $df = 2$ ,  $p < .0005$ ). Table 13 reports the number and percentage of participants endorsing each category of response.

Table 13.  
*Participants' Responses to the Statement 'In general, psychology students do not disclose psychological problems for fear of negative consequences, eg. not being selected into a training program of their choice, or being thought incompetent'.*

Response	N (153)	(Collapsed)	%	(% Collapsed)
Strongly Disagree	4	25	2.6%	16.3%
Disagree	21		13.7%	
Uncertain	45	45	29.4%	29.4%
Agree	58	83	37.9%	54.3%
Strongly Agree	25		16.4%	

Participants were asked about their satisfaction with the degree of emphasis, during their postgraduate study, placed on developing self-care plans, ie. plans to prevent burnout or any of the other possible negative consequences of pursuing a career in psychology. When using the five categories described above, analysis using the chi goodness-of-fit-test revealed that participants were more likely to report that they ‘disagreed’ they were satisfied with this aspect of their training than make any other response ( $\chi^2 = 64.092$ ,  $df = 4$ ,  $p < .0005$ ). When the two disagree and two agree categories were collapsed, and the analysis repeated, a significant result remained. Participants were more likely to report they either ‘strongly disagreed’ or ‘disagreed’ that they were satisfied with the degree of emphasis, during their postgraduate study,

placed on developing self-care plans than report one of the other two categories ( $\chi^2 = 96.157, df = 2, p < .0005$ ).

A further significant result was obtained when participants were once again requested to use the same categories to rate their satisfaction with the degree of emphasis, during their postgraduate study, placed on looking at how their own histories could impact on their practice as psychologists. Using the chi goodness-of-fit-test, participants were more likely to report that they ‘disagreed’ that they were satisfied with the degree of emphasis, during training, placed on self-reflection ( $\chi^2 = 27.104, df = 4, p < .0005$ ). Once again a significant result remained when the categories were collapsed. Participants were more likely to report they either ‘strongly disagreed’ or ‘disagreed’ that they were satisfied with the degree of emphasis, during their training, placed on self-reflection than report they were ‘uncertain’, or either ‘agreed’ or ‘strongly agreed’ ( $\chi^2 = 35.935, df = 2, p < .0005$ ). Tables 14 and 15 report the number and percentage of participants endorsing each category of response for these two questionnaire items.

Table 14.  
*Participants’ Responses regarding their Satisfaction with the Degree of Emphasis Placed on Self-Care During their Postgraduate Study in Psychology.*

Response	N (153)	(Collapsed)	%	(% Collapsed)
Strongly Disagree	48	107	31.4%	69.9%
Disagree	59		38.6%	
Uncertain	13	13	8.5%	8.5%
Agree	25	33	16.3%	21.6%
Strongly Agree	8		5.2%	

Table 15.

*Participants' Responses regarding their Satisfaction with the Degree of Emphasis Placed on Self-Reflection During their Postgraduate Study in Psychology.*

Response	N (154)	(Collapsed)	%	(% Collapsed)
Strongly Disagree	34	85	22.1%	55.2%
Disagree	51		33.1%	
Uncertain	26	26	16.9%	16.9%
Agree	32	43	20.8%	27.9%
Strongly Agree	11		7.1%	

4.8     **ADDITIONAL FINDINGS**

4.81    **Effect Size and Power Calculations**

Effect size and power calculations were performed for each statistical test carried out under hypotheses one to six and those carried out in analysing the additional aims. Effect sizes for the chi-square tests were derived from the difference between the arcsine transformations of the ‘success’ proportions of the two groups and power was approximated from power tables or charts (Cohen, 1988; Lipsey, 1990). Effect sizes for t-test calculations were derived by dividing the difference between the two sample means by the pooled standard deviation (Lipsey, 1990). The power of these tests was calculated using Faul and Erdfelder’s (1992) ‘GPOWER’ computer program. These calculations are set out in Table 16.



Table 16.

*Effect Size and Power Calculations for Hypotheses One to Six and Additional Aims.*

Hypothesis No. and Brief Description	Significance Reached ( $p < .05$ )	Effect Size	Effect Size Strength*	Power Estimate
<b>ONE</b>				
Clinical/Counselling participants more likely to have had prior mental illness than comparison participants.	Yes	.301	s	.52
Clinical/Counselling participants more likely to have had family member/close friend with mental illness than comparison participants.	Yes	.328	s	.60
<b>TWO</b>				
Clinical/Counselling participants more likely to have had prior exposure to death of a family member than comparison participants.	Yes	.348	m	.62
Clinical/Counselling participants more likely to have had prior exposure to death of a close friend than comparison participants.	No	.077	s	.10
Clinical/Counselling participants more likely to have had prior exposure to traumatic brain injury than comparison participants.	No	.284	s	.50
Clinical/Counselling participants more likely to have had prior exposure to childhood sexual abuse than comparison participants.	No	.186	s	.25
Clinical/Counselling participants more likely to have had prior exposure to other sexual abuse than comparison participants.	No	.092	s	.12
Clinical/Counselling participants more likely to have had prior exposure to rape than comparison participants.	Yes	.536	m	.88
Clinical/Counselling participants more likely to have had prior exposure to physical abuse than comparison participants.	Yes	.392	m	.72
Clinical/Counselling participants more likely to have had prior exposure to emotional abuse than comparison participants.	Yes	.332	m	.59
Clinical/Counselling participants more likely to have had prior exposure to feelings of being neglected in childhood than comparison participants.	No	.081	s	.11
Clinical/Counselling participants more likely to have had prior exposure to problems associated with own alcohol or substance abuse than comparison participants.	No	.252	s	.41
Clinical/Counselling participants more likely to have had prior exposure to other psychological trauma than comparison participants.	No	.186	s	.30

Table 16. (continued)

Hypothesis No. and Brief Description	Significance Reached ( $p < .05$ )	Effect Size	Effect Size Strength*	Power Estimate
<b>TWO (continued)</b>				
Clinical/Counselling participants more likely to have had prior exposure to life threatening illness in a family member or close friend than comparison participants.	Yes	.360	m	.65
Clinical/Counselling participants more likely to have had prior exposure to psychological trauma in a family member or close friend than comparison participants.	No	0	0	0
Clinical/Counselling participants more likely to have had prior exposure to alcohol or substance abuse in a family member or close friend than comparison participants.	No	.279	s	.47
Clinical/Counselling participants more likely to have had greater number of prior psychological traumatic experiences than comparison group:				
untransformed data	Yes	.436	m	.7996
untransformed data without outliers	Yes	.465	m	.8345
transformed data without outliers	Yes	.506	m	.8846
<b>THREE</b>				
(a) Clinical/Counselling participants more likely to have been Influenced to study psychology by their prior traumatic experiences than comparison participants.	No	.238	s	.2692
(b) Clinical/Counselling participants more likely to have been Influenced to study psychology by their prior traumatic experiences via a family member or close friend than comparison participants.	No	.135	s	.1459
THREE (a) including reclassification of not applicable responses as no influence.				
untransformed data	Yes	.357	m	.6520
transformed data	Yes	.445	m	.8128
THREE (b) including reclassification of not applicable responses as no influence.				
untransformed data	Yes	.420	m	.7733
transformed data	Yes	.522	m	.9085
<b>FOUR</b>				
Participants with prior traumatic experiences who received psychotherapy/counselling <b>prior</b> to training more likely to report negative or both positive and negative effects on their future practice of psychology than comparison participants.	No	.151	s	.16
Participants with prior traumatic experiences who received psychotherapy/counselling <b>during</b> their training more likely to report negative or both positive and negative effects on their future practice of psychology than comparison participants.	No	-.066	s	0

Table 16. (continued)

Hypothesis No. and Brief Description	Significance Reached ( $p < .05$ )	Effect Size	Effect Size Strength*	Power Estimate
Participants with prior traumatic experiences <b>via a family member or close friend</b> who received psychotherapy/counselling <b>prior</b> to training more likely to report negative or both positive and negative effects on their future practice of psychology than comparison participants.	No	.185	s	.26
Participants with prior traumatic experiences <b>via a family member or close friend</b> who received psychotherapy/counselling <b>during</b> their training more likely to report negative or both positive and negative effects on their future practice of psychology than comparison participants.	No	.157	s	.18
<b>FIVE</b>				
Participants with prior traumatic experiences who received psychotherapy/counselling <b>prior</b> to training more likely to report a greater effect on their future practice of psychology than comparison participants.	Yes	.648	l	.8812
Participants with prior traumatic experiences who received psychotherapy/counselling <b>during</b> their training more likely to report a greater effect on their future practice of psychology than comparison participants.	Yes	.944	l	.9888
Participants with prior traumatic experiences <b>via a family member or close friend</b> who received psychotherapy/counselling <b>prior</b> to training more likely to report a greater effect on their future practice of psychology than comparison participants.	Yes	.677	l	.9169
Participants with prior traumatic experiences <b>via a family member or close friend</b> who received psychotherapy/counselling <b>during</b> their training more likely to report a greater effect on their future practice of psychology than comparison participants.	Yes	.602	l	.8220
<b>SIX</b>				
(a) Clinical/counselling participants more likely to be influenced by dysfunctional motivators to enter their profession than comparison participants.	Yes	.416	m	.7489
As above (SIX (a)) excluding problematic item.	Yes	.353	m	.6247
Exploratory analysis to see if groups differed in their reporting of items of functional motivation.	No	.037	s	.0547
<b>ADDITIONAL AIMS</b>				
In general psychology students do not disclose psychological problems for fear of negative consequences (discriminatory).	Yes	.427**	m	>.995
Psychologists/psychology students are dissatisfied with the degree of emphasis placed on self-care during their post-graduate study in psychology.	Yes	.758**	l	>.995
Psychologists/psychology students are dissatisfied with the degree of emphasis placed on self-reflection during their postgraduate study in psychology.	Yes	.447**	m	>.995

Table 16. (continued)

\* Lipsey (1990) recommends the following classification of effect sizes: .00 to .32 as small (s), .33 to .55 as medium (m), and .56 to 1.20 as large (l). Cohen's (1988) guidelines are .20 small, .50 medium, and .80 large.

\*\*Based on the collapsed three item scale analysis. The relevant transformed proportion is subtracted from the transformed constant proportion of .33. This calculation is considered conservative as it is suggested that most educators would not expect a proportion as large as one third of their students to feel discriminated against or be dissatisfied with elements of their education.

In the body of this research, excluding analysis of effects due to demographics, 39 separate tests, as summarised in table 16, were performed. The effect sizes of the 23 significant findings ranged from .301 to .944 ( $M = .479$ ,  $SD = .157$ ), the power of these tests averaged at .79. The effect sizes of the 16 non-significant findings ranged from -.066 to .284 ( $M = .138$ ,  $SD = .107$ ), these tests yielded an average power of .21.

#### 4.82 Gender Effects

Women were more likely than men to report pre-training experiences of 'other sexual abuse' ( $\chi^2 = 4.722$ ,  $df = 1$ ,  $p < .05$ , two tailed), and 'rape' ( $\chi^2 = 4.104$ ,  $df = 1$ ,  $p < .05$ , two tailed). However, in the 'other sexual abuse' analysis one cell (25%) had an expected count of 2.87, and in the analysis of the 'rape' category two cells (50%) had expected counts less than five with the minimum expected count being 2.51.

Men were more likely than women to report pre-training experiences of 'problems with own alcohol/substance abuse' ( $\chi^2 = 3.930$ ,  $df = 1$ ,  $p < .05$ , two tailed). However, this analysis revealed one cell (25%) with an expected count of 3.23.

A gender effect was also found among clinical/counselling participants who reported prior direct exposure to mental illness or traumatic psychological experiences. Women were more likely than men to report that these experiences would have either no effect or a positive effect on their practice of psychology in the future. Men, on the other

hand, were more likely than women to report that these experiences would have both positive and negative effects on their future practice of psychology ( $\chi^2 = 4.619$ ,  $df = 1$ ,  $p < .05$ , two tailed). 53.6% of the male participants and 76.9% of the female participants reported either no effect or a positive effect, while both positive and negative effects were reported by 46.4% of the men and 23.1% of the women.

A further gender effect was found in the rating of the item 'professional achievement' as an influential factor in the decision to become a psychologist. The female respondents were more likely to rate this item higher ( $M = 4.11$ ,  $SD = .881$ ) than the male respondents ( $M = 3.80$ ,  $SD = .826$ ), ( $t = -2.60$ ,  $df = 149$ ,  $p < .05$ , two tailed).

#### 4.83 Age Effects

Older participants were more likely than younger participants to report the death of a family member prior to their undertaking postgraduate study in psychology ( $\chi^2 = 9.817$ ,  $df = 4$ ,  $p < .05$ , two tailed). This result, however, revealed one cell (10%) with an expected count of 3.98. A significant difference was not found between age groups for the reported death of a close friend prior to undertaking training.

A one-way between groups ANOVA was conducted on the ratings obtained for the factors influential in the decision of participants to become a psychologist. A significant age effect was found in the ratings of the item 'genuine interest in the subject matter' ( $F = 2.969$ ,  $df = 4, 149$ ,  $p < .025$ ). Post-hoc analysis using the Tukey HSD test found that respondents aged 20 to 29 years were significantly more likely to rate this item as more influential ( $M = 4.75$ ,  $SD = .447$ ) than respondents aged 60 years plus ( $M = 4.11$ ,  $SD = .601$ ). Differences between other age group combinations were not

significant, however, a trend was evident with the younger age groups rating this item as more influential than the older age groups (30 to 39 years,  $M = 4.67$ ,  $SD = .640$ ; 40 to 49 years,  $M = 4.67$ ,  $SD = .478$ ; 50 to 59 years,  $M = 4.47$ ,  $SD = .548$ ). Although the differences between the mean scores appeared small, a medium effect size of .07 was calculated using eta squared<sup>1</sup>. However, the data for this item was skewed and kurtoic to a highly significant extent therefore must be interpreted cautiously.

A further age effect was found in the ratings of the item 'A wish to be a positive force for those less capable than oneself' ( $F = 2.564$ ,  $df = 4, 145$ ,  $p < .05$ ). However, post-hoc analysis, using the Tukey HSD test, did not reveal statistical differences in the mean scores of any combination of the age groups (20 to 29 years,  $M = 3.81$ ,  $SD = .834$ ; 30 to 39 years,  $M = 3.00$ ,  $SD = 1.206$ ; 40 to 49,  $M = 3.28$ ,  $SD = 1.099$ ; 50 to 59 years  $M = 3.59$ ,  $SD = 1.048$ ; 60 years plus,  $M = 2.89$ ,  $SD = 1.616$ ). Although statistical significance between specific groups was not revealed, a medium effect size of .07, calculated using eta squared, was obtained.

#### **4.84 Effects due to Status**

There were no significant differences found on the basis of the status of participants in this study

#### **4.85 Effects due to Time Elapsed Since Commencement of Postgraduate Study in Psychology**

A one-way between groups ANOVA was conducted on the responses obtained for the ratings of influential factors in the decision to become a psychologist, two of the items

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<sup>1</sup> Eta squared was utilised as a measure of effect sizes for ANOVA calculations. Cohen (1988) suggests interpreting strength of effect by the following guidelines: .01 = a small effect, .06 = a moderate effect, and .14 a large effect.

revealed significant differences on the basis of time elapsed since participants commenced their postgraduate training in psychology.

The item 'genuine interest in the subject matter' reached significance ( $F = 2.747$ ,  $df = 2.144$ ,  $p < .05$ ), although, post-hoc analysis using the Tukey HSD test did not reveal significant differences between the groups. However, a trend in the mean scores was apparent with those who commenced their training more recently more likely to have been more influenced to become a psychologist by their interest in the subject matter than those who commenced their training some time ago (0 to 10 years ago,  $M = 4.66$ ,  $SD = .602$ ; 11 to 20 years ago,  $M = 4.66$ ,  $SD = .479$ , 21 to 30 years ago,  $M = 4.42$ ,  $SD = .620$ ; 31 to 40 years ago,  $M = 4.22$ ,  $SD = .441$ ). An effect size, nearing medium strength, of .05 was calculated using eta squared.

A further effect due to time elapsed since postgraduate training was commenced was found for the item 'a wish to better cope with a sense of loneliness/isolation experienced in childhood' ( $F = 3.953$ ,  $df = 3,140$ ,  $p = .01$ , equal variances not assumed). Post-hoc analysis using the Tukey HSD test indicated that those who had most recently commenced their training were more likely to rate this item as less influential than those who had commenced their training 31 to 40 years ago (0 to 10 years ago,  $M = 1.12$ ,  $SD = .458$ ; 31 to 40 years ago,  $M = 1.78$ ,  $SD = .833$ ). The other two time groups fell midway between these groups revealing an upward trend from shortest to longest time-frames (11 to 20 years ago,  $M = 1.41$ ,  $SD = .717$ ; 21 to 30 years ago,  $M = 1.5$ ,  $SD = .938$ ). A medium effect size of .08 was calculated using eta squared.

It is important to note that the results in this section must be interpreted with caution due to the data used for these two items being skewed and kurtotic to a highly significant extent.

#### **4.9 QUALITATIVE FINDINGS**

At the end of the questionnaire participants were invited to make any comments they chose with regards to any issues raised in the questionnaire. Many participants did choose to comment and from these comments three major themes arose along with several other minor themes.

The major themes were:

1. The perception that addressing self-care and self-reflective issues may be necessary, and may be lacking in the training of psychologists in New Zealand.
2. The perception that undergoing one's own therapy may be a useful tool in the training of psychologists.
3. The perception that psychology students/psychologists may be fearful of disclosing their psychological problems.

The minor themes were:

1. The perception that many psychology students have problems.
2. The perception that self-care, self-reflection issues are irrelevant to the field of Industrial /Organisational psychology.
3. A perceived importance of research into the areas covered in this study.
4. Not all individuals who study psychology at the postgraduate level want to become psychologists.

The comments made by participants that support these themes have been reproduced in Table 17 in Appendix D.



## **CHAPTER 5**

### **DISCUSSION**

#### **5.1 DISCUSSION OF THE FINDINGS**

Individuals who choose to enter the profession of clinical or counselling psychology may have personal histories that include having been exposed to mental illness or psychological trauma. This exposure may be either directly experienced or experienced through association with an afflicted family member or close friend. Additionally, exposure to these experiences may exist to a greater extent in those who choose to become clinical or counselling psychologists than in those who choose to specialise in some other area of psychology.

A mail questionnaire may be a sufficient exploratory tool for drawing attention to the types of histories found among clinical/counselling psychologists, and perhaps may be used to highlight related issues. Additionally, using a tool of this type to investigate the degree of influence of these personal histories in the choice to study psychology at an advanced level, and the effects these histories are believed to have on the future practice of psychology can be described as a worthwhile initial stage. This first step provides a foundation for further work, which is indicated by the results of this study.

The present author subscribes to the belief that unconscious processes influence career choice. Obholzer and Roberts (1994) have previously discussed aspects of unconscious influence in the work place. Questioning participants, on the issues of influence, and perceived type and extent of effect of personal histories on their future practice of

psychology, through using an anonymous pen and paper questionnaire with necessarily simple rating systems may not fully capture this notion. It is reasonable to suggest that participants will only endorse and rate items of which they are fully aware at the time the questionnaire is completed, therefore, influences and effects that may not have reached this level of awareness may remain unacknowledged.

In considering the results of this study, it may be sensible to suggest that some of the results obtained may have been strengthened if it had been possible to bring about deeper levels of awareness in the participants. Although a more difficult task, this may have been possible if a more in-depth approach had been used such as face to face interviews that incorporated a standardised system of structured questioning.

Clinical and counselling participants were significantly more likely than participants specialising in other areas of psychology to report, prior to undertaking their postgraduate study in psychology, that they had suffered from a mental illness, and/or had experienced a family member or close friend with a mental illness. In addition, the clinical/counselling participants were also significantly more likely than other specialties participants to have experienced, prior to their training, the death of a family member, physical abuse, emotional abuse, and rape. They were also more likely to report having a family member or close friend with a life threatening illness. A significant difference was also found in the number of different types of psychological trauma experienced prior to training in the two groups. Clinical/counselling participants were more likely to report a greater number of traumatic psychological experiences than participants specialising in other areas of psychology.

These results were similar to those found by Elliott and Guy (1993) who found female therapists were more likely to report higher prevalence rates for physical abuse, sexual molestation, parental alcoholism, hospitalisation of a parent for mental illness, and death of a parent or sibling than non-mental-health female professionals.

These findings also support those of Brems, Tyrck, Garlock, Freemon and Bernzott (1995) who found significantly higher levels of reported childhood emotional abuse, and higher, although non-significant, levels of reported childhood sexual and physical abuse among clinical psychology students than students of other disciplines.

When it came to illustrating the influence of either direct experiences or experiences via a family member or close friend on participants' choices to study psychology, the results were not clear-cut. In analysing only those who reported the experiences under investigation, significant results were not achieved. However, the present author suggests that the participants may not have been fully aware of the influence of these experiences. Therefore, some participants may have reported that these experiences had no or little influence on their decision to study psychology when, at a deeper level of awareness, the influence may have been greater. It can not be easily ascertained from this study, the full degree of influence the histories of participants have played in the decision to study postgraduate psychology. However, the findings that clinical/counselling participants experienced exposure to mental illness, certain pre-training traumatic experiences, and total number of pre-training traumatic experiences to a greater degree than the comparison group, may lead the reader to infer that there is a possibility that the influence of these experiences in the clinical/counselling group may have been greater than that in the other specialties group.

A significant result regarding the influence of prior experiences was obtained when all participants were considered and those who selected 'not applicable' due to not having experienced the events were reclassified as not being influenced by their personal histories. This re-analysis showed that, as a group, the clinical/counselling participants were more influenced by their experiences than their non-clinical/counselling counterparts.

The issue of the influence of earlier experiences is raised again when seeking information about motivation to become a psychologist. Significant results were achieved in this study with clinical/counselling psychologists and students more likely to select and rate higher possible or potentially dysfunctional motivators than psychologists and students specialising in other areas of psychology. This result indicated the extent to which clinical/counselling psychologists, in their present levels of awareness, reported they were more motivated to become psychologists by distressing past experiences than the comparison participants. If it had been possible to take into account more fully the influence of earlier experiences, perhaps the results may have been more striking. However, the nature of this study was retrospective and participants were asked to what extent their decision to become a psychologist was influenced by certain factors. Some participants who made this decision some time ago may have been influenced in their reporting by hindsight. Participants who were not fully aware of their motivations at the time they made their decisions to become psychologists may have become more aware of these over time and therefore able to accurately report these motivations at the time of answering the questionnaire.

Although significant results in the hypothesised direction were not obtained for the type of effects psychologically affected clinical/counselling participants believed their experiences would have on their future practice of psychology, trends were evident. Participants, whether or not they received psychotherapy or counselling prior to or during their training, tended to believe, prior to commencing their training, that their prior exposure to mental illness and/or traumatic psychological experiences would lead to their future practice of psychology being positively affected. These participants tended to believe their experiences would enhance their ability to practice as a psychologist. There were no significant differences found between those participants who received psychotherapy or counselling prior to or during training and those who did not. However, a greater number of participants who had not received psychotherapy or counselling than those who did tended to believe their personal histories would have no effect on their future practice of psychology.

Of particular interest is that not one of the clinical/counselling participants reported that their prior experiences would have only a negative effect on their ability to practice as a psychologist. However, a number of participants did indicate that their experiences would both positively and negatively affect their practice of psychology.

The results of this study lend support to the findings of Hilton, Jennings, Drugge, and Stephens (1995) where a sample of clinicians, who worked with sex offenders and reported a history of childhood sexual abuse, perceived the effects of their experiences as having either a positive or non-existent effect on their work with these clients.

It may appear optimistic and healthy that clinical/counselling psychologists with traumatic life histories see these experiences as having a positive influence on their ability to practice psychology in the future. However, this study indicates it may be a smaller number who are able to recognise, or perhaps not deny, at the time postgraduate training is commenced, the possible negative effects that may accompany the positive effects.

The effect of counselling does appear to be evident in connection with the extent of effect participants believe their experiences would have on their practice of psychology. Clinical/counselling psychologists and students may accurately perceive that having had traumatic personal histories, these experiences may greatly affect their practice of psychology, although they may be overly optimistic about what type of effect they expect these experiences to have.

This finding may indicate that individuals who choose to undergo therapy or counselling already understand the great impact their personal histories will have on their future psychological practice. Alternatively, it could be that those who undergo therapy or counselling come to realise the magnitude of the effect of their personal histories through the process of undergoing this treatment.

A total disregard of the possible negative consequences may not be beneficial to either the psychologist or client in the practice of clinical or counselling psychology. There may also, however, be possible positive consequences associated in having had a traumatic history. These may include increased empathy (Cain, 2000; Guy, 1987; Pope & Feldman-Summers, 1992), positive attitudes toward those with mental health

problems (Roth, Antony, Kerr, and Downie, 2000), and increased positive coping behaviours when dealing with clients with similar histories (Follette, Polusny, Milbeck, 1994; Little & Hamby, 1996). However, the possible negative consequences should not be ignored. Consequences such as reduced therapeutic effectiveness (Guy, 1987; Lambert, 1989), secondary or vicarious traumatisation (Kassam-Adams, 1995, cited in Brady, Guy, Poelstra & Brokaw, 1999; Pearlman and Mac Ian, 1995), burnout (Justice, Gold and Klein, 1981; Pines, 2000), countertransference issues (Cain, 2000; Guy & Brady, 2001; Little & Hamby, 1996), and perceived stigmatisation (Browne & Finkelhor, 1986; Cain, 2000; Hilton, Jennings, Drugge, & Stephens, 1995) should be addressed. Although all therapists, irrelevant of their personal history, are at risk of succumbing to negative consequences, therapists with a prior history of mental illness or psychological trauma may be particularly vulnerable.

It is possible that this optimistic view of the positive effect that a prior traumatic history may have on the practice of psychology stems from a denial of the possible negative effects. This study found that, in general, psychologists and psychology students believe that students are reluctant to disclose psychological problems due to a fear of negative consequences such as not being selected into a training program of their choice or of being thought incompetent. This belief may reinforce the denial of psychological problems and/or their negative effects, and may lead students to create only a positive view of the effects of their prior experience with mental illness or psychological trauma.

Significant effects due to gender, age, and time elapsed since the commencement of postgraduate study in psychology were also found. Women were more likely than men to report incidents of early sexual abuse and rape. These findings support existing

research (Finkelhor, 1979; Little & Hamby, 1996; Pope & Feldman-Summers, 1992; Russell, 1984). In addition, men were found to be more likely than women to report a prior history of problems with their own alcohol or substance abuse. This is consistent with the general finding that men are more likely than women to suffer from these problems (Kaplan & Sadock, 1998).

A further interesting gender effect found in this study was that female clinical/counselling participants were more likely than their male counterparts to report the effects of their prior history of exposure to mental illness and/or psychological trauma would have either no effect or a positive effect on their future practice of psychology. Men, on the other hand, were more likely than women to report that their traumatic histories would both positively and negatively affect their future psychological practice. It may be that men are more open to the possibility of the negative effects of their histories than women. Women may feel a greater need to deny or hide their personal histories and/or the effects these histories may have on their future practice of psychology in order to succeed in their chosen profession.

This explanation may be supported further by the finding, in this study, that women were significantly more likely than men to rate more highly the item 'professional achievement' as an influential factor in their decision to become a psychologist. If women do place a greater importance on professional achievement than men do, it then follows that women may have more to lose by acknowledging, either to themselves and/or to others, any negative effects that may be attributed to the existence of psychologically traumatic histories. This postulation is consistent with the finding that a perception appears to exist among psychology students and psychologists that



psychology students may be fearful of disclosing their psychological problems because of the perceived negative consequences associated with such disclosure.

The results of this study showed an age effect with older participants more likely than the younger participants to report having experienced the death of a family member prior to their undertaking postgraduate study in psychology. It may appear that this result may be due to a misunderstanding in the reading of the question. Older participants would have been more likely to have had this experience during their lifetime than the younger participants and may have inadvertently selected this item even if the event had occurred after the commencement of their training.

It is interesting to note, however, that the older age groups did not endorse the item 'death of a close friend' to a significantly greater extent than the younger participants, even though this event would probably have also been more likely to have been experienced by older participants in general. Therefore the significantly higher reporting of the item 'death of a family member' by the older participants may have been a genuine finding. In addition this finding does support that of Black and Jeffreys (1993) where social work students were more likely than business students to report the death of a family member in their family of origin occurring prior to their 18<sup>th</sup> birthday. It is possible this finding may generalise to those in the helping professions. Therefore grief may be an experience that may influence the career choice and/or future psychological practice of some psychology students and may be indicated as an area worth considering further.

With regards influential factors in the decision to become a psychologist, younger psychology students/psychologists may have been more motivated than their older counterparts by a genuine interest in the subject matter and a wish to be a capable force for those less capable than themselves. These findings may represent a cohort effect with younger prospective psychologists being able to choose their career based on their interests and ideals where older psychologists may have needed to take into account other factors, for example financial concerns, that may have been considered more important at the time their career decisions were made.

The finding that younger participants were more influenced than older participants to become psychologists by a genuine interest in the subject matter was further supported by the finding that those who had commenced their postgraduate study in psychology more recently were also significantly more likely to rate this item more highly than those who had commenced their training some time ago.

## **5.2 STRENGTHS OF THE PRESENT STUDY**

This research complements the existing research, which predominantly investigates childhood sexual and physical abuse in American samples of mental health workers. Data were obtained on a variety of traumatic psychological experiences in conjunction with the influence these experiences have on choosing to study psychology and the perceived type and extent of effect these experiences would have on becoming a practicing psychologist.

In addition, questioning participants regarding motivating factors for choosing to become a psychologist has highlighted the importance and relevance of investigating the influence of earlier experiences in choosing their profession.

This research also pinpointed aspects of the training of psychologists as being relevant but not sufficient in the training of psychologists in New Zealand. A significant number of participants were not satisfied with the degree of emphasis placed on self-care and self-reflection during their postgraduate training, and many specifically commented as to the importance of these issues.

This study used a comparison group (psychologists/students from specialties of psychology other than clinical/counselling psychology) that was shown to be very similar on a number of variables to the group of interest (clinical/counselling students/psychologists). It is therefore possible to infer that any differences found between these groups may be attributed to the essential difference between the groups. The present author believes this critical difference to be that clinical/counselling students/psychologists have an interest in and/or training in psychotherapy, whereas students/psychologists of other specialties do not.

In completing multiple tests on randomly arranged data it is likely that, due to the family-wise error rate, for every 20 tests there will be one 'significant' difference found by chance (Coolican, 1994). However, the effect sizes of the significant findings of this research were clearly demarcated from those of the non-significant findings by their strength. It is suggested that this is evidence of the genuineness of these findings. In addition, it is further suggested that the statistically significant results found in this

study could also be described as clinically significant due to the medium to large strength of the effect sizes found. It is worth noting here that power calculations on the non-significant findings typically resulted in low power averaging .21 in comparison with an average power of .79 calculated for the significant results. Therefore, it is possible that significance may have been attained, in some non-significant cases, if greater power had been achieved by way of increasing participant numbers.

### **5.3 LIMITATIONS OF THE PRESENT STUDY**

This research was based on a collection of self-reports of past experiences. When relying on this type of information, biases that may have affected the memories of respondents should be acknowledged. These biases may include the effects of time and of present psychological functioning, either may distort or reduce recollection (Briere, 1992).

Because this research included gathering information about prior traumatic psychological experiences, there is a possibility respondents may have under-reported these experiences due to the repression of traumatic memories. Conscious memories may be easily reported, however, unconscious memories may lead to the truthful under-reporting of traumatic experiences and the subsequent incorrect classification of some respondents as non-trauma participants (Briere, 1992).

Psychoanalytic theory expounds that motivations for career choice are often partly unconscious (Pines & Yanai 2001). There are aspects of human mental life, which although remaining hidden, affect conscious processes (Halton, 1994). The level of

awareness of respondents may have affected their accurate completion of the section of the questionnaire relating to influential factors in the decision to become a psychologist. Some pertinent factors may not have been in the full awareness of respondents at the time the questionnaire was completed, and therefore not selected as being influential.

Other possible memory biases may have included the representativeness heuristic, where participants may have tended to report behaviours that were more consistent with their self-images than with actual occurrences, and the availability heuristic, where participants may have tended to report more recent or prominent events (Dane, 1995).

Distortions to responses may have occurred due to the sensitive nature of some of the information being collected. Truthfully answering certain items may have appeared threatening to some participants. Although surprising to the present author, due to the anonymous nature of the questionnaire, in trialing the questionnaire feedback was received from a prospective participant to this effect. Therefore, it is possible that questions perceived as threatening may have been answered in a socially desirable way. The questionnaire did not contain any measure of social desirability, nor was there any means of verifying the responses of participants.

It has been argued, however, that concern over the accuracy of answering sensitive questions may be overestimated due to the tendency respondents may have to assume their own behaviour is similar to that of others, therefore reducing reluctance to share such information (Schuman & Kalton 1985).

The age of respondents ranged from 20 years to 60 years plus. It is possible the way the older participants responded may have produced some cohort effects whereby the older people may have been more reluctant to admit to some prior traumatic experiences due to their perception of the trauma as being more embarrassing or stigmatised than the younger participants (Briere, 1992). Alternatively, older participants may have been well established in their careers and successful, therefore early events may not have been reported as they occurred long ago and were perceived as non-influential. If these biases in reporting did occur, then some older participants may have been incorrectly classified as not having prior exposure to mental illness and/or traumatic psychological experiences, therefore affecting the findings of the study.

This research was conducted as a mail questionnaire, and is therefore subject to a possible bias in responding (Deutsch, 1985). There is no way of ascertaining if those who responded differed in any significant way to those who did not respond. It is possible that individuals with a traumatic history may have been more likely to respond because of their personal interest in the subject matter. Alternatively, these same respondents may have been less likely to respond because of their reluctance to engage in thinking about the sensitive nature of the questions, or because of their mistrust of the anonymity of the questionnaire.

Apart from the response bias described above, the sample may not have been representative of all psychologists in New Zealand. The majority of the mailing list for this study was compiled by random selection from the register of psychologists. Therefore, unregistered psychologists were excluded, and it is possible that unregistered psychologists may differ from registered psychologists in important ways. At best the

results of this study may be considered generalisable to registered psychologists or more conservatively as descriptive and exploratory only.

Additionally, although small in number, postgraduate psychology students were also included in the research sample. However, the results of this study are not considered affected by the inclusion of student participants as effects due to the status of participants (ie. whether participants classified themselves as students, practitioners, or academics) were tested for and no significant findings resulted.

When the questionnaire for this study was developed, definitions of the traumatic experiences asked about were deliberately not specified. The definition of what would constitute each item was left to the respondent to decide upon, for example, asking if the respondent had experienced sexual abuse may have resulted in different respondents endorsing this item differently due to their own interpretation as to its definition. This approach does not lend itself to external validation and comparisons with other similar studies may not be easily made. However, this was a deliberate stance taken by the present author in the belief that psychological trauma is a very personal experience and to provide a 'scientific definition' of each item may devalue the person's experience of how they perceived their own trauma.

## 5.4 IMPLICATIONS FOR PRACTICE

There is a body of evidence that suggests all psychologists, and in particular psychologists with a pre-training history of exposure to mental illness or psychological trauma, would benefit from adequate training at the postgraduate level in self-care and self-reflective issues. The results of this study have shown that a significant number of practicing psychologists and psychology students in New Zealand do not believe these areas are or were satisfactorily addressed in their postgraduate training.

Clinical/counselling students/psychologists appear to believe that self-care and self-reflective issues are important areas to be considered in their training. However, it appears that students/psychologists from the area of industrial/organisational psychology may, perhaps mistakenly, not believe these areas are of relevance to their specialty.

Training in self-care issues may centre on investigating the possible negative consequences of choosing a career as a psychologist, and in particular how trainees' own personal histories may interact with these possible negative consequences and either exacerbate or possibly ameliorate them. The aim is to be preventative, so that trainees will become able to identify when problems are beginning to occur and be able to seek help. Seeking help should be held up as a positive coping behaviour. It seems from the number of participants who agreed that psychology students are reluctant to admit to having psychological problems that actively seeking help for those problems may not be a priority for this group. Perhaps students need to be encouraged in this



area, and receive training on the benefits of seeking help in order to prevent later problems such as secondary or vicarious traumatisation, or burnout from occurring.

Training in self-reflective issues may include paying specific attention to areas such as trainees' own problematic interpersonal relationships and countertransference issues, which if not investigated could result in reduced therapeutic effectiveness once trainees become practicing psychologists. These two areas may be core areas for inclusion in a self-reflective training module for postgraduate psychology students, as these issues are likely to be relevant to some extent to all trainees, whether or not psychological trauma has been endured in their personal histories. Although, the extent of effect upon psychological practice may, however, be dependent upon the degree of psychological trauma endured in these histories.

Identifying motivations, which individuals may not be fully aware of, when choosing a career in psychology may also be a relevant component of a self-reflective training module. Moving motivations into the full awareness of trainees may have the effect of allowing trainees to consider whether they are entering the profession for the right reasons. In addition, this may have the effect of signalling to trainees, areas in their personal lives that require acceptance or healing and that may need to be worked through before trainees can continue in their training.

Finally, it is suggested that it is not sufficient for self-care and self-reflection themes to be emphasised only in training. These issues may be best continuously readdressed over the entire career of the psychologist within the supervision relationship (Guy, 1987).

## 5.5 RECOMMENDATIONS FOR FURTHER RESEARCH

Further research may extend the present study by reinvestigating some of the questions this study posed within a qualitative framework. The purpose of this reinvestigation being to gather more descriptive and richer data in order to acquire a more complete understanding of the influences and motivations of psychologists. This type of data may be gained through analysis of in-depth face to face interviews or, perhaps, through the discourse analysis of published autobiographical accounts of the experiences of mental health professionals with psychiatric or psychologically traumatic histories. However, it must be noted that the trade-off in obtaining this type of information, through moving away from a quantitative framework, would be the potential loss in reliability. The enriched data drawn from such a study, however, could well compensate for this.

Participants' comments tended to support the opinion that personal therapy for psychotherapists may be of benefit to therapists during their training, even though there is no clear evidence as to its effect on therapeutic effectiveness. It is interesting to note, however, that some overseas programs insist students undergo personal therapy, for example in Switzerland where this is compulsory (Merrick, personal communication). This may indicate the need to extend research into the area of the effects of personal therapy for psychologists, perhaps incorporating personal therapy into a trial training program.

The development, trial, and evaluation of educational programs for postgraduate psychology students incorporating self-care and self-reflective issues is indicated as

another basis for further research. Evaluation of such programs could take the initial form of user evaluation. This could be followed by longitudinal studies that take into account the therapeutic effectiveness of psychologists who have had such training. In addition, experiences of the negative consequences of pursuing a career in clinical/counselling psychology could be investigated in terms of comparing participants on the basis as to whether or not the psychologist had undergone training specifically targeting these areas. Investigations such as these are likely to further enhance clinical practice through highlighting important issues relating to the effects of the prior histories of future clinical psychologists.

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## **APPENDIX A**

### **QUESTIONNAIRE USED IN THE STUDY**

## Psychologists' Experiences Prior to Undertaking Postgraduate Study in Psychology

1. Please indicate whether you experienced any of the following events **prior to undertaking postgraduate study in psychology**. Please respond by circling the answer that applies and, if applicable, writing the answer in the space provided.
 

Death of a family member	YES	NO	
Death of a close friend	YES	NO	
Traumatic brain injury	YES	NO	
Childhood sexual abuse	YES	NO	
Other sexual abuse	YES	NO	
Rape	YES	NO	
Physical abuse	YES	NO	
Emotional abuse	YES	NO	
Feelings of being neglected in childhood	YES	NO	
Problems associated with your own alcohol or substance abuse	YES	NO	
Other psychological trauma	YES	NO	- if YES, please specify on the line below.

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2. **Prior to undertaking postgraduate study in psychology**, did you ever suffer from a psychological disorder, for example: depression, panic attacks, anorexia nervosa?
 

YES    NO
3. If you answered YES to Question 2, and you choose to respond to this question, please write the name of the specific disorder on the line below.
 

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4. To what extent was your decision to study psychology influenced by the event(s) you identified in questions 1 to 3? Please respond by circling the number that corresponds with your answer.
  1. no influence
  2. little influence
  3. moderate influence
  4. great influence
  5. extreme influence
  6. not applicable – did not experience any of these events
5. **Prior to undertaking postgraduate study in psychology**, what type of effect did you believe your experience of the event(s) you identified in questions 1 to 3 would have on your practice of psychology in the future?
  1. **No effect** – you believed your practice of psychology would not be affected at all by any of these experiences.
  2. **A positive effect** – you believed your practice of psychology may be positively affected by these experiences, i.e. your experiences may enhance your ability to practice as a psychologist.
  3. **A negative effect** – you believed your practice of psychology may be negatively affected by these experiences, i.e. your experiences may hinder your ability to practice psychology.
  4. **Both positive and negative effects** – you believed your practice of psychology may be affected in both positive and negative ways by these experiences.
  5. **Not applicable** – you did not experience any of these events
6. To what extent did you believe the effect you selected in Question 5 would impact on your practice of psychology once you graduated? – **remember this question relates to how you felt prior to undertaking your postgraduate study.**
  1. no effect
  2. little effect
  3. moderate effect
  4. great effect
  5. extreme effect
  6. not applicable – did not experience any of these events

7. Please indicate whether you experienced any of the following events, **prior to undertaking postgraduate study in psychology**. Please respond by circling the answer that applies.
- |   |     |    |
|---|-----|----|
| Psychological disorder in a family member or close friend<br>(for example: depression, panic attacks, anorexia nervosa) | YES | NO |
| Life threatening physical illness in family member or close friend  | YES | NO |
| Psychological trauma in a family member or close friend<br>(for example: abuse, death of someone close)                 | YES | NO |
| Alcohol or substance abuse in a family member   | YES | NO |
8. To what extent was your decision to study psychology influenced by the event(s) you identified in question 7. Please respond by circling the number that corresponds with your answer.
1. no influence
  2. little influence
  3. moderate influence
  4. great influence
  5. extreme influence
  6. not applicable – did not experience any of these events
9. **Prior to undertaking postgraduate study in psychology**, what type of effect did you believe your experience of the event(s) you identified in question 8 would have on your practice of psychology in the future?
1. **No effect** – you believed your practice of psychology would not be affected at all by any of these experiences.
  2. **A positive effect** – you believed your practice of psychology may be positively affected by these experiences, i.e. your experiences may enhance your ability to practice as a psychologist.
  3. **A negative effect** – you believed your practice of psychology may be negatively affected by these experiences, i.e. your experiences may hinder your ability to practice psychology.
  4. **Both positive and negative effects** – you believed your practice of psychology may be affected in both positive and negative ways by these experiences.
  5. **Not applicable** – you did not experience any of these events
10. To what extent did you believe the effect you selected in Question 9 would impact on your practice of psychology in the future? – **remember this question relates to how you felt prior to undertaking your postgraduate study.**
1. no effect
  2. little effect
  3. moderate effect
  4. great effect
  5. extreme effect
  6. not applicable – did not experience any of these events
11. **Prior to undertaking postgraduate study in psychology**, did you ever receive, as a client, any type of counselling or psychotherapy for any psychological problem?
- YES    NO
12. **During your postgraduate study in psychology**, did you ever receive, as a client, any type of counselling or psychotherapy for any psychological problem?
- YES    NO



13. To what extent was your decision to become a psychologist influenced by any of the following factors? Please respond by using the following scale, and circling the number that best corresponds with your answer.

1 no influence	2 little influence	3 moderate influence	4 great influence	5 extreme influence
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Concern for the welfare of others	1	2	3	4	5
A desire to resolve your own problems or conflicts	1	2	3	4	5
Genuine interest in the subject matter	1	2	3	4	5
A desire to learn to cope with life stresses through seeing others cope	1	2	3	4	5
Self-development	1	2	3	4	5
Professional achievement	1	2	3	4	5
Prestige	1	2	3	4	5
A desire to give back to the community	1	2	3	4	5
A wish to better cope with a sense of loneliness/isolation experienced in childhood	1	2	3	4	5
A desire to express caring and warmth	1	2	3	4	5
A wish to be a positive force for those less capable than oneself	1	2	3	4	5
Other – please specify _____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5

14. To what extent do you agree with each of the following statements? Please respond by using the following scale, and circling the number that best corresponds with your answer.

1 strongly disagree	2 disagree	3 uncertain	4 agree	5 strongly agree
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In general, psychology students do not disclose psychological problems for fear of negative consequences, e.g. not being selected into a training program of their choice, or being thought incompetent.

1 2 3 4 5

In general, I am satisfied with the degree of emphasis, **during my postgraduate study**, placed on developing self-care plans, i.e. plans to prevent burnout or any of the other possible negative consequences of pursuing a career in psychology.

1 2 3 4 5

In general, I am satisfied with the degree of emphasis, **during my postgraduate study**, placed on self-reflection, i.e. looking at how my own life history could impact on my practice as a psychologist.

1 2 3 4 5

15. Demographic Information – please respond to each item by circling the number that corresponds with your answer and, if applicable, writing the answer in the space provided.

What is your gender?

1. Male
2. Female

What is your age?

1. 20 to 29 years
2. 30 to 39 years
3. 40 to 49 years
4. 50 to 59 years
5. 60 years plus

What is your primary status?

1. Student
2. Practitioner
3. Academic
4. Other – please specify \_\_\_\_\_

What is your highest, fully completed, qualification?

1. Bachelors degree
2. Postgraduate diploma
3. Masters degree
4. Postgraduate diploma in Clinical Psychology
5. Doctorate
6. Other – please specify \_\_\_\_\_

In what year did you commence your postgraduate study in psychology?

1. Please specify year \_\_\_\_\_

What is, or will be your area of specialty?

1. Clinical Psychology
2. Counselling Psychology
3. Industrial/Organisational Psychology
4. Social Psychology
5. Educational Psychology
6. Health Psychology
7. Other – please specify \_\_\_\_\_

If applicable, please select your theoretical orientation.

1. Experiential
2. Psychodynamic
3. Behavioural
4. Cognitive-Behavioural
5. Eclectic
6. Other – please specify \_\_\_\_\_
7. Not Applicable

16. Please make any comments below with regards to any issues raised in this questionnaire.

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(please use reverse side if you require more room)

**Thank you for taking the time to complete this questionnaire**

**APPENDIX B****INFORMATION SHEET USED FOR  
REGISTERED PSYCHOLOGISTS**

*(Massey University Letterhead)*

## **The Prevalence and Perceived Effects of Prior History of Exposure to Mental Illness and/or Traumatic Psychological Experience in Psychologists**

### **INFORMATION SHEET FOR PSYCHOLOGISTS**

My name is Sheila Boyland and I am completing a Master of Arts Degree in psychology at Massey University. My supervisor is Paul Merrick, Associate Professor, School of Psychology, who is based at Massey University, Albany, Auckland.

This study is looking at the prevalence and perceived effects of a prior history of exposure to psychological disorder and/or traumatic psychological experience in psychologists. The overall aim of this study is to bring awareness to the psychological community of the need for further research into self-care and self-reflective educational programs for trainee psychologists.

To achieve my goal I require the help of psychologists to collect the required data. I have used a list of registered psychologists obtained from the New Zealand Psychologists Board to contact you and invite you to participate in this study.

This study will involve approximately ten minutes of your time and will require you to complete the attached questionnaire and return it to me in the FREEPOST envelope provided. Please be aware the questionnaire contains sensitive questions regarding personal psychological disorder and trauma.

Completion and return of the attached questionnaire implies your consent to participate in this study. You have the right to decline to answer any particular question.

Any information you provide will be anonymous and your reply will not be identified as yours in any way. Only the researcher and supervisor will see the raw data. At the conclusion of the study all returned questionnaires will be held for a period of five years and then destroyed. The final research reports will present aggregated data only therefore confidentiality will be preserved.

Should you choose to receive a summary of the findings of this study please provide an email or postal address to the researcher. These details can be advised by emailing the researcher at the email address stated below.

Please do not hesitate to contact me should you have any queries regarding this study. My email address is [sheila.b@clear.net.nz](mailto:sheila.b@clear.net.nz). Alternatively, Paul Merrick can be contacted on ph. (09) 443 9799 ext. 9865 or by email at [P.L.Merrick@massey.ac.nz](mailto:P.L.Merrick@massey.ac.nz).

Regards

Sheila Boyland  
Researcher

**APPENDIX C**

**INFORMATION SHEET USED FOR  
POSTGRADUATE PSYCHOLOGY STUDENTS – E-MAIL**

*(Massey University Letterhead)*

## **The Prevalence and Perceived Effects of Prior History of Exposure to Mental Illness and/or Traumatic Psychological Experience in Psychologists**

### **INFORMATION SHEET FOR STUDENTS -EMAIL**

My name is Sheila Boyland and I am completing a Master of Arts Degree in psychology at Massey University. My supervisor is Paul Merrick, Associate Professor, School of Psychology, who is based at Massey University, Albany, Auckland.

This study is looking at the prevalence and perceived effects of a prior history of exposure to psychological disorder and/or traumatic psychological experience in psychologists. The overall aim of this study is to bring awareness to the psychological community of the need for further research into self-care and self-reflective educational programs for trainee psychologists.

To achieve my goal I require the help of postgraduate psychology students to collect the required data. I have obtained permission from your course co-ordinator to contact you and invite you to participate in this study.

This study will involve approximately ten minutes of your time and will require you to print off the attached questionnaire, complete it and return it to me at the FREEPOST ADDRESS stated below.

**FREEPOST 800 AT3  
Sheila Boyland  
School of Psychology  
MASSEY UNIVERSITY  
Private Bag 102 904 NSMC  
AUCKLAND**

Please be aware the questionnaire contains sensitive questions regarding personal psychological disorder and trauma.

Completion and return of the attached questionnaire implies your consent to participate in this study. You have the right to decline to answer any particular question.

Any information you provide will be anonymous and your reply will not be identified as yours in any way. Only the researcher and supervisor will see the raw data. At the conclusion of the study all returned questionnaires will be held for a period of five years and then destroyed. The final research reports will present aggregated data only therefore confidentiality will be preserved.

Should you choose to receive a summary of the findings of this study please provide an email or postal address to the researcher. These details can be advised by emailing the researcher at the email address stated below.

Please do not hesitate to contact me should you have any queries regarding this study. My email address is [sheila.b@clear.net.nz](mailto:sheila.b@clear.net.nz). Alternatively, Paul Merrick can be contacted on ph. (09) 443 9799 ext. 9865 or by email at [P.L.Merrick@massey.ac.nz](mailto:P.L.Merrick@massey.ac.nz).

Regards

Sheila Boyland  
Researcher

## **APPENDIX D**

### **QUALITATIVE FINDINGS**

Table 17.

*Emergent Themes Derived from Voluntary Comments Made by Participants*

Theme	Supporting Comments
Theme 1 <b>A perception that addressing self-care and self-reflective issues may be necessary, and may be lacking in the training of psychologists in New Zealand.</b>	<p>“Experiences working along side foreign graduates show the weakness of New Zealand training. There is not enough emphasis on ‘self’ in our training ... We are still at the infant stage of training compared to other countries.”</p> <p>“It was because my training in no way prepared me for the personal impact of working clinically, and insufficiently with interpersonal skills, I sought specific psychotherapy training.”</p> <p>“I have always been interested in this question myself. Does one’s life experience affect the decision to enter a profession such as this, or any of the caring professions. I don’t think my sexual abuse experience (which was relatively minor) was even in my awareness when I first trained. I probably thought of it as sibling experimentation rather than abuse.”</p> <p>“In NZ we are still stuck with an excess focus on CBT. Too few alternative models or role models are available. Focus almost purely on academic performance. We need a broader experiential base.”</p> <p>“Experiencing loss and grief, and the stress of long term caring for an ill family member has been invaluable for me in developing empathy and formulating effective treatment strategies – as has the experience of receiving very competent psychological input through the latter part of this time. The impact of my husband’s death powerfully influenced my career path but it should be noted that some of this was to do with practicalities – I need to support myself and didn’t want to spend my life in something boring or trivial. The fact that I had experienced personal difficulties was, I think, an advantage for me when I applied for selection into the clinical programme.”</p> <p>“I am an Otago graduate, and the support at that programme for students and their distress or anxiety has historically been appalling. I hope it will improve in the future – it certainly needs to.”</p> <p>“Most of my awareness of own issues has developed after postgrad[uate] study, with further training and my own personal supervision.”</p> <p>“This [emphasis, during postgraduate study, placed on self-reflection] occurred more when I did papers for the diploma in counselling.”</p> <p>“I trained in the age of steam – little consideration given to this aspect [self-care] – strongly behavioural”</p> <p>“... The terms ‘self-care’ and ‘reflective practice’ are bandied about with no exposition of their meaning or practical application. Psychologists get mixed messages about ‘taking care of oneself’ and yet are reinforced for being perfectionistic and carrying huge caseloads...”</p> <p>“... As psychologists, we do not explore personal issues in supervision enough – while supervision is not a forum for therapy, it certainly is a forum for examining self-care...”</p>



Table 17. (*continued*)

Theme	Supporting Comments
	<p>“Trained overseas. Great emphasis put on this aspect [self-care, self-reflection] – more than what I have observed in NZ.”</p> <p>“Through some practice in supervising psychologists for registration, I think there may be room for improvement in issues of self knowledge and self reflection for students of psychology.”</p> <p>“Psychological study and practice does not need to dwell on ‘pathology’ dimensions. Constructive elements and the contribution of dynamic relationships, affirmation and reflective experiences are powerful processes in human development.”</p> <p>“I find this area [self-care, self-reflection] very interesting and much neglected in the training (and selection) of clinical psychology students...”</p> <p>“Could usefully look at influence of positive events on the embryonic psychologist – they interact with the pathological. I suspect trauma acquires meaning from its context.”</p> <p>“This [emphasis on self-care plans, during postgraduate training] didn’t happen when I trained.”</p> <p>“[Self-reflection during postgraduate training] did not exist but would be hugely beneficial. After 9 years clinical practice and further training overseas the need to include self-reflection in clinical training and as part of supervision is paramount. I think this is vital for any psychologist regardless of their past experience of trauma or not. Personal values and attitudes are not recognised in training.”</p> <p>“Probably won’t find many people [say they] are influenced by traumatic events/perceived effects of prior history prior to postgrad psychology, but you would find these would have greatly effected people studying psych in the first place - you might not find sig[nificant] results, but yet exposure to history/traumatic events will still have been prevalent in psychologists’ pasts.”</p> <p>“I do enough self reflection, but I don’t know if there is much formal work done on it.”</p> <p>“...From what I have experienced to date, we have had little self-care and self-reflection via the Massey course. I am struggling to think of even one example. I guess that suggests what you are looking at here is important...”</p> <p>“Q14 educational institutions need a huge ‘rev-up’ in this area. Unethical how post-grad[uate] training skimps.”</p> <p>“I certainly feel that clinical training courses should provide greater opportunities for self-reflection...”</p> <p>“[regarding emphasis on self-care and self-reflection during postgraduate training] Had good training and supervision – but not seen the same emphasis in NZ.”</p>

## Theme 2

**A perception that undergoing one’s own therapy may be a useful tool in the training of psychologists.**

“...Students should go into therapy – a focus on learning core skills...”

Table 17. (continued)

Theme	Supporting Comments
	<p>"It is imperative that any psychologist should undergo their own therapy, whatever their theoretical orientation. A lot of harm is done because of psychologists' own lacunae."</p> <p>"... There is no requirement for any kind of therapy for students during training - I believe this is [a] significant lack in training courses..."</p> <p>"UK trained. Had developmental tutor system and were required to undertake some counselling (13 sessions paid by course) to understand what it felt like to be a client."</p> <p>"Extensive counselling was necessary for me following my postgraduate qualification to resolve earlier issues in my life ... I believe personal issues and resolution should be part of all training for psychologists. I believe my past issues did help my practise and do today. It was my personal life that suffered as I put work first. I think working helped me delay the necessity to do my personal work. Much later all the processes now help me with my work as a psychologist ie. - the counselling as well as the original events."</p> <p>"... Awareness of students needs and available support is very much neglected in training programme. Personally, some more awareness of self-care issues, work lead management, and access to some form of therapy and self-reflection of patterns (as a requirement) would have greatly enhanced outcomes for me. I have supervised many clinical psychologists over the past ten or so years and these themes come up over and over with the general theme being that students feel their general emotional well-being is irrelevant and overlooked in training..."</p> <p>"I believe undergoing one's own therapy should be a prerequisite when entering postgraduate study."</p> <p>"I believe it is helpful to have had some 'knocks' in life - for empathy etc - as long as [no] serious ongoing trauma has been experienced (hard to recover from). The key is whether you face up to childhood experiences to do the hard on-going work of personal growth. But many counsellors/psychologists I have met have serious, unresolved personal issues and get a kick out of their 'superiority'."</p> <p>"...and even make it a component of the course that individuals pursue some time-limited therapy. This would not only provide an experience of being 'the client'. But also encourage individuals to become more self-aware."</p>
Theme 3	
<b>A perception that psychology students/psychologists may be fearful of disclosing their psychological problems.</b>	<p>"Students that I have supervised have disclosed problems which were not disclosed before entry into the programme..."</p> <p>"...Psychologists seem to think that they are incompetent if they acknowledge stress."</p> <p>"...I still feel my history would be unacceptable to my colleagues..."</p> <p>"I did disclose my psych[ological] difficulties with the supervisors before I was selected - so they would have that knowledge also that I was on medication - ongoing basis. I felt ethically it was important they were aware of that. Many colleagues don't know though"</p>

Table 17. (continued)

Theme	Supporting Comments
	<p>“There are myths that surround the selection process that maintain the lack of disclosure [of psychological problems]. These should be dispelled and personal experience valued further. I used my experiences to my advantage in both my selection and training.”</p> <p>“Having dealt with serious depression I decided I wasn’t strong enough to deal with clinical – i.e. my perception is/was that listening to people talking about their problems all day would have a negative impact on my own psychological well being. However, having dealt with my own demons, I’m a lot more understanding, accepting and supportive with others who are dealing with severe stress, depression or others’ feelings in general.”</p> <p>“... As someone who has been through the clinical application process I think it is desirable to disclose a certain amount of psychological problems because it is seen as being advantageous to indicate you have personal life experience. However, I think most of us would be too threatened to ‘confess’ a ‘proper’ psychological problem...”</p> <p>“...I wanted to become a researcher, but I am aware that I have been driven by my personal process. It concerned me most in a family therapy class of approx 40 students, I was one of only two who were prepared to admit that their own families had problems...”</p> <p>“[regarding psychology students fear of disclosure of psychological problem for fear of negative consequences] was not trained in NZ – seems to be more discrimination here.”</p> <p>“I think the issue raised in Q14(a) is pertinent, although I suspect that student perceptions or fears of discrimination for disclosure are real but not so significant to course selection panels.”</p>
Theme 4	
<b>A perception that many psychology students have problems.</b>	
	<p>“The questionnaire reminded me that during block courses (my only contact with school/fellow students) that I felt that a number of students had/or were having a few life issues.”</p> <p>“With all the other grad students I have met, I feel like I am the only one without any problems now or in the past – I certainly feel like the odd-one-out.”</p> <p>“I found that in some of the post grad courses students were encouraged to disclose personal trauma and I felt disadvantaged not having issues to disclose – I ended up having to write a paper about how ‘normal’ is actually abnormal.”</p> <p>“When I completed my BSc(Hons) in 1980 I decided not to pursue clinical psych because most of the students did seem to have issues to deal with and I was only 20 at the time...”</p>
Theme 5	
<b>A perception that self-care, self-reflection issues are irrelevant to the field of Industrial /Organisational psychology.</b>	
	<p>“Specialising in I/O psych means less risk of negative consequences of pursuing a career in psychology.”</p>

Table 17. (continued)

Theme	Supporting Comments
	<p>"Q14 – doesn't really come up in I/O psych."</p> <p>"Q14 is irrelevant to an I/O course – there is no examination during this course of any personally relevant issues."</p>
Theme 6	
<b>A perceived importance of research into the areas covered in this study.</b>	
	<p>"I am delighted to see you are researching this important area."</p> <p>"Great project. Good that these issues are being raised."</p> <p>"Fantastic subject matter but potentially quite scary"</p> <p>"I am really pleased you are doing this. Thank you for giving me the chance to take part though I don't fit your boxes very well..."</p> <p>"...It [completing the questionnaire] made me think about how I have changed since starting to study at Massey, and what was really driving me."</p> <p>"Good study to do"</p>
Theme 7	
<b>Not all postgraduate psychology students want to become psychologists.</b>	
	<p>"Q13 is assuming that postgrads are going to practice psychology – I'm not for eg."</p> <p>"...Another problem I anticipate is that a number of students who complete this questionnaire do not aspire to be psychologists."</p> <p>"...I do not, and never did, intend to become a practicing psychologist...I am in the third year of psychodrama training and hope to practise psychodrama eventually. I have engaged in personal development work, including psychotherapy and alternative psychologies for ten years. I was shocked to learn of the high suicide rate among psychologists, and considered that it detracted from the credibility of the profession. I, though not totally, have changed my views now. Further I now believe that my own experiences give me a strength and an understanding and an optimism that would enhance my practice as a psychologist (if I intended to be one, which I don't)..."</p>