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PSYCHOLOGIST SELF-CARE, PERCEIVED STRESS, PSYCHOLOGICAL
DISTRESS, AND COPING SELF-EFFICACY ACROSS THE CAREER-SPAN

BY

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Submitted in partial fulfillment of the requirements for the degree
Ph.D. in Counseling Psychology
Department of Professional Psychology and Family Therapy
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Abstract

Psychologist self-care, perceived stress, psychological distress, and coping self-efficacy
over the career-span

Psychologists are expected to engage in self-care strategies aimed at promoting and maintaining well-functioning in themselves (Saakvitne & Pearlman, 1996) in order to effectively manage the demands of their profession and better ensure the provision of quality care. However, self-care is also a clinical competency of professional psychology that has historically been insufficiently addressed in training (Donovan & Ponce, 2009). According to the APA Board of Professional Affairs Advisory Committee on Colleague Assistance, a better understanding of functioning in psychologists is necessary to properly promote self-care across the career-span (2005). There is a need for research in this area to establish evidence-based self-care practices. This study lends empirical support for an increased focus on psychologist self-care with specific attention to the relationships between Perceived Stress, Psychological Distress, and Coping Self-Efficacy across the career-span. Results largely support hypotheses that there are significant relationships between the variables. With regard to differences in sample means across the career-span, Late career psychologists' scores were significantly higher than Early career psychologists' for Self-Care frequency and Coping Self-Efficacy. Late career psychologists' Perceived Stress levels were significantly lower. Further, there are differences in frequency and type of Self-Care practices between Early and Late career psychologists. Implications, limitations, and suggestions for future research are provided.

Keywords: psychologist, career-span, self-care, perceived stress, coping self-efficacy

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Dedications

This manuscript is dedicated to the memory of my father, who inspired my research at its foundation. And to my mother, whose tireless efforts, hard work, and selflessness have served as the model for my own life's work and balance. Without both of you, I could not have known these achievements.

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CHAPTER I

Introduction

Statement of the Problem

Painters have brushes. Musicians have instruments. Surgeons have scalpels. All such professions endeavor to keep their essential tools as sharp and tuned as possible, to optimally deliver their services. While psychologists are equipped with expertise, and specialized training, the “self” as it relates to connectedness, capacity for insight, and clinical judgment is the most important tool in a psychologist’s toolbox. It is the self that generates clinical wisdom and successful practice (Barnett, Baker, Elman, & Schoener, 2007). As such, keeping the self fit for practice is of the utmost importance in the ability to responsibly perform professional duties.

Although the imperative for psychologist self-care is well established and widely recognized, the unique challenges and stressors often confronted by psychologists increase the risk of detrimental consequences (Barnett et al., 2007). Psychologists are expected to engage in physical, psychological, emotional, spiritual, and professional strategies and behaviors aimed at promoting and maintaining well-functioning in themselves (Saakvitne & Pearlman, 1996) to effectively manage the demands of their profession, and better ensure the provision of quality care. If appropriate self-care skills are practiced, these skills can assist in maintaining life-long learning as well as optimal levels of professional and personal functioning throughout the career-span (Kuyken, Peters, Power, & Lavender, 2003).

Unfortunately, the nature of the professional training and personal dispositions of those who enter the helping professions frequently lead to blind spots or breakdowns in attention to their own needs and concerns (O’Connor, 2001). Several researchers highlight the dilemma that psychologists often do not receive sufficient training in self-care and do not seek assistance,

despite their awareness of the harmful impact of their distress on the services they provide (e.g., Donovan & Ponce, 2009; Sherman, 1996). Regardless of the ethical imperative to remain sensitive to signs of distress, and ameliorate them when necessary, this dilemma persists. This inattention to self-care needs to be better understood in order to be adequately resolved. Using empirical research to drive a remedy for the situation on a broader scale is essential for the profession of psychology to sufficiently promote competency in self-care and further enhance ethical practice. Self-care concerns clearly require further attention, both by individual psychologists and the profession as a whole (Baker, 2003).

As the science of psychology continues to advance, self-care skills are coming into recognition as a core competency necessary for clinical training (Rodolfa, Bent, Eisman, Nelson, Rehm, & Ritchie, 2005). The promotion of preventative self-care practice at the graduate school level can form a foundation for career-long efforts (Elman, Illfelder-Kaye, & Robiner, 2005). However, merely encouraging the vague concept of self-care is insufficient. Concrete, empirical data are needed to support the relationships of specific factors and behaviors. For example, results of a study conducted by Myers et al. (2012) suggest that instructing psychology graduate students on self-care practices is fundamental to helping them manage stress. Therefore, understanding the role of stress in self-care is necessary to inform more specificity in self-care as an effective stress management strategy (Myers et al., 2012). Translation of such data into ecological interventions could promote development of training curricula that emphasize both personal and professional facets of self-care for use in graduate programs and continuing education across the career-span (Barnett et al., 2007).

For such programs to be developed and implemented, changes need to take place within the culture of professional psychology (Handelsman, Gottlieb, & Knapp, 2005). As the field

moves toward a focus on competencies, the zeitgeist may be prime for introducing these changes (Nelson, 2007). Moreover, research needs to support a systematic effort to establish a culture that places sincere value on self-care as evidenced by standards and assessment. Evidence-based action needs to be taken to more centrally promote self-care as an ethical competency (Barnett et al., 2007).

While the subject of self-care has experienced a resurgence of support (Mahoney, 1997), the dearth of systematic investigation on the topic is disconcerting (Norcross, 2000). Psychologists have a responsibility to examine the significance, obligation, accountability, necessity, and challenges of self-care, personally and professionally, across their career-span (Barnett et al., 2007). Hence, the current study contributes to the extant literature and lends empirical support for an increased focus on psychologist self-care, with specific attention to the relationships between perceived stress, psychological functioning and distress, and coping self-efficacy.

Significance of the Study

No debate exists against the claim that ongoing self-care supports psychological wellness and helps prevent distress. Purported contributors to the maintenance of healthy, well-functioning have been influenced by theories of stress, coping, and life-span development (Coster & Schwebel, 1997). Interestingly, the relationships between self-care practices, perceived stress, psychological functioning and distress, and coping self-efficacy have not been examined among psychologists across the career-span.

In addition, little empirical research has been conducted to explore changes in psychologists' general patterns of practice across the career-span (Pingitore & Scheffler, 2005). With increasing levels of experience, career activity patterns may change, thus affecting self-care

patterns. For example, Myers et al. (2012) purport that more seasoned students may develop more effective strategies for coping with challenges of graduate school over time, and therefore perceive less stress than newer students. Comparisons can contribute to the understanding of how self-care skills develop or change over time. Given the changing landscape of professional psychology, it is especially important to understand the relationships between these factors over time, as this may inform more effective well-functioning strategies that are sensitive to evolving demands and resources. As such, the present research is aimed at contributing to the literature on self-care of psychologists across the career-span, namely Early, Mid, and Late career stages, within a theoretical framework of stress and coping theory. Furthermore, the insight gained from an examination of these factors may facilitate increased attention to the assessment and reinforcement of self-care at various points in the career-span. As such, the following research questions were addressed in this study:

Research Questions

1. To what extent (frequency and type) do Early (1-7 years), Mid (8-20 years), and Late-career (21+ years) psychologists engage in self-care activities?
2. What is the relationship between career stage and Self-Care frequency, Perceived Stress levels, Psychological Distress, and Coping Self-Efficacy?

Research Hypotheses

1. Based on the premise that practice demands and stressors change over time, the frequency and type of self-care activities in which Early, Mid, and Late-career psychologists engage is expected to vary across the career-span.

2. Similarly, sample means on measures of Self-Care, Perceived Stress, Psychological Distress, and Coping Self-Efficacy are expected to differ across the three career stage groups.
3. Furthermore, positive correlations were expected between (a) frequency of engagement in Self-Care activities and Coping Self-Efficacy, (b) Perceived Stress and Psychological Distress, (c) number of years in practice and frequency of engagement in Self-Care activities, and (d) number of years in practice and Coping Self-Efficacy. Negative correlations were expected between (a) Coping Self-Efficacy and Psychological Distress, (b) Coping Self-Efficacy and Perceived Stress, (c) frequency of engagement in Self-Care activities and Psychological Distress, (d) frequency of engagement in Self-Care activities and Perceived Stress, (e) number of years in practice and Perceived Stress, and (f) number of years in practice and Psychological Distress.

Conclusion

Self-care is touted as an ethical imperative in the careers and personal lives of psychologists (Barnett et al., 2007). The significance of this warrants a need for data in support of existing theoretical interpretations, aimed at more clearly understanding the relationships between Self-Care, Perceived Stress, Psychological Distress, and Coping Self-Efficacy. Further research illuminating self-care patterns can prove invaluable to the professional psychology community. A review of the literature in these areas provides a more complete context from which to view the purported relationships of these factors.

Definitions

Self-care. For the purpose of this study, Self-Care is defined as the active engagement in physical, psychological, emotional, spiritual, and professional strategies and behaviors aimed at

promoting and maintaining well-functioning (Saakvitne & Pearlman, 1996). Self-care frequency and type was measured by the Self-Care Assessment Worksheet (SCAW; Saakvitne & Pearlman, 1996).

Perceived stress. For the purpose of this study, Perceived Stress is operationally defined as scores on the Perceived Stress Scale-14 (PSS), which reflect the degree to which situations in one's life are perceived as stressful (Cohen, Kamarck, & Mermelstein, 1983).

Psychological distress. For the purpose of this study, Psychological Distress is operationally defined on a continuum of scores measured by the Outcome Questionnaire-45 (OQ-45; Lambert et al., 2004). Scores reflect participants' subjective emotional states, and provide cutoffs for scores of clinical significance (Barnett et al., 2007).

Coping self-efficacy. For the purpose of this study, Coping Self-Efficacy is operationally defined as scores on the Coping Self-Efficacy Scale (CSE), reflecting participants' confidence in performing coping behaviors when confronted with challenges (Chesney, Neilands, Chambers, Taylor, & Folkman, 2006).

Career stage. For the purpose of this study, career stage is operationally defined as number of years in practice for a licensed psychologist, with 1-7 years being Early career, 8-20 years being Mid career, and 21+ years Late career. No uniform categorization strategy was found in review of previous research on this topic. As such the ranges for years in practice chosen for each stage were based on commonly known definitions such as that for an APA Early Career member (less than 7 years in practice), and resemble ranges used in a variety of studies (e.g., Lindstrom, 2011).

CHAPTER II

Review of Literature

A review of extant literature sets the foundation for the theoretical framework of this study. In addition to introducing the general structure of professional psychology, a summary of related research expands upon the rationale for the variables being examined. Perceived Stress, Psychological Distress, Coping Self-Efficacy, and Self-Care are addressed.

Professional Psychologists

The American Psychological Association (APA) Center for Workforce Studies (CWS) estimates there are 93,000 clinically trained, practicing psychologists in the U.S. The APA currently serves approximately 87,885 members (2013). CWS data show that the majority of members place themselves in the category of health service providers while others label themselves as researchers and practitioners in other psychology subfields such as industrial-organizational consulting. With regard to demographics, a majority of APA members are White, at an estimated 58%. Thirty-six percent did not specify ethnicity and approximately 2% reported each Hispanic, Black, and Asian respectively (APA, 2013). The gender composition of the membership is 58% female and 42% male (APA, 2013). The mean age of members is 55 years, with a standard deviation of 15 (APA, 2013). These numbers represent a large fraction of psychologists in the United States, and provide a snapshot of demographics.

As with any career choice, the choice to become a psychologist is impacted by a constellation of factors. Among these motivations may be interest, altruism, pursuit of satisfaction, and desire for vocational success (Murphy & Halgin, 1995). Though, research also implies that those in mental health professions may pursue such as a means to resolve their own psychological distress (Guy, 1987), fulfill needs of intimacy that were insufficient during childhood (Liaboe & Guy, 1987), or to maintain caretaking roles once held within the family of

origin (DiCaccavo, 2002). An interactive model of personal history factors, in combination with the context of work in psychology, best describes the vulnerabilities and occupational hazards that psychologists are likely to experience across their career-span (APA Board of Professional Affairs Advisory Committee on Colleague Assistance, 2005).

Over the course of an individual's life, critical developmental milestones and transitions impact stress levels, leading to positive development, stagnation, or regression (Erikson, 1980). In the same vein, the health of those individuals who go on to become psychologists is a product of these life experiences. As people, they are subject to positive and negative influences across the life-span (Coster & Schewbel, 1997). Upon entering the profession of psychology, their education and training do not inherently protect them from the stresses of developmental transitions and daily life (Coster & Schewbel, 1997). Theoretically, those who learn to anticipate, prevent, and cope with stress will better achieve developmental goals, across both the life-span and career-span (Coster & Schewbel, 1997).

Throughout their careers, psychologists must cope with both personal and professional stressors (Coster & Schewbel, 1997). While their work provides many benefits, it also encompasses challenges and pressures that may increase risk of distress or even impairment. Barnett et al, (2007) summarize a number of these challenges such as serving clients with high emotional demands, severe and persistent psychopathology, chronic issues with frequent relapse, high-risk behaviors and crises, suicidality, and aggression; as well as the administrative requirements of the profession. These include insurance and managed care, which increase bureaucracy and paperwork, difficulty obtaining payment for services rendered, long hours, crisis management, and professional isolation. Coster and Schewbel (1997) further note the need to keep up with new developments, maintain a niche and clientele, and anticipate impacts of

healthcare reform, in addition to fulfilling and balancing multiple professional and personal roles.

Over time, demands and thus practice patterns are expected to change for individual psychologists as well as between generations of psychologists (Pingitore & Scheffler, 2005). As such, self-care needs change over time, making self-care a career-span issue. The process of becoming more attuned to and responsible for one's own needs is a developmental process, with gradual transitions from dependence to autonomy. On an individual level, psychologists move through stages of launching, advancing, maintaining, and retiring from their careers (Pingitore & Scheffler, 2005). New professionals struggle with enhancing and proving their competence. Mid-career professionals who entered the field at a traditional age may struggle with balancing family and increasing career demands. Seasoned professionals may experience more limited time and energy (Pingitore & Scheffler, 2005).

Furthermore, research demonstrates experienced-based differences in psychologists' income, predominant work settings, perceived quality of work, and attitudes toward managed care (Murphy, DeBernardo, & Shoemaker, 1998; Phelps, Eisman, & Kohout, 1998; Pion, Kohout, & Wicherski, 2000; Williams, Wicherski, & Kohout, 2000). The structure of the industry has been such that psychologists are likely to transition from salaried positions at public institutions to independent practice with different types of patients, payment sources, and treatment modalities (Pingitore & Scheffler, 2005).

More specifically, according to Sanders, Breland-Noble, King, and Cubic (2010) early career psychologists (ECPs) of today have a higher likelihood of more varied roles than previous generations of psychologists. Lower income and significant debt are more common for ECP's today than their predecessors. To alleviate financial burden, many ECPs are undertaking added

responsibilities such as adjunct teaching, consulting, secondary private practice, and grant-writing (Sanders et al., 2010). These added responsibilities are compounded by professional issues of obtaining licensure, specializing (Green & Hawley, 2009), finding mentorship, and learning new systems of varied work settings all while attempting to balance career and personal life. These are fundamental developmental tasks of the ECP phase of psychologist career development, however the dangers include risks of becoming overextended and unable to satisfactorily complete tasks (Sanders et al., 2010).

Mid-career psychologists have “arrived,” successfully demonstrating the achievement of important career milestones such as promotions, income increases, and hopefully a number of other recognized professional accomplishments (Sanders et al., 2010). After ten years in the field, maintenance of these gains becomes a focus (Super, Zelkowitz, & Thompson, 1981). During this period, psychologists in clinical practice work a comparable number of weekly hours as their newer colleagues, provide more hours of direct patient care, and spend more time in solitary practice (Pingitore & Scheffler, 2005). As a thriving career trajectory continues into the late-career stage, the possibility of overload becomes one of the greatest jeopardies to professional and personal well-functioning. This is the phenomenon of “Mid-Late Career Overload,” in which many report they are strained and overextended (Sanders et al., 2010). Similarly, Hurrell and Lindstrom (1992) suggest higher degrees of psychosomatic symptoms reported by mid-career managers, as opposed to early or late-career, as a function of higher workloads and job demands.

While each new opportunity is understood as a privilege of advancement, capturing of all these opportunities over time becomes nearly impossible with an already harried schedule. Eventually, the balance must shift with the realization that there will be more professional

opportunities than time (Sanders et al., 2010). During late career, work activity begins to decline and self-image may evolve as independent of career (Ornstein, Cron, & Slocum, 1989).

According to Kramen-Kahn and Hansen (1998), more experienced clinicians report perceiving fewer occupational hazards. Conversely, they note that the perception of more hazards puts psychologists at greater risk for distress and impairment. In Osipow, Doty, and Spokane's (1981) earlier research, older workers reported less strain, which the authors attributed to greater use of self-care and recreational coping skills learned throughout their careers. A meta-analysis by Lindstrom (2011) indicates that more effective coping contributes to a decrease in stress symptoms for late career individuals.

On a generational level, among the changing trends is the feminization of professional psychology, which continues to vary the gender composition of cohorts, as more females continue to enter the field (Pion et al., 1996). Further trends include changes in the foci and scope of doctoral education and training due to increases in technology and multicultural awareness, as well as changes to managed care systems. Therefore, newly licensed psychologists may practice differently than their more seasoned colleagues (American Psychological Association, 1995). Considering generational differences, Millennials, who are currently entering the workforce may embark on their training seeking greater work-life balance from the start (Leiter, Jackson, & Shaughnessy, 2009). If practice differences exist across cohorts it is likely that activities such as self-care also differ across cohorts, with regard to frequency and type. Likewise, Lindstrom's (2011) work supports that the moderating effect of career stage demonstrates differences between job characteristics and well-being as varying from one period to another.

While psychologists experience the universal stressors shared by the general population, they also experience specific vulnerabilities, which are products of professional psychology. Psychologists have strengths in their knowledge, training, and resources, yet their human characteristics of life-experiences and emotional injuries play a role in their work. Continuous exposure to the emotional material of others, monitoring of one's own emotional reactions, prudent maintenance of boundaries, limited control over outcomes, and isolated work environments are all factors that present additional stress (APA Board of Professional Affairs Advisory Committee on Colleague Assistance, 2005).

Literature on occupational stress of psychologists is compelling, yet surprisingly minimal (APA Board of Professional Affairs Advisory Committee on Colleague Assistance, 2005). Existing research strongly supports the reality of distress in the lives of psychologists (Guy et al., 1989; Pope et al., 1987). However, the stigma associated with admitting distress creates a Conspiracy of Silence (Pope, 1994). Still and though, psychologists' self-awareness can serve as their best protection (APA Board of Professional Affairs Advisory Committee on Colleague Assistance, 2005), in conjunction with the preventative actions they take.

Perceived Stress

As previously noted, psychologists are regularly exposed to stressful experiences in their work as well as their personal lives. Effective methods of decreasing perceived stress are necessary to avoid distress and impairment, so as to maintain the quality of care psychologists are expected to provide (Murtagh & Wollersheim, 1997). The negative consequences of stress on helping professionals include increased depression, emotional exhaustion and anxiety (Radeke & Mahoney, 2000; Tyssen, Vaglum, Gronvold, & Ekeberg, 2001), psychosocial isolation (Penzer, 1984), decreased job satisfaction (Blegen, 1993), reduced self-esteem (Butler & Constantine,

2005), disrupted personal relationships (Myers, 1994), and loneliness (Lushington & Luscri, 2001). Major life events and daily stressors alike have been associated with negative health and psychological well-being outcomes (Baum & Posluszny, 1999; Grzywacz, Almeida, Neupert & Ettner, 2004; Kiecolt-Glaser, McGuire, Robles, & Glaser, 2002; Pinquart & Sorenson, 2003). While stress may be a symptom of pathology, the perception of stress alone is not an indication of pathology (Cohen et al., 1983). More recently, interest in stress research has focused on examining factors related to experience of and reactivity to daily stressors in distinguishing risk and resilience factors (Almeida, 2005).

Given that daily stressors often incite negative affect, understanding the degree to which these stressors exacerbate negative affect can inform research and practice regarding stress tolerance and reactivity. In a nationally representative sample of 25- to 74-year-olds, Mroczek and Almeida (2004) found that older adults displayed the greatest rise in negative affect in relation to daily stressors. Conversely, Uchino, Berg, Smith, Pearce, and Skinner (2006) found the reverse in a sample of 36- to 75-year-olds. Their findings demonstrated that stress-related increases in negative affect declined with aging. Almeida and Horn (2004) revealed that older adults (60–74 years old) less frequently reported daily stressors than did younger (25–39 years old) and middle-aged (40–59 years old) adults. Similarly, Stawski, Sliwinski, Almeida, and Smyth (2008) also demonstrated that reporting of daily stressors decreased with age, however, emotional reactivity to stressors did not contrast between younger and older adults.

Understanding the impact of age on stress is valuable, as it can assist in improving well-being across the life-span. However, evidence for daily stressor effects on affect with regard to age continues to be inconsistent (Mroczek & Almeida, 2004; Sliwinski, Smyth, Hofer, & Stawski, 2006).

According to Lazarus (1977), people dynamically interact with their environments, and assess potentially threatening or demanding situations in relation to their coping resources. Objective measures of stress imply that experiences directly give rise to pathology (Cohen et al., 1983). However, perceived stress refers to the degree to which an individual judges situations in his or her life as stressful (Cohen et al., 1983). From this viewpoint, situations are only presumed to be stressors if they are judged as threatening or challenging and coping resources are deemed insufficient. Therefore, the causal factor is actually the cognitively mediated emotional reaction to an objective situation, not the situation itself (Lazarus, 1977). Responses are not primarily caused by any inherent quality of the event, but rather are dependent on personal and contextual factors as well. The significant role of cognitive appraisal supports the importance of measuring perceived stress, as opposed to solely objective stress. Furthermore, perceived stress can serve as an outcome variable in exploring stress levels as a function of coping (Cohen et al., 1983). As such, perceived stress can be examined in conjunction with objective assessments of stressors in an effort to determine the protective role of coping style against pathogenic effects of stressful experiences (Cohen et al., 1983). An additional benefit of assessing global perceived stress versus specific, objective stressors is that global assessments are more sensitive to the chronic stress of enduring conditions, as well as stress from events occurring in the lives of one's social support network, stressors not examined, and expectations of anticipated stressors (Cohen et al., 1983).

Stress may also harm professional effectiveness because it appears to negatively impact attention and concentration (Skosnik, Chatterton, & Swisher, 2000), impinge on decision-making skills (Klein, 1996), and reduce providers' ability to establish strong relationships with patients (Enochs & Etbach, 2004; Renjilian, Baum, & Landry, 1998). Further, stress can increase the

likelihood of occupational burnout (Rosenberg & Pace, 2006), a syndrome that involves depersonalization, emotional exhaustion, and a sense of low personal accomplishment. Knowing the stress of clinical practice, Murtagh and Wollersheim (1997) hypothesized that working with depressed clients could further affect psychologists' moods. However, a three-week evaluation of psychologists' moods pre and post session with depressed clients, showed no significant effect. The authors posited that coping strategies mediated the stress of working with depressed clients, thus preventing the therapists from also becoming depressed. In light of this finding, the authors recommend that mental healthcare providers engage in problem-focused coping in an effort to reduce the effects of stress. The progression of stress, to distress, to impairment is preventable for those who act on appropriate ameliorative efforts by engaging in a level of self-care that serves to adequately reduce stress (APA Board of Professional Affairs Advisory Committee on Colleague Assistance, 2005).

Psychological Functioning: Distress

Extant literature warns that psychological distress a serious concern for those who work in the field of mental health (Sherman, 1996; Forrest, Elman, Gizara, & Vacha-Haase, 1999). Much research documents the negative interface between therapists' personal issues and job functioning (e.g., Guy, Poelstra, & Stark, 1989; Wood, Klein, Cross, Lammers, & Elliott, 1985). Psychologists who are preoccupied with personal issues are unable to effectively employ their skills. As a result, their therapeutic effectiveness is likely to deteriorate (Sherman & Thelen, 1998). Unfortunately, such occurrences are not historically uncommon, as Pope, Tabachnick, and Keith-Spiegel (1987) reported, 60% of survey respondents, all practicing psychologists, acknowledged they have worked when too distressed to be effective. According to Wood et al. (1985), 63% of those surveyed acknowledged their awareness of a colleague whose work had

been impacted by burnout or depression. Similarly, Mahoney (1997) investigated a sample of mental health practitioners who reported their most common afflictions as emotional exhaustion and fatigue. Interpersonal problems, isolation, disenchantment with their profession, anxiety, and depression were also reported. Somatic issues and substance abuse problems were among the least reported ailments. Gender differences were only apparent with regard to alcohol use, which was a greater concern for men than women in the sample.

Research on psychological functioning of psychologists has demonstrated mixed results. As previously mentioned, less recent uncontrolled and observational studies reveal that mental healthcare professionals are at risk for experiencing significant distress including occupational stress, financial troubles, medical problems, depression, and relationship issues (Deutsch, 1985; Laliotis & Grayson, 1985; Thoreson, Miller, & Krauskopf, 1989). Conversely, while limited in number and scope, controlled studies demonstrate lower rates of anxiety, depression, dissociation, sleep disturbance, and interpersonal problems in mental health professionals than other types of professionals. It is important to note that female mental health professionals have been noted to seek psychotherapy more than women in other professions (78% vs. 41%, respectively) (Elliott & Guy, 1993). Thus healthier psychological functioning observed in female mental health professionals may be attributable to participation in treatment (Elliott & Guy, 1993).

Psychological functioning and distress are important to address not only because of their impact on individuals, but also because of their impact on colleagues, clients, and the profession of psychology in general (Schwebel, Skorina, & Schoener, 1994). A question that naturally emerges in this discussion is whether all distressed professionals are considered impaired. In terms of psychological functioning, distress and impairment exist on a continuum. Sherman and Thelen (1998) purport that psychologists generally view their work as impeded to some degree

when they experience personal or professional problems. No doubt, there is variability in the levels of distress generated by different life experiences. Of the life events investigated by Guy and Souder (1986), relationship issues and major illness/injury caused the most distress. Likewise, malpractice claims and managed care restrictions led to considerable distress. With the morphing health care system, it is likely that psychologists will be encountering an increase in such situations in the future (Hersch, 1995). As this has already been classified as a source of likely distress, it is important to monitor psychologist well-functioning during this time of change (Sherman & Thelen, 1998). Such distress cannot only leave psychologists feeling less satisfied with their work, but many also report a decrease in promptness, availability, and conscientiousness. Subsequently, stress compromises psychologists' ability to adequately fulfill basic requirements of their roles (Sherman & Thelen, 1998).

Interestingly, Sherman and Thelen (1998) noted that psychologists reporting low levels of distress did not engage in extensive preventive activities. It cannot therefore be concluded that preventive behaviors preclude individuals from experiencing distress altogether. The authors suggest that future research focus on frequency of preventive behaviors, as well as amount of time spent engaging in these behaviors.

A majority of individuals experience major life changes and stressful work conditions throughout the course of their careers; as discussed, this is particularly true for psychologists. In light of this, Sherman and Thelen (1998) suggest that graduate programs be proactive in appropriately preparing trainees for successfully coping with inevitable distress. Education can occur in many forms such as mandatory workshops, imposing program requirements, and facilitating discussion in courses. Furthermore, informal conversation between supervisors and trainees regarding coping gives experienced practitioners the opportunity to provide practical tips.

Maintaining and communicating an attitude of importance with regard to decreasing distress in healthy ways at the start of one's career can help minimize professional impairment later in one's career (Sherman & Thelen, 1998).

Toward this effort, historically, many professions including attorneys, physicians, and nurses have offered formal colleague assistance programs. These programs originated in the early 1970s and were established to identify and aid distressed practitioners (Lalotis & Grayson, 1985). However, research indicates that psychology has not responded as well to addressing the difficulties of distressed psychologists (Lalotis & Grayson, 1985; Orr, 1997; Sherman, 1996). Surprisingly, the American Psychological Association did not begin to tackle this important issue until 1981 when the Board of Professional Affairs established an Advisory Committee on the Impaired Psychologist (Floyd, Myszka, & Orr, 1998; Kilburg, Nathan, & Thoreson, 1986; Lalotis & Grayson, 1985; Sherman, 1996). A self-help group, "Psychologists Helping Psychologists" was then formed in addition to publication of the book *Professionals in Distress: Issues, Syndromes, and Solutions in Psychology* (Kilburg et al., 1986). It was also during this time that researchers began to systematically examine resource availability for distressed psychologists. Lalotis and Grayson (1985) found that no state psychological associations reported colleague assistance programs, but eight associations were in the program development process. In 1989, the APA charged the committee with the task of developing a manual to guide state psychological associations in developing these programs (Thoreson, Miller, & Krauskopf, 1989).

In conceptualizing colleague assistance issues, focus must first be placed on pertinent areas of professional distress (Barnett & Hillard, 2001). Thoreson et al. (1989) revealed that 10% of 379 psychologists reported distress traversing a number of dimensions, including depression,

loneliness, relationship dissatisfaction, chronic physical illness, and alcohol abuse. With regard to psychologists' perceptions of their colleagues, those surveyed viewed their colleagues as distressed due to psychological problems (10%) and substance abuse difficulties (9%) (Floyd et al., 1998).

Findings from a number of studies indicate that at some time across psychologists' careers, many of them will experience significant distress (Guy, Poelstra, & Stark, 1989; Pope et al., 1987; Sherman, 1996; Sherman & Thelen, 1998). Lalotis and Grayson (1985) emphasize that by the very nature of their professions, psychologists are particularly vulnerable to impairment. The virtue of working with mental illness, conducting therapy, and meeting demanding role obligations increase the likelihood of distress and impairment (Sherman, 1996; Sherman & Thelen, 1998). While psychologists can be considered experts in assessing and treating clinical distress and impairment in others, it appears that many still fail to acknowledge and address distress in their own lives (Barnett & Hillard, 2001). As such, this may lead to psychologists causing harm to both themselves and to those whom they provide services. Moreover, the reputation of psychology and the utility of therapy may be doubted when psychology consumers work with distressed professionals (Haas & Hall, 1991; Lalotis & Grayson, 1985). Pope et al. (1987) observed that approximately 60% of 456 psychologists surveyed reported that they have worked when they felt they were too distressed to be effective. Likewise, Guy et al. (1989) observed that 74.3% of 318 psychologists surveyed reported personal distress experienced at some point over the last three years. Of those, 36.7% acknowledged that this distress negatively impacted the quality of their work, and 4.6% admitted that this distress lead to provision of unsatisfactory treatment.

The Ethical Principles of Psychologists and Code of Conduct (APA, 2002), which were enacted to protect the public from potential harm of inadequate professional practice and to ensure competent and effective services, further command attention to the matter of distress and impairment. General Standard 2.06, Personal Problems and Conflicts, advises that personal problems may hamper therapeutic effectiveness and professional competence (American Psychological Association, 2002). Thus, it is imperative that psychologists have an awareness of emerging distress or impairment (Barnett & Hillard, 2001), as it is each psychologist's ethical responsibility to seek appropriate resolve with respect to difficulties. Such actions include pursuing professional consultation, supervision, or services provided by colleague assistance programs (Haas & Hall, 1991).

Unfortunately, many psychologists who are aware of distress and possible impairment in themselves and colleagues tend not to confront the issue (Floyd, Myszka, & Orr, 1998; Good, Thoreson, & Shaughnessy, 1995). Data support this conclusion in that all state psychological associations reported the under use of their colleague assistance programs. Reflected in these data, 13% stated that no psychologists sought assistance, 60% reported between one and five psychologists sought assistance, and 27% reported between six and 25 psychologists sought assistance (Barnett & Hillard, 2001). Clearly, psychology as a profession needs to reduce stigma of seeking help for themselves and colleagues (Barnett et al., 2007).

Prior research has examined sources, relationships, and outcomes of poor psychological functioning in healthcare workers (Firth-Cozens & Payne, 1999). Orr (1997) postulated, for the issue of distress to be adequately addressed specifically by the profession of psychology, successful interventions require a centralized approach of principles, procedures, and guidelines, not restricted to a single area of the APA Practice Directorate, and must address all psychologists

including researchers, academicians, and clinicians alike. As the importance of psychologist distress and impairment continues to be emphasized, it is expected that research will inform the development and application of lucrative prevention and intervention programs (Sherman & Thelen, 1998). Distress, impairment, and improper behavior are not synonymous, but exist along a continuum as do stress, distress, and impairment (APA Board of Professional Affairs Advisory Committee on Colleague Assistance, 2005). It is not the presence of stressors or even distress that directly leads to impairment, but rather the ineffective management of stress that leads to compromised functionality (APA Board of Professional Affairs Advisory Committee on Colleague Assistance, 2005). Additional research suggests that psychological impairment is not inherent to distress or a deficiency in skills, but more precisely is an issue of not employing adequate coping resources (Coster & Schwebel, 1997). It is proposed that well-functioning can be achieved by enhancing coping mechanisms, such as self-care.

Coping Self-Efficacy

Lazarus and Folkman (1984) define coping as cognitive or behavioral efforts put forth by individuals in an attempt to manage stressors (Pisanti, Lombardo, Lucidi, Lazzari & Bertini, 2008). In line with stress and coping theory, stress is conceived as a person-environment interaction that is assessed as significant, as well as exceeding an individual's resources for coping (Lazarus & Folkman, 1984). Coping styles, according to Lazarus and Folkman, can be emotion-focused or problem-focused in nature. After the primary appraisal of stress, secondary appraisal or selection of coping strategy is then based on perceived options. This involves judgment as to whether or not the individual has perceived control over the situation outcome. As such, self-efficacy or an individual's beliefs regarding his or her own ability to perform

certain behaviors (Bandura, 1997), influences this judgment, which further impacts coping (Park & Folkman, 1997).

Self-efficacy is an element of social cognitive theory in that one's beliefs of efficacy also influence the further procurement of skills (Bandura, 1997). Thus, coping self-efficacy, or beliefs about an individual's ability to perform certain coping behaviors, influences outcomes of both learning and employing coping skills (Chesney et al., 2006). Maladaptive coping occurs when individuals use problem-focused coping to respond to stressors outside of their control or emotion-focused coping alone to respond to stressors within their control (Strentz & Auerbach, 1988; Vitaliano, DeWolfe, Maiuro, Russo, & Katon, 1990). They therefore do not succeed in reducing distress or managing problems. In this way, adaptive coping denotes a match between actual control over the stressful situation and the selection of coping strategy. When this adaptive coping is employed, individuals experience a reduction in psychological symptoms and distress as well as enhanced well-being, that does not occur when coping is maladaptive (Park, Folkman, & Bostrom, 2001).

Self-efficacy is not a general characteristic, meaning, high self-efficacy in one sphere may or may not correlate with high levels of self-efficacy in other spheres (DiClemente, 1986). Research on self-care behaviors of diabetics demonstrated self-efficacy as a fundamental variable (Glasgow & Osteen, 1992; Jenkins, 1995), associated with diet, exercise, and blood glucose testing (Williams & Bond, 2002). Self-efficacy has also been shown to predict adherence to activities that lower cardiovascular risk and myocardial infarction prevention in individuals with coronary heart disease (Jensen, Banwart, Venhaus, Popkess-Vawter, & Perkins, 1993).

Occupational stress studies reveal that the higher an individual's self-efficacy in completing a task, the more proactive and persistent coping efforts are expected (Schwarzer,

2003). Researchers have also used cross-sectional designs to examine the mediator and moderator roles of coping self-efficacy on stress and strain (e.g. Kraij, Garnefski, & Maes, 2002). Kraij et al. (2002) purported that coping self-efficacy may have direct and indirect effects on emotional well-being, as it impacts distress levels in addition to coping strategies. Respondents with higher coping self-efficacy utilized significantly more task-oriented coping and less emotion- and avoidance-oriented coping. As such, the authors suggest including measures of self-efficacy when investigating stress-coping processes.

In addition, a number of studies have suggested the likelihood of changes in coping style across the life-span, however there is still no consensus. Trouillet, Gana, Lourel, & Fort (2009) provide rationale for this dissent, noting that age has been previously misinterpreted as a coping determinant. They suggested that changes in coping resources, taking place as a result of age, have been underestimated. As such, their study demonstrated that coping resources such as self-efficacy, perceived stress, and social support actually mediate the effect of age on coping. Furthermore, with regard to life satisfaction, perceived stress was shown to be a better predictor for younger adults, while coping resource effectiveness was a better predictor for middle-aged and older adults (Hamarat, Thompson, Zabucky, Steele, Matheny, & Aysan, 2001). Collectively, these studies demonstrate an apparent relationship between perceived stress and coping across the life-span.

Self-Care

Without a doubt, psychologists encounter numerous unique challenges and stressors which put them at increased risk for distress, burnout, vicarious traumatization, and impairment (Barnett et al., 2007). Failure of psychologists to sufficiently attend to their own psychological wellness exacerbates this risk. As such, psychologists are expected to employ self-care practices

in the form of active engagement in physical, psychological, emotional, spiritual, and professional strategies and behaviors aimed at promoting and maintaining well-functioning (Meyers et al., 2012; Saakvitne & Pearlman, 1996). Research on the negative consequences of stress and its impacts to psychological functioning highlight the importance of self-care for psychologists.

Furthermore, it appears that self-care needs may change over time, making self-care a life-span issue. Evidence demonstrates that newer psychologists are exceptionally vulnerable to occupational stress (Skovholt & Ronnestad, 2003; Vander-Kolk, 1982; Vredenburgh et al., 1999). Young professional may be struggling to prove their competence. Mid-career psychologists who entered the field at a traditional age may be balancing family with demands of advancing within their career. Seasoned psychologists may experience costs of maturity, including limits to time and energy (Pingitore & Scheffler, 2005). Moreover, the benefits and gratifications of self-care can accrue over time.

Kramen-Kahn and Hansen (1998) suggest more proactive prevention efforts be implemented for both trainees and seasoned psychologists, rather than assuming they will acquire self-care skills over the career-span. No paradigm currently exists for teaching self-care other than discussion of the APA ethics code (Barnett et al., 2007). Moreover, supervisors and faculty often do not model appropriate self-care behaviors to their trainees. An important message must be communicated, that self-care is as respected as hard work and scholarly productivity (Barnett et al., 2007). A recent APA document, *Advancing Colleague Assistance in Professional Psychology* (APA Board of Professional Affairs Advisory Committee on Colleague Assistance, 2005) attempts to communicate this message by noting that a better understanding of functioning in psychologists is necessary to properly promote self-care across the career-span.

Ironically, the APA website entitled “Self-Care Across the Life Continuum” contained only a mere eight postings at the time of this research (2014).

In general, the positive image of psychologists can be portrayed as happy, healthy individuals who find satisfaction in their work. Mahoney’s (1997) study revealed that four out of five mental health professionals reported reading for leisure, participating in hobbies, taking vacations, watching movies, and attending art shows or exhibits. Three out of four practiced physical exercise. And nearly three fourths reported obtaining colleague feedback and support. Over 50% reported recreational activities, and 50% reported the use of meditation or prayer. Personal therapy, religious services, massage or chiropractic care, and personal journaling were among the less frequently endorsed forms of self-care. Similarly, Coster and Schwebel’s (1997) study asked New Jersey psychologists to rate 29 strategies in terms of the degree to which each strategy contributes to their well-functioning. The most highly rated contributors were self-awareness, values, work-life balance preservation, relationships, personal psychotherapy, and vacations. Results also uncovered gender differences, with women more highly rating strategies involving supervision, mentoring, consultation, and peer support.

In his article entitled *Psychotherapist Self-Care*, John Norcross (2000) relays a collection of recommended, research informed self-care strategies. First he emphasized the importance of acknowledging the possible perils of a career in psychology, which requires a certain level of immersion in the lives of distressed individuals. Second, given the vast availability of resources and preferences, he encourages psychologists to think in terms of strategies and goals as opposed to specific techniques. Multiple strategies can be employed from various theoretical orientations. Variation is key, as one might seek psychodynamic treatment as well as use stimulus control and counter conditioning in the everyday environment. All of this, of course, should begin with self-

awareness and monitoring of stress levels and signs of distress. Human elements such as social support need be included in psychologists' regular routines. Moreover, psychologists are encouraged to minimize self-blame and to maximize appreciation of the rewards of their careers. In the same vein, Orr (1997) set forth the conviction that psychologists must address their own vulnerabilities and fears as human beings. Without shame, psychologists must care for themselves in the ways they care for others. If they do not constructively manage stress, they will be without their basic tools, leaving them unable to give to patients, students, or clients more than they have maintained for themselves (Orr, 1997).

Conclusion

It is clear how the challenges of being a psychologist and an individual can progress from normal stress to the experience of distress, or intense stress that is not readily resolved, subsequently impacting well-being and psychological functioning. Disturbance of thinking, mood, and other health issues described earlier, are likely to impede professional functioning, and thus require preventative care across the career-span. Systematic exploration of Self-Care activities, Perceived Stress, Psychological Distress, and Coping Self-Efficacy illustrates the interconnection between these variables in the lives of psychologists across the career-span.

CHAPTER III

Method

In this chapter, the sample and procedures employed by this study are detailed. Measures utilized, as well as their psychometric properties are described. Participant recruitment and statistical design are also discussed.

Participants

Participants were drawn from a national sample of psychologists who identify as licensed, doctoral level psychologists currently working in the field of psychology.

Power Analysis

As the research questions aimed to explore the relationships between Self-Care, Perceived Stress, Psychological Distress, and Coping Self-Efficacy across the three career stages, a one-way MANOVA was conducted. A priori power analyses, as determined by G*Power 3 (Faul, Erdfelder, Lang, & Buchner, 2007) indicated a minimum of 159 participants were required, using the typical parameters of a .05 alpha, power of .80 and effect size of .25. Dependent on the results of the MANOVA, follow-up ANOVAs were also planned. The Bonferroni procedure was used to control for Type I errors across multiple ANOVAs. Pearson correlation coefficients were also calculated to further explore relationships between the variables. Exploratory analyses to determine mean sample differences between subtypes of Self-Care were also conducted.

Measures

The measures used in this study are the Coping Self-Efficacy Scale (CSE; Chesney et al., 2006), Outcome Questionnaire (OQ-45; Lambert et al., 1996, 2004), Perceived Stress Scale (PSS-14; Cohen et al., 1983), Self-Care Assessment Worksheet (SCAW; Saakvitne & Pearlman, 1996), and a demographic questionnaire including additional questions regarding self-care patterns.

Coping self-efficacy scale. The Coping Self-Efficacy Scale (CSE; Chesney et al., 2006) is a 26-item measure assessing individuals' confidence in performing coping behaviors when confronted with challenges. Participants are asked to respond to the question, "When things aren't going well for you, or when you're having problems, how confident or certain are you that you can do the following?" A 10-point scale is used to rate the extent to which participants believe they can perform different adaptive coping behaviors. Scale anchor points are 1 ('cannot do at all'), 5 ('moderately certain can do'), and 10 ('certain can do'). An overall CSE score is created by summing item ratings ($\alpha = .95$; $M=137.4$, $SD = 45.6$). (Chesney et al., 2006). Three factors contribute to the CSE scale; problem focused coping ($\alpha=.91$), stopping unpleasant thoughts or emotions ($\alpha =.91$), and social support ($\alpha =.91$) (Chesney et al., 2006). Internal consistency and test-retest reliability ($r=.4$ to $.8$) are high for all three factors (Chesney et al., 2006). Concurrent validity analyses demonstrate that these factors assess self-efficacy for different types of coping. Predictive validity analyses showed that using problem- and emotion-focused coping skills was predictive of reduced psychological distress and increased psychological well-being over time (Chesney et al., 2006).

Outcome questionnaire-45. The Outcome Questionnaire-45 (OQ-45) is a 45-item, five point Likert-type scale that was used to assess psychologists' levels of psychological distress. In general, the measure is designed to assess baseline psychological functioning across variables (e.g., internal feelings, relationship conflict, and tasks of daily living). The measure also assesses common symptoms of adult psychopathology. Lambert et al. (2004) reported the OQ-45 to have high internal consistency ($r=.93$) and three week test-retest reliability ($r=.84$). When correlated with assessments commonly used to measure psychotherapeutic outcome (e.g. Beck Depression Inventory), concurrent validity was reported at moderate to high ($r = .5$ to $.85$) (Lambert et al.,

2004). This measure has been used with various populations across settings (outpatient, inpatient, group, etc.) Three subscales of the OQ-45 measure symptom distress (SD), quality of interpersonal relations (IR), and social role functioning (SR) (Lambert et al, 1996). Subscales show a high correlation, suggesting the OQ-45 can be described by a single factor (Mueller, Lambert, & Burlingame, 1998).

Perceived stress scale-14. The Perceived Stress Scale-14 (PSS) is a psychological instrument designed to measure the degree to which situations in one's life are perceived as stressful. The 14 items are general in nature and hence relatively free of content specific to any sub-group. For example "In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?" A five point Likert –type scale is used to rate the items. The PSS is not a diagnostic tool, and thus cut-off scores have not been ascertained. Test-retest reliability is reported at .55 to .85 (Cohen et al., 1983). PSS correlations with symptomalogical measures are high (.52 to .76) (Cohen et al., 1983). Although highly correlated with depressive symptomology, the PSS is found to measure a different and independently predictive construct (Cohen et al., 1983).

Self-care assessment worksheet. The Self-Care Assessment Worksheet (SCAW) assessment tool provides a measure of frequency of engagement in effective self-care maintenance strategies (Saakvitne & Pearlman, 1996). Six dimensions of self-care are defined within the measure: physical, psychological, emotional, spiritual, workplace or professional, and balance. Each of these dimensions contains activity items which respondents rate from one to five in terms of how often he or she engages in each (1 = never occurred to me; through 5 = frequently occurs). The items listed are suggestive, not exhaustive (Saakvitne & Pearlman, 1996). For the purpose of this study, the frequency scale has been adapted to reflect more

concrete choices (i.e. “5=frequently occurs” changed to “5=frequently/several times a week”). The higher the total score, the more frequently engaged the respondent reports he or she is in self-care activities. Sample items from the Self-Care Assessment Worksheet include (a) exercise (physical), (b) have your own personal psychotherapy (psychological), (c) stay in contact with important people in your life (emotional), (d) pray (spiritual), (e) take a break during the workday (workplace or professional), and (f) strive for balance among work, family, relationships, play, and rest (balance). This measure is not meant to be a diagnostic tool, but rather provides descriptive data on the extent to which individuals engage in self-care activities. No reliability and validity data are available for this measure, as it is a behavior checklist (Saakvitne & Pearlman, 1996).

Demographic questionnaire. This questionnaire requests that participants provide basic information about age, race, and gender. Career information was also requested including location, primary practice setting (academia, counseling center, hospital, private practice, etc.), primary job function (research, psychotherapy, teaching, assessment, etc.), degree (Ph.D., Psy.D., Ed.D.), discipline (Clinical, Counseling, School, Combined), number of years in practice/career stage (early, mid, late), and theoretical orientation. Questions on the demographic questionnaire provided descriptive statistics on the participating sample. For exploratory purposes, additional questions regarding self-care behaviors included average time spent in self-care activities and factors informing and reinforcing self-care.

Procedure

Prior to data collection, approval for the study was obtained through the University’s institutional review board.

Participant recruitment. Participants were recruited nationally via email and professional internet listserv postings (e.g. APA Division 17 Society of Counseling Psychology, Division 19 Society for Military Psychology, Division 20 Adult Development and Aging, Division 38 Health Psychology, Division 54 Society of Pediatric Psychology). Requests were sent to Training Directors of APA accredited Clinical and Counseling psychology programs, as well as current members of APA, NJPA, and NYSPA. Potential participants were sent an email request describing the study and requesting they anonymously complete the four measures; Self-Care Assessment Worksheet (Appendix A), Perceived Stress Scale (Appendix B), Coping Self-Efficacy Scale (Appendix C), Outcome Questionnaire-45 (Appendix D), and demographic questionnaire (Appendix E). The email, including description of the study, recruitment letter (Appendix G), and informed consent (Appendix F) contained an active internet link to the research measures in ASSET, an online data collection tool. Subjects were able to discontinue participation at any time and had the option of contacting the principal investigator with any questions. Furthermore, they were asked to forward the email on to other potential participants to form a snowball sampling effect.

CHAPTER IV

Results

Overview

The purpose of this study was to examine Self-Care habits of psychologists across the career-span, in relation to Perceived Stress, Coping Self-Efficacy, and Psychological Distress. This chapter details descriptive statistics for the sample, as well as analyses and findings. Results largely confirmed the purported hypotheses.

Descriptive Statistics

Sample. A total of 173 individuals completed the online study measures. Inclusion criteria required eligible participants to be licensed, doctoral level psychologists currently working in the field of psychology. After an initial review of the sample, six cases were excluded from the analyses, as those participants indicated not meeting these inclusion criteria. The remaining sample consisted of 167 eligible participants who provided valid and complete information, which exceeded the requirements set by previous power analyses.

Of the eligible participants, approximately 75% were women ($n = 126$) and 25% men ($n = 41$), ranging in age from 26 to 78 years ($M = 45$, $SD = 13$). The majority of participants identified as White (89%, $n = 148$), followed by 4% as Hispanic/Latino/a ($n=7$), 3% as Asian or Pacific Islander ($n = 5$), 2% as African American/Black ($n = 3$), and 2% as “Other” ($n = 4$). Participants represented 39 of the 50 states, Canada and Puerto Rico. The most largely represented states were New Jersey ($n = 21$), New York ($n = 20$), and Pennsylvania ($n = 18$).

With regard to education, approximately 72% of participants hold a Ph.D. ($n = 120$), 25% a Psy.D. ($n = 42$), and 3% an Ed.D. ($n = 5$). Approximately 70% studied in the area of Clinical Psychology ($n = 116$), 19% in Counseling Psychology ($n = 31$), 10% in Combined programs

($n = 17$), and 2% in School Psychology ($n = 3$). In terms of participants' reported primary theoretical orientations, approximately 44% reported Cognitive Behavioral ($n = 73$), 21% as Integrative/Eclectic ($n = 35$), 14% Psychodynamic ($n = 23$), 8% as "Other" ($n=14$), 5% Humanistic/Existential ($n = 8$), 4% Family Systems ($n = 7$), 4% Interpersonal ($n = 6$), and 1% Psychoanalytic ($n = 1$).

In terms of career, approximately 45% work in a hospital as their primary setting ($n = 75$), 24% in private or group practice ($n = 40$), 18% in university or academic departments ($n = 30$), 6% in university counseling centers ($n = 10$), 6% in mental health clinics ($n = 10$), and 1% in schools ($n = 2$). Psychotherapy was reported as the highest primary work function of participants (52%, $n = 87$), followed by teaching/supervision (14%, $n = 23$), research (11%, $n = 18$), consultation (10%, $n = 17$), testing/assessment (8%, $n = 14$), and administration (5%, $n = 8$).

Career stage. Participants ranged from one year of practice post degree to 47 years of practice post-degree, with a mean of 14 years, and a mode of two years ($SD = 11.87$). Approximately 47% ($n = 78$) of participants indicated they are currently in the Early stage of their careers (1-7 years), 25% ($n = 41$) in Mid career (8-20 years), and 29% ($n = 48$) in Late career (21-47 years). Those in the Early stage range in age from 26 to 59 years, while in Mid stage they range from 38 to 61, and 48 to 78 in Late stage. The hospital work setting was most commonly reported for those in the Early stage (53%, $n = 41$), as was similar for Mid stage (59%, $n = 24$). Private/group practice was the most common work setting reported by those in Late stage (48%, $n = 23$).

Self-care. The majority of Early (56%) and Mid (68%) career psychologists reported that they spend seven or less hours per week purposefully engaged in self-care activities. Conversely,

a majority of Late career psychologists (56%) reported that they spend seven or more hours per week. Figure 1 illustrates this pattern.

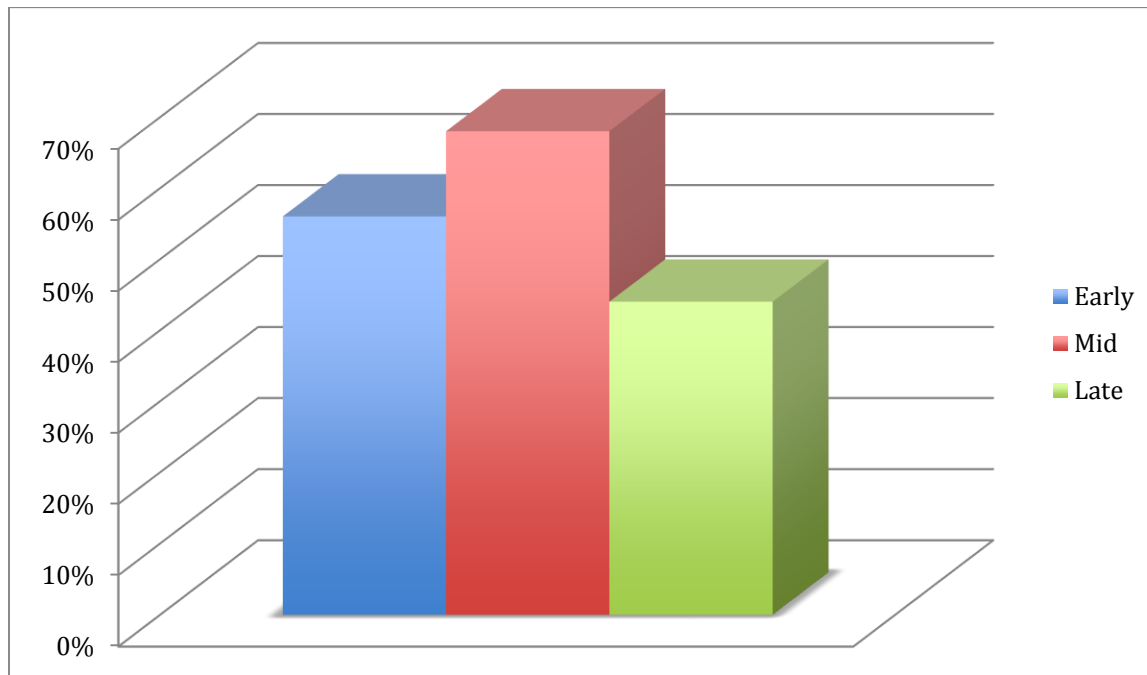


Figure 1. Participants who spend 7 hours or less per week engaged in self-care activities

On average, psychologists in all three career stages reported “eating regularly” and “eating healthy” as the types of self-care they engage in most frequently, followed by “get sufficient sleep” for Early career psychologists, “spend time with others whose company you enjoy” for Mid career psychologists, and “allow yourself to feel and express emotion” for Late career psychologists. Table 1 shows the top ten most frequently engaged self-care activities by career stage, as rated on the SCAW.

Table 1

Top ten most frequently engaged self-care activities by career stage

	Early	Mid	Late
Eat regularly (#1)	1	1	1
Eat healthy (#2)	2	2	2
Get sufficient sleep (#10)	3	6	8
Spend time with others whose company you enjoy (#23)	4	3	4
Allow yourself to feel and express emotion (#27)	5	4	3
Strive for balance among work, family, relationships, play, and rest (#45)	6	7	9
Take time to chat with co-workers (#35)	7		
Stay in contact with important people in your life (#24)	8	9	5
Strive for balance within your work life and work day (#44)	9		
Exercise (#3)	10	5	7
Identify what is meaningful to you and notice its place in your life (#32)			6
Seek medical care when needed (#5)		8	
Identify and seek out comforting activities, objects, people, or places (#26)		10	
Make quiet time to complete tasks (#36)			10

On average, psychologists across all three career stages reported “write in a journal” as the self-care activity they engage in least frequently, followed by “have your own personal psychotherapy,” and “get massages.” Table 2 shows the top ten least frequently engaged self-care activities by career stage, as reported on the SCAW.

Table 2

Top ten least frequently engaged self-care activities by career stage

	Early	Mid	Late
Write in a journal (#17)	1	1	1
Have your own personal psychotherapy (#16)	2	2	2
Get massages (#7)	3	3	3
Engage in religion/spirituality (#29)	4	7	
Pray (#30)	5	8	
Take vacations (#12)	6	10	8
Meditation (#31)	7	5	6
Take day-trips or mini vacations (#13)	8		7
Negotiate for your needs, benefits, pay, etc (#42)	9	6	4
Take time away from telephones, email, etc (#14)	10	9	10
Have a peer support group (#43)		4	5
Get regular supervision or consultation (#41)			9

Across all three career stages 68% of participants ($n = 114$) reported that their self-care practices are not regularly evaluated by themselves or any other entity. Of those who responded that their self-care activities are evaluated regularly, some provided additional information. A summary of responses is found in Table 3.

Table 3

Individual responses to personal evaluation of self-care

Always think about whether they are working and whether I need to do more or less.

Always thinking about how to do this better!

Annual personal retreat

As needed

Ask self if I feel satisfied/happy with "life/work"

Awareness of weekly exercise schedule and any changes in involvement or motivation d/t fatigue, etc.

Biannual review per mandated occupational stress program; and regular conversations with husband

Check physical and emotional health and job performance

Daily through Meditation and Ignatian spirituality practice

Discussed at work with others

Frequently check in to make sure I am doing something for myself on a daily basis. Set new self-care goals (new year's resolution is to start a journal)

Always mindful of the balance I am able to strike between my healthy self care (healthy food, exercise, sex and unhealthy (booze, drugs)

I assess where I'm doing well, where I'm getting off track, what might need to be done better, regularly

I check to see if I am doing enough self-care. When I feel more tired, less energy, or more irritable, even if a little, then I reflect on my life and my activities from that past week and make changes so the next week can be better.

I focus on living a balanced life and evaluating self-care practices on a regular basis.

I have a routine and I have adapted with age!

I have asthma, chronic pain, diabetes, HTN, and hypothyroid dz. It is critical that I focus on appropriate self-care practices. I wish you'd asked about medical aspects of self-care, too.

I often think about achieving balance in my life and focusing on what is important to me and for my future.

I review with my supervisees

I spend time daily assessing my physical, emotional, and cognitive responses to self-care activities including 60 minutes of aerobic + weight training exercise; 60 minutes of strenuous piano exercises; and 60 minutes of family prayer time following the Catholic Liturgy of the Hours tradition. I further communicate intimately each moment with the Holy Spirit regarding my progress in caring for myself in accord with keeping of the 5th Commandment: Thou Shalt Not Kill which exhorts me to take care of my own life and health.

I track my walking everyday (wear a pedometer); it is an important self-care activity.

I try to be aware of whether my de-stressing activities are actually helping to reduce my stress, if they're not, I try to switch activities.

I try to check in with myself to keep from getting burned out.

In the beginning of the semester I make plans for self care activities

Is what I am doing helpful

Just checking in with myself, or doing nice things for myself if I'm feeling stressed.

Just mental check ins with self to evaluate how well strategies are working to keep me feeling happy and stable.

Just reflecting on what I am doing and how much

Keep a log of working out/week, make time each weekend to prepare healthy meals each week.

Me, in therapy

Meet bi weekly with peer consultation group for feedback and talk regularly with wife to assure participating in sufficient self care activities.

Mental review

Not analytically, but experientially: I just do them and experience them and trust my experience to guide or correct.

Periodic discussions with friends

Personal trainer, coach

Psychologists always bring this up. Easier though to discuss than to do.

Re-evaluate my exercise routine to continue challenging myself and also decrease stress

Reflect and adjust

Self-examination and self-awareness pretty much on a daily basis

Sometimes I try to reflect on need for more

Through ongoing self-reflection

When I feel more stressed, I look back to see what self care activities I did or did not take part in this past week.

When asked what informs their self-care practices, Early (86%, $n = 67$), Mid (83%, $n = 34$), and Late (92%, $n = 44$) career psychologists all indicated Family/Friends as their top influence. Figure 2 further elaborates upon these results.

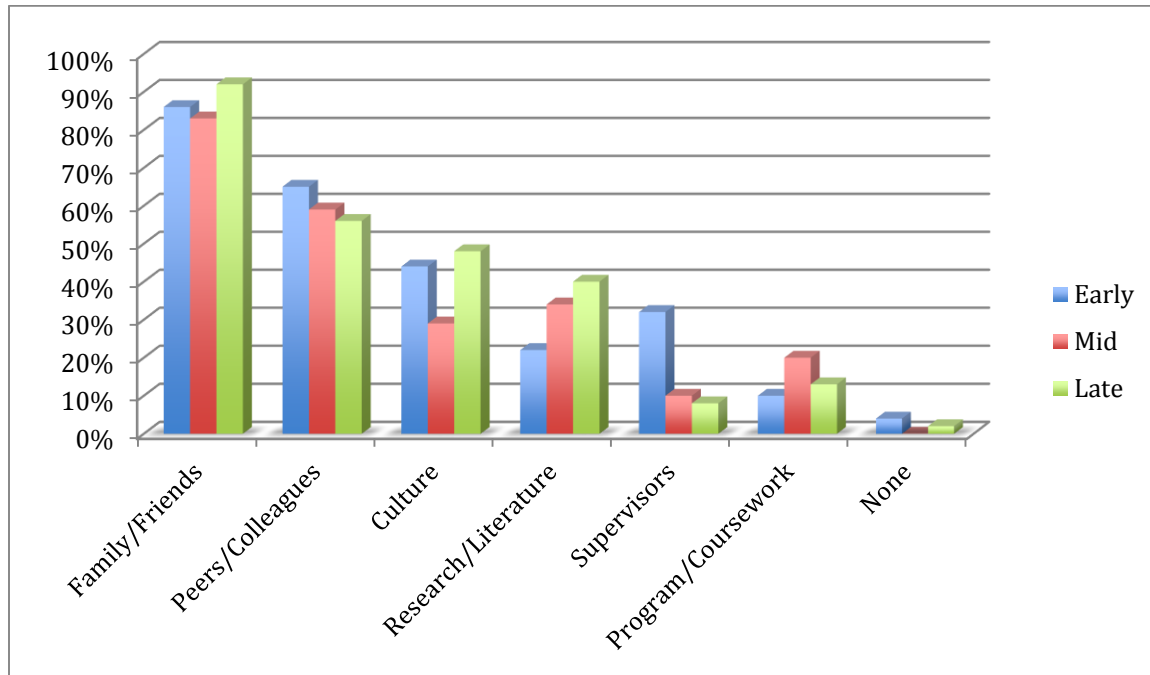


Figure 2. Entities that inform participants' self-care practices

Likewise, when asked what provides reinforcement for their self-care practices, Early (99%, $n = 77$), Mid (78%, $n = 32$), and Late (94%, $n = 45$) career psychologists all indicated Family/Friends as their greatest influence. Figure 3 displays additional responses.

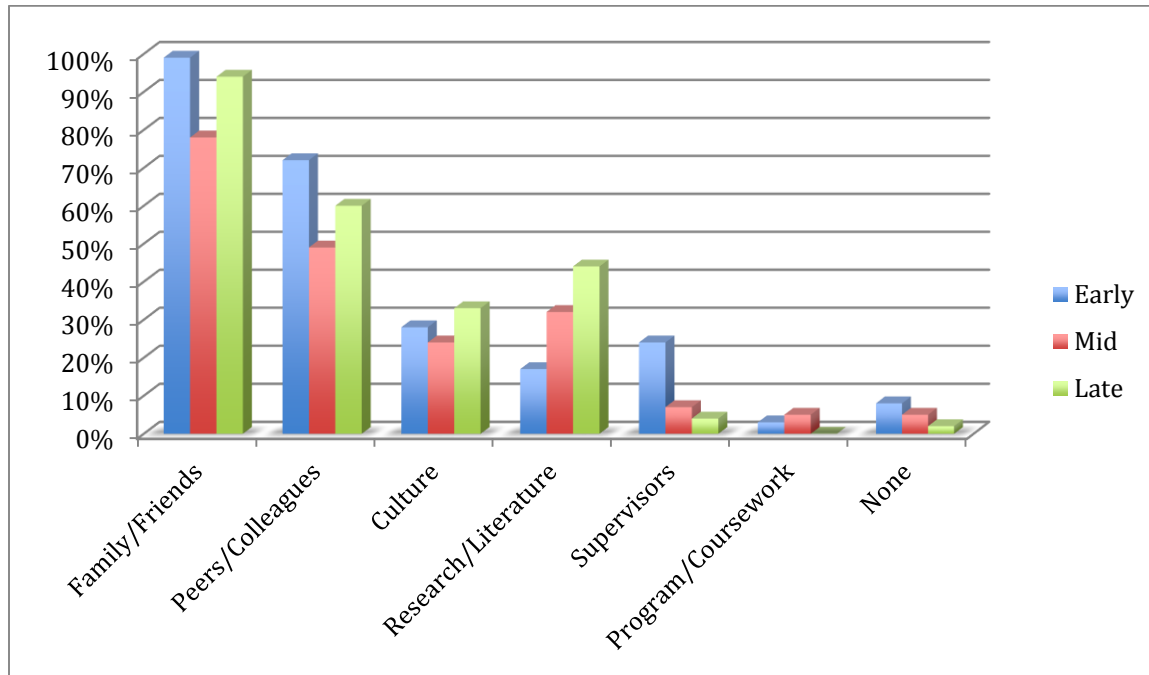


Figure 3. Entities that reinforce participant's self-care practices.

Self-Care Assessment Worksheet (SCAW) scores, used to measure frequency of engagement in self-care activities, ranged from 119 to 213, ($M = 173.04$, $SD = 16.997$). Also calculated were mean scores for the six subtypes of Self-Care on the SCAW; Physical (e.g. eat healthy), Psychological (e.g. write in a journal), Emotional (e.g. allow yourself to feel and express emotion), Spiritual (e.g. prayer), Professional (e.g. get regular supervision or consultation), and Balance (e.g. strive for balance). These differences will be addressed later in this section.

Perceived stress. PSS scores, used to measure Perceived Stress, ranged from four to 39. Given that the PSS is not a diagnostic instrument, no cut off scores are provided. The mean score for all participants was 17.89 ($SD = 7.51$). The mean score for Mid career psychologists was highest at 19.42 ($SD = 7.71$), while the mean score for Late career psychologists was lowest at 14.35 ($SD = 5.98$). A summary of descriptive statistics for all measures can be found in Table 4 at the end of this section.

Coping self-efficacy. CSE scores, used to measure Coping Self-Efficacy, ranged from 109-260. As with the PSS, the CSE is not a diagnostic instrument, but rather a self-appraisal of ability to cope with environmental demands. Therefore, no cut-off scores are provided. The mean score for all participants was 196.93 ($SD = 33.45$). The mean score for Early career psychologists was the lowest of the stages at 189.80 ($SD = 31.65$), while the mean score for Late career psychologists was highest at 211.56 ($SD = 28.26$).

Psychological distress. OQ-45 scores, used to measure Psychological Distress, ranged from three to 97. No participants endorsed critical items indicating substance abuse, suicide, or violence. Seven participants (4%) scored above 63 (range 64-97), indicating clinical significance. Clinical significance was further examined via the subscales. On the Symptom Distress subscale,

participants' scores ranged from one to 48. Three participants (2%) reported scores of 36 or higher, indicating clinical significance. On the Interpersonal Relationship subscale, 14% ($n = 24$) of participants scored 15 or higher (15-26), indicating clinical significance. Finally, on the Social Role functioning subscale, 16% ($n = 27$) of participants reported a score of 12 or higher (12-18), indicating clinical significance.

Table 4

Descriptive statistics for dependent variables

	Self-Care	Psychological Functioning	Perceived Stress	Coping Self - Efficacy
Mean	173.04	34.86	17.89	196.93
Median	173.00	33.00	17.00	199.00
Mode	173.00	25.00	15.00	181.00
SD	16.997	15.25	7.51	33.45
Observed Range	119-213	3-97	4-39	109-260
Possible Range	45-225	0-180	0-56	26-260

Analyses

Statistical analyses were conducted to examine the research questions in greater depth and test the hypotheses. This includes a focus on the relationships between career stage and Self-Care frequency, Perceived Stress levels, Psychological Distress, and Coping Self-Efficacy. Differences in subsample means, as well as directionality and strength of relationships were examined.

First, a one-way multivariate analysis of variance (MANOVA) was conducted to determine the effect of the three career stages (Early, Mid, Late) on Self-Care, Perceived Stress, Coping Self-Efficacy, and Psychological Distress. Significant differences were found among the three stages on the dependent measures, Wilks's $\Lambda = .823$, $F(8, 322) = 4.12$, $p < .001$, $\eta^2 = .093$. The multivariate $\eta^2 = .093$ indicates 9% of multivariate variance of the dependent variables is associated with career stage. Table 5 contains the means and standard deviations on the dependent variables for the three stages.

Table 5

Descriptive statistics for dependent variables by career stage

	Stage	<i>M</i>	<i>SD</i>
Self-Care	Early	168.12	15.87
	Mid	171.39	16.83
	Late	182.44	15.28
	Total	173.04	16.99
Psychological Functioning	Early	36.12	16.84
	Mid	36.61	14.15
	Late	31.31	12.97
	Total	34.86	15.25
Perceived Stress	Early	19.27	7.61
	Mid	19.42	7.71
	Late	14.35	5.98
	Total	17.89	7.51
Coping Self-Efficacy	Early	189.80	31.65
	Mid	193.37	37.53
	Late	211.56	28.26
	Total	196.93	33.45

Analyses of variance (ANOVA) on each dependent variable were conducted as follow-up tests to the MANOVA. Using the Bonferroni method, each ANOVA was tested at the .0125 level. The univariate ANOVAs for Self-Care $F(2, 164) = 12.27, p < .001, \eta^2 = .13$, Perceived Stress $F(2, 164) = 8.12, p < .001, \eta^2 = .09$, and Coping Self-Efficacy $F(2, 164) = 7.08, p < .001, \eta^2 = .08$, were statistically significant. The univariate ANOVA for psychological functioning was not statistically significant, $F(2, 164) = 1.85, p = .16, \eta^2 = .02$.

Post hoc analyses to the univariate ANOVAs for Self-Care, Perceived Stress, and Coping Self-Efficacy scores consisted of conducting pairwise comparisons. Each pairwise comparison was tested at the .0125 divided by 3 or .004 level. With regard to mean scores on the Self-Care Assessment Worksheet (See Table 5), pairwise comparisons demonstrate a significantly higher frequency of engagement in self-care activities for Late career psychologists compared to Early ($p < .001$) and Mid ($p = .004$) career psychologists. Frequency of self-care for Mid career psychologists was only slightly higher than for Early career psychologists and was not statistically significant ($p = .866$). PSS scores demonstrate a significantly lower level of perceived stress for Late career psychologists compared to Early ($p = .001$) and Mid ($p = .004$) career psychologists. Perceived stress was only slightly higher for Mid career psychologists than Early career psychologists. This difference was also not statistically significant ($p = 1$). Pairwise comparisons for CSE scores demonstrate a significantly higher level of coping self-efficacy for Late career psychologists compared to Early career psychologists ($p = .001$). Pairwise comparisons indicated results that were not statistically significant for coping self-efficacy levels of Mid career psychologists which were only slightly higher than Early ($p = 1$) career psychologists, and slightly lower than Late ($p = .027$) career psychologists.

While Psychological Distress levels appeared highest for Mid career psychologists, no significant differences were found compared to Early ($p=1$) and Late ($p=.259$) career psychologists. Figure 4 demonstrates these distributions.

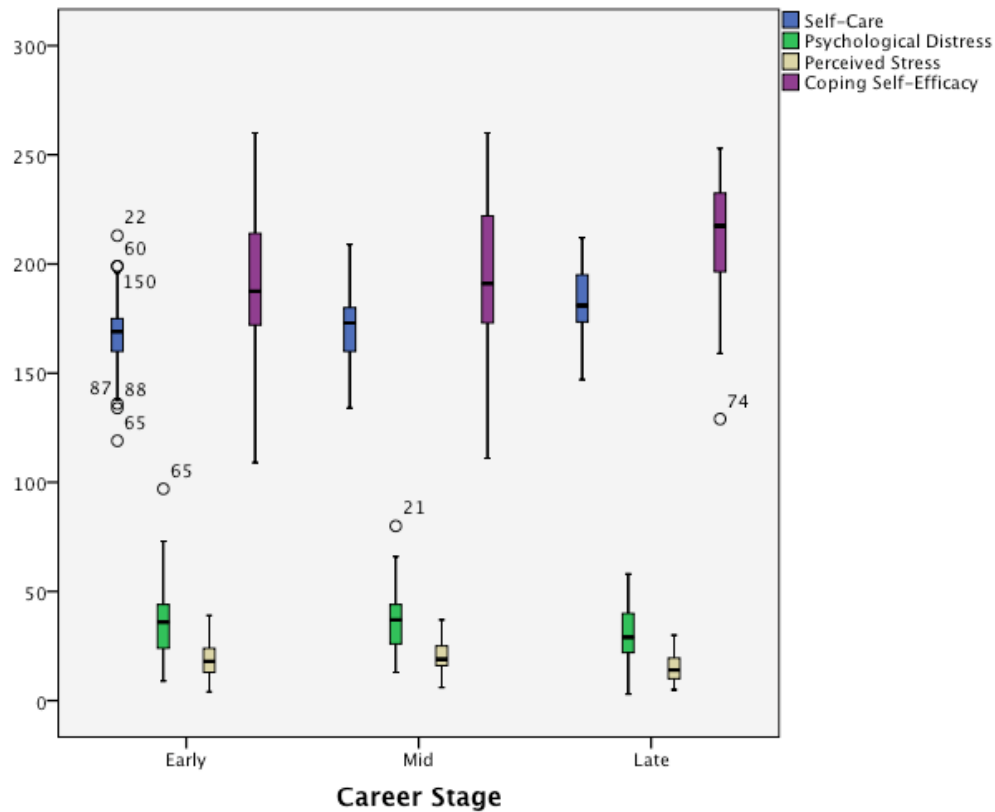


Figure 4. Distributions of variable scores by career stage

Further, Pearson correlation coefficients were computed among the five variables. Using the Bonferroni approach to control for Type I error across the 10 correlations, a p value of less than .005 ($.05 / 10 = .005$) was required for significance. The results of the correlational analyses presented in Table 6 show that nine of the 10 correlations were statistically significant, seven of the nine being greater than .35.

Table 6

Pearson Correlations of Variables

	Self-Care	Psychological Distress	Perceived Stress	Years in Practice
Psychological Distress	-.496**			
Perceived Stress	-.575**	.770**		
Years in Practice	.418**	-.135	-.276**	
Coping Self- Efficacy	.605**	-.641**	-.669**	.284**

** . Correlation is significant at the $<.001$ level (2-tailed).

Results demonstrate significant positive correlations between perceived stress and psychological distress $r(165) = .770, p < .001$, as well as frequency of engagement in self-care activities and coping self-efficacy $r(165) = .605, p < .001$. Significant negative correlations were found between coping self-efficacy and psychological distress $r(165) = -.641, p < .001$, frequency of engagement in self-care activities and perceived stress $r(165) = -.575, p < .001$, frequency of self-care activities and psychological distress $r(165) = -.496, p < .001$, and perceived stress and coping self-efficacy $r(165) = -.669, p < .001$. Significant but weaker correlations were found with regard to number of years in practice, which was found to be

positively correlated with frequency of self-care activities $r(165) = .418, p < .001$ and coping self-efficacy $r(165) = .284, p < .001$, but negatively correlated with perceived stress $r(165) = -.276, p < .001$. No significant correlation was found between years in practice and psychological distress $r(165) = -.135$.

Next, to examine differences in patterns of Self-Care (type and frequency) across the career-span, a one-way multivariate analysis of variance (MANOVA) was conducted to determine the effect of the three career stages (Early, Mid, Late) on the six sub-types of Self-Care on the SCAW. As evaluated by Box's Test, results of the test for homogeneity of dispersion matrices was not significant $F(42, 51316) = .96, p = .545$. On the dependent variable subscale measures, significant differences were found among the three career stages, Wilks's $\Lambda = .765, F(12, 318) = 3.799, p < .001$. The multivariate $\eta^2 = .125$ indicates 12.5% of multivariate variance of the dependent variables is associated with career stage. Table 7 contains the means and standard deviations of the SCAW Self-Care sub-types for the three stages.

Table 7

Descriptive statistics for SCAW self-care sub-types

	Stage	<i>M</i>	<i>SD</i>
Physical Self-Care	Early	53.64	5.08
	Mid	55.15	6.26
	Late	56.69	4.79
	Total	54.89	5.44
Psychological Self-Care	Early	26.81	3.71
	Mid	27.95	4.25
	Late	30.19	3.82
	Total	28.06	4.11
Emotional Self-Care	Early	21.01	2.46
	Mid	20.95	2.78
	Late	22.39	2.29
	Total	21.39	2.56
Spiritual Self-Care	Early	20.08	3.97
	Mid	21.61	3.36
	Late	23.92	3.98
	Total	21.56	4.14
Professional Self-Care	Early	38.04	4.54
	Mid	37.34	4.33
	Late	40.39	4.97
	Total	38.54	4.75
Balance Self-Care	Early	8.54	1.22
	Mid	8.39	1.55
	Late	8.85	1.29
	Total	8.59	1.33

Analyses of variances (ANOVA) for each subscale were conducted as follow-up tests to the MANOVA. Each ANOVA was tested at the .008 level. The univariate ANOVAs for Physical Self-Care $F(2, 164) = 4.95, p = .008, \eta^2 = .057$, Psychological Self-Care $F(2, 164) = 11.30, p < .001, \eta^2 = .121$, Emotional Self-Care $F(2, 164) = 5.43, p = .005, \eta^2 = .062$, Spiritual Self-Care $F(2, 164) = 14.89, p < .001, \eta^2 = .154$, and Professional Self-Care $F(2, 164) = 5.72, p = .004, \eta^2 = .065$, were significant. The univariate ANOVA for the general Striving for Balance Self-Care sub-type was not significant, $F(2, 164) = 1.47, p = .232, \eta^2 = .018$.

Post hoc analyses to the univariate ANOVAs for the five significant subscale scores consisted of conducting pairwise comparisons. Each pairwise comparison was tested at the .008 level using the LSD method for control of Type I error for pairwise comparison among three groups. With regard to mean scores on the Physical Self-Care subscale (See Table 7), pairwise comparisons demonstrate a significantly higher frequency of engagement in Physical Self-Care activities for Late career psychologists compared to Early career psychologists ($p = .002$), but not Mid career psychologists ($p = .175$). No significant difference was found between Early and Mid career psychologists ($p = .144$). Frequency of Psychological Self-Care was significantly higher for Late career psychologists than Early ($p < .001$) and Mid career psychologists ($p = .007$). No significant difference was found between Early and Mid career psychologists ($p = .128$). Frequency of Emotional Self-Care for Late career Psychologists was significantly higher than both Early ($p = .003$) and Mid career ($p = .007$). While Mid career psychologists scored lower on average than Early career psychologists, no significant difference was found ($p = .898$). Frequency of Spiritual Self-Care was significantly higher for Late career psychologists compared to both Early ($p < .001$) and Mid career ($p = .005$). No significant difference was found between Early and Mid career psychologists ($p = .040$). Frequency of Professional Self-Care was

significantly higher for Late career psychologists than Early ($p = .006$) and Mid ($p = .002$) career.

While Mid career psychologists scored lower on average than Early career psychologists, no significant difference was found ($p = .564$). Figure 5 displays these distributions.

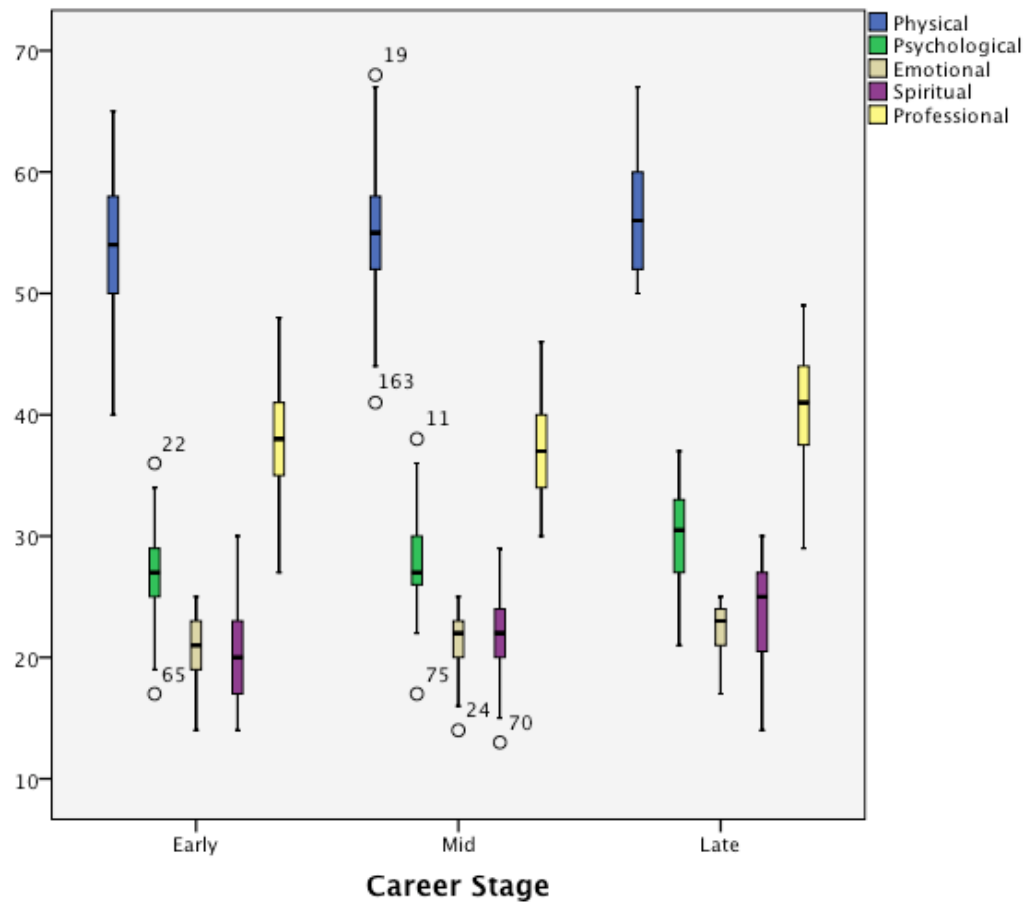


Figure 5. Distributions of self-care subtype scores by career stage

CHAPTER V

Discussion

Overview

Here, findings of this study will be discussed in the context of existing literature on stress and coping theory and the stress-distress continuum. Results will be interpreted in terms of the research questions, hypotheses, and methodological limitations. Suggestions for future research will also be presented.

Interpretation

The initial inquiry that guided this investigation sought to explore the extent to which Early, Mid, and Late career psychologists engage in self-care activities (frequency and type). Further examination was aimed at establishing the relationships between career stage and Self-Care frequency, Perceived Stress levels, Psychological Distress, and Coping Self-Efficacy. As no prior research has examined these factors collectively, hypotheses were based on findings and positions taken separately from the extant literature in these areas. Based on the premise that practice demands and stressors change over time, the frequency and type of Self-Care activities in which Early, Mid, and Late career psychologists engage was expected to also vary across the career-span. Results largely confirmed this. However, similarities were still found with regard to specific Self-Care activities practiced by psychologists of all three career stages. Relevant findings indicated differences between sample mean scores on measures of Self-Care, Perceived Stress, and Coping Self-Efficacy across the career-span, as well as significant correlations between the variables. Interestingly, Psychological Distress did not vary significantly across the career-stages. These results are evaluated more in depth with regard to theory and previous research.

Results support the hypothesis that there are differences in Self-Care practices throughout the career-span, with frequency tending to increase From Early career to Late career. Moreover, within the six subtypes of Self-Care, Late career psychologists engage in Psychological, Emotional, Spiritual, and Professional activities significantly more frequently than Early or Mid career psychologists. In addition, Late career psychologists engage in Physical Self-Care more frequently than Early, but not Mid career psychologists. However, across the career -span no significant differences were found in the perceived strive for balance. While there were differences between overall subtypes, all three career stages shared seven out of 10 of their top rated activities in common (See Table 1). Likewise, they also shared in common six of their top 10 least rated activities (See Table 2). Similar to Mahoney's (1997) study, personal therapy, religious engagement, massage, and journaling were among the least frequently endorsed forms of self-care for participants in the present study. In another similarity across stages, the majority of psychologists reported that their self-care practices are not formally evaluated. Those that reported their self-care activities are regularly evaluated, did not indicate formal, research based processes of assessment or outcome, but rather anecdotal reflections and conversation. Furthermore, the majority of psychologists across all stages indicated that family and friends are the greatest informers and reinforcers of their self-care. In a field based on assessment and evidence-based practices, it is curious that such skills are not being employed in this area.

As Self-Care was observed to increase with number of years in practice, so was Coping-Self Efficacy. Conversely, lower Perceived Stress levels were observed with more years in practice. Late career psychologists scored significantly lower on Perceived Stress and higher on Self-Care frequency and Coping Self-Efficacy than Early or Mid career psychologists. This finding corroborates the research of Osipow et al. (1981), in which the Late career group,

consisting of the largest number of older workers, less strain, which the authors attributed to greater use of self-care and recreational coping skills learned throughout their careers. Likewise, Lindstrom's (2011) work supports that the moderating effect of career stage demonstrates differences between job characteristics and well-being as varying from one period to another.

In general, psychologist Coping Self-Efficacy also tended to increase with frequency of Self-Care activities. This was similarly demonstrated by previous research regarding coping self-efficacy and adherence to health behaviors (e.g., Jensen et al., 1993). Also corroborated is Schwarzer's (2003) work demonstrating that higher self-efficacy is related to more proactive and persistent coping. Additionally, results of the current study indicate that as Self-Care frequency and Coping-Self Efficacy increase, Perceived Stress levels tend to decrease from Early career to Late career. This result is in line with Lindstrom's (2011) meta-analysis, indicating that more effective coping contributes to a decrease in stress symptoms for late career individuals. Similarly, Cohen et al. (1983) demonstrated that perceived stress has a direct relationship to coping. Thus if coping mechanisms are deemed sufficient to handle perceived stress, adequate psychological functioning is expected to follow suit. Supporting this idea, the current study found a strong positive correlation between Perceived Stress and Psychological Distress.

As previously mentioned, research on psychological functioning of psychologists has demonstrated mixed results. The literature, however, does not contest the risk and existence of distress for psychologists (Guy et al., 1989; Pope et al., 1987). Thoreson et al. (1989) found that 10% of their sample ($n = 379$) reported distress traversing a number of dimensions, including depression, loneliness, relationship dissatisfaction, chronic physical illness, and alcohol abuse. Similarly, in the present study, between 4% and 16% of participants reported distress of clinical significance on the OQ-45 or its subscales. Five of the seven psychologists who reported

clinically significant overall scores on the OQ-45 are in the Early stage of their careers. The most common disorders affecting those with clinically significant scores on the OQ-45 included anxiety, affective disorders, adjustment disorders, and stress related illness (Chesney et al., 2006). Likewise, scores on the Symptom Distress subscale correlate highly with measures of depression (e.g., the BDI) and anxiety (e.g., the State-Trait Anxiety Inventory). All three of the psychologists who reported scores in the clinical significance range on this subscale were also in their Early careers. Scores within the clinical range on the Social Role subscale connote difficulty, conflict, or perceived inefficiency with social roles (e.g. worker, spouse, student). Of the 16% ($n = 27$) that scored within the clinical range, the majority are in their Early career ($n = 16$). The Interpersonal Relationship subscale assesses loneliness, conflicts with others, and family and marriage problems. Of the 14% ($n = 24$) scoring in the clinical range, the majority were also in their Early career ($n = 14$). Results show that more Early career psychologists reported scores in the clinical range than did Mid or Late career psychologists, however Mid career psychologists reported higher scores on average (below clinical significance). Yet, there was no statistically significant difference between groups on Psychological Distress scores.

According to Pingitore and Scheffler (2005), newer psychologists tend to work in public institutions and move later in their careers to independent practice, with different types of patients, payment sources, and treatment modalities. This was true for the current study, as the majority of Early and Mid career psychologists reported working in institutional settings (e.g. hospitals) while Late career psychologists reported working in private or group practice. Similarly, Hurrell and Lindstrom (1992) suggest higher degrees of psychosomatic symptoms reported by mid-career managers, as opposed to early or late-career, as a function of higher workloads and job demands. The phenomenon of “Mid-Late Career Overload,” in which

professionals become strained and overextended (Sanders et al., 2010), did not seem present within this sample. While it might be expected that Mid career psychologists would experience more stressors due to work and life demands, they may also perceive them as less stressful and cope with them better through increased self-care. This may reflect the result in higher overall scores that do not reach clinical distress levels.

Again, while it seems there is a pattern of newer psychologists reporting clinical distress at a higher rate, no significant relationship was found between Psychological Distress and career stage. As number of years in practice increase, Self-Care and Coping Self-Efficacy tend to increase, while Perceived Stress tends to decrease. Therefore, it would be expected that Psychological Distress would also decrease the longer one is in practice, due to the negative relation of the variables. However, this hypothesis was not supported in the current findings.

A more in depth examination in this area is suggested, as statistical hypothesis testing may not necessarily establish the clinical significance of these results. It is possible that levels of Psychological Distress stay stable throughout the career span due to sufficient coping and self-care, but it is curious that the majority of psychologists experiencing symptoms of clinical concern are in their Early career stage. Thus, it does not appear that the values of statistical significance alone convey the complete picture of the differences between groups. It is possible that a different working definition of distress might bring about a more statistically significant result with regard to changes over the career-span (e.g. depression, burnout, compassion fatigue, etc.). Furthermore, the stigma associated with admitting distress and the aforementioned “conspiracy of silence” (Pope, 1994), should be acknowledged, as underreporting of symptoms is likely.

There is a clear need for further research on psychologist self-care with an emphasis stress and coping theory, as well as on the importance of the stress-distress continuum. If promotion of self-care practice at the training level is thought to form a foundation for career-long efforts (Elman et al., 2005), the guidance of research is essential in establishing effective self-care programs to maintain wellness over the career-span.

Implications and Future Research

The current study underlines the need for psychology to increase its research focus on self-care to create evidence-based standards of practice, including assessment of competency and outcomes. Theoretically, this can reduce the effects of perceived stress and enhance coping self-efficacy. Previous literature demonstrates that the field of psychology has a long-standing history of difficulty addressing issues of distress and impairment in psychologists, insofar as imposing ethical and legal mandates to protect the public. As attention toward assessment of professional competencies and evidence-based practices continues to gain strength, it would benefit the field and those it serves, to approach this issue in the same way. In order to appropriately and effectively aid distressed or impaired professionals, the nature and prevalence of the problem need to first be assessed within a universally accepted working definition of the terms. Early focus was placed on negative terms such as “wounded healer” (Sherman, 1996), and called upon professionals to present themselves for treatment for serious issues such as substance abuse. Research has focused on depression, life stressors, burnout, and boundary violations. Thereby establishing that there is undoubted need and rationale for effective colleague assistance. However, it has been purported that professionals may ignore signs of stress or distress in themselves and others as a sign of respect for rights of privacy and autonomy, to prevent further burden, to protect public image, or for fear of legalities, conflict, embarrassment, shame, or

criticism (Brady, Guy & Norcross, 1995; Guy, 1987; VandenBos & Duthie, 1986). With efforts focused on such negative factors, it is clear why individuals do not want to fully engage this issue. Perhaps a shift of focus toward strengths, resilience, and capacities that foster recovery (Bonanno, 2004; Kelley, 2005), might prove more fruitful in engaging psychologists in the prevention of distress. Such a shift toward positivity could further promote self-care practices in terms of wellness, and normalizing life stress for psychologists.

Both interest and frustration have been expressed in addressing this need. Extreme underuse and under availability of colleague assistance are evident (Barnett & Hilliard, 2001). While there are logistical concerns regarding economic and human resources for service delivery, additional concern surrounds the lack of models and/or clear strategic alternatives for interventions at various levels of need for psychologists (e.g., prevention vs. severe and harmful impairment) (ACCA, 2003). The field, as a whole, needs to take an active role in encouraging wellness in its own psychologists. Be it through the proactivity of training and continuing education opportunities, or research and literature, raising consciousness about the effects of prevention efforts (e.g., self-care) on the stress-distress continuum is essential. It is possible that crises, practice indiscretions, and disciplinary action can decrease if the roles of positive factors such as self-care and coping self-efficacy were more clearly understood, and further empirically supported preventative measures were put into place. One effort toward normalizing and managing stress might be maintaining strong personal and professional support systems, as Orlinsky and Ronnestad (2005) found these strategies to be integral to effective practice.

Wellness would be better supported and maintained if professional psychology fostered a culture shift in which the assessment and practice of self-care are more concretely supported through research. Competence, as referring to the consistent and judicious integration and

application of discrete knowledge, skills, and attitudes (Epstein & Hundert, 2002), has been an increasing focus for training and regulatory bodies in professional psychology. The Competency Benchmarks for Professional Psychology (Fouad et al., 2009) were a breakthrough development in this movement. Based on the Cube model set forth by Rodolfa and colleagues (2005) and incorporating the work of the 2002 Competencies Conference (Kaslow et al., 2004), foundational and functional competency components and behavioral anchors were laid out for three levels of professional development. Included are important tenets of professional psychology that have historically been insufficiently addressed in training, such as reflection and awareness of the need for self-care (Donovan & Ponce, 2009).

Self-care has been formally established as a foundational competency of professionalism within these Benchmarks. However, as has been set forth in the present research, empirically derived processes to operationalize and evaluate self-care are still needed (Donovan & Ponce, 2009). Kaslow et al. (2009) structured the Competency Assessment Toolkit for Professional Psychology with the aim of promoting use of measurements from multiple informants across the career-span in various practice settings (Schulte & Daly, 2009). Left undefined, addressing self-care competency can lead to uneasiness and hesitance among faculty, supervisors, and colleagues when they must confront inadequacies, because standards have not been clearly communicated and assessed (Donovan & Ponce, 2009). A competency-based model ideally creates transparent and explicit requirements for a shared understanding of expectations across the career-span. Proper measurement and documented progress of self-care and related outcomes would create a clear record of strengths and limitations should grievances need to be pursued (Gilfoyle, 2008). Still, much remains undone, and requires continued and collaborative efforts within the profession's research and practice domains (Schulte & Daly, 2009).

Previously, greater focus has been on training and education, however self-care is a competency that requires adjustment and flexibility across the career-span in conjunction with life changes. As such, it is necessary to understand the predictable course of lifelong professional development and how competencies evolve over the career-span (Goldfried, 2001; Orlinsky & Ronnestad, 2005), including post-licensure education and life experiences that foster or hinder competency maintenance (McCutcheon, 2009). More specifically, support of this endeavor is directly in line with the values of Counseling Psychology. As a specialty, Counseling Psychology emphasizes optimal functioning across the life-span with regard to emotional, social, vocational, educational, health-related, and developmental concerns (APA, 2014). The issue of competence in psychologist self-care across the career-span touches all of these domains. Commitment to the joining of research and practice further reinforces the role of Counseling Psychology in this pursuit. A strength-based, developmental perspective in attaining these goals is emphasized, as lives, careers, and needs change over time. Self-care, stress, and coping could be further normalized if open discussion of stressors and evidence-based preventative practices could take place regularly in various settings, targeted appropriately for psychologists in different stages of their careers. Training programs highlight the value of assessment, intervention, and research, and should further utilize these skills to adequately address these issues in didactics, discussion, and practice. The term self-care is frequently spoken, but in a broad, almost elusive sense, that does not include specifics or sufficient modeling. Social learning theory would surely support self-care modalities based in developmental modeling. Kramen-Kahn and Hansen (1998) suggest more proactive prevention efforts be implemented for both trainees and seasoned psychologists, rather than assuming they will acquire self-care skills over the career-span. No paradigm currently exists for teaching self-care other than discussion of

the APA ethics code (Barnett et al., 2007). Moreover, supervisors and faculty often do not model appropriate self-care behaviors to their trainees. An important message must be communicated, that self-care is as respected as hard work and scholarly productivity (Barnett et al., 2007).

Further research is needed to guide this endeavor.

A majority of individuals experience major life changes and stressful work conditions throughout the course of their careers; as discussed, this is particularly true for psychologists. While much research has been done with regard to stress and coping in various populations, psychologists are a unique group and therefore require a deeper understanding within these areas as they pertain to psychologists' personal and professional roles. The factors of Perceived Stress, Coping-Self-Efficacy, Self-Care, and Psychological Distress are strongly correlated, and demonstrate a number of differences and similarities over the career-span. Many questions still remain. It would be interesting to examine these factors longitudinally, or to replicate this study in seven years with a new group of ECPs. This could help ascertain at what point these factors actually increase or decrease and why. Future research can also determine further patterns with regard to gender, age, ethnicity, work setting, and theoretical orientation. A closer look at different variables might help determine any shared characteristics of those that acknowledged experiencing distress, and how to target this sub group. Many participants indicated family, friends, and culture as informing and reinforcing their self-care. It would be worthwhile to examine these trends, as understanding these supports can possibly lead to further ecologically valid interventions. Future research can also establish sensitive ways for colleagues to approach one another about this issue without being critical or punitive. In sum, psychologists are taught the value of empirically based treatments for their clients. This attitude should be shared with regard to their own self-care. The same questions need to be answered... What was the

intervention? How did it work? Who might it work for? Who might it not work for? How frequently should it be done and for how long? And finally, what is the evidence for its continued use?

Limitations

Data has been interpreted in light of the methodological limitations of this study. First, the cross-sectional design may confound age and cohort effects. Varying frames of reference can influence variables across the three groups. Furthermore, measures used may have elicited responses from different time periods in participants' histories. Although results can speak to stage differences between the variables of interest, they cannot inform how they change with increasing career experience. Also, the present design cannot demonstrate causality, or other dynamic reciprocal relationships and interactions. It remains unclear whether results reflect stable characteristics (high-stress person vs. low-stress person) or the context in which participants were assessed (high-stress time vs. low-stress time), or both. A longitudinal design might better address these issues. In addition, detailed interviews or clinical case studies may provide for a better description of how professional practice and self-care are shaped across the life-span, including involvement in professional groups, or the ratio of how many hours are worked compared to how many hours are spent in active self-care over time, in conjunction with work related and personal life stressors. From this research, it cannot be concluded that coping strategies and self-care at one point in time predict future psychological functioning or distress. Further variations may exist in terms of chronic and acute stressors. As such, the role of time in the stress process would need to be examined at a deeper level.

Furthermore, it is important to note that limitations of this research also stem from the online, self-report method of data collection. Assessing Self-Care, Perceived Stress,

Psychological Functioning, and Coping Self-Efficacy by self-report (in the same order) could lead to artifacts such as priming and consistency effects associated with the bias of common method variance. As such, correlations between variables could be inflated. Findings need to be replicated in future studies using objective measures of stress, functioning, and self-care (e.g. cortisol levels, evaluation by another professional, etc.). Examining both the role of cognitive appraisal, as well as effects on objective measures, would further support the conclusions of this study.

In addition, the electronic nature of the sampling increases opportunity for error and uncertainty. While the target sample was reached, the response rate remains largely unknown. Participants were not randomly assigned, but self-selected. They also self-selected to forward the request on to their colleagues, or not. Psychologists may have chosen to participate based on a number of different factors such as time constraints, social roles, willingness to disclose, perceived value of the research, inclination to use technology, or level of activity within psychological organizations. As such, it is noteworthy that a little less than half the sample fell into the Early career category. Additionally, despite, anonymity, self-report methods may also result in social desirability responding, such as underreporting of distress and impairment. Psychologists may have been deterred from disclosure of personal difficulties. This suspicion is even more likely given the previous research that a majority of psychologists do not seek assistance or use resources when necessary. This sample counts for a small percentage of the greater population, including mostly white women, and these biases may further weaken generalizability.

Conclusion

In spite of expected limitations, the present study gives credence to the need for more

research on the topic of self-care and related variables. While previous literature is compelling, it is surprisingly minimal. Much of what has been published is anecdotal and suggestive in nature, rather than founded in empirical research.

Just as theoretical orientation is woven throughout the different areas of psychological practice, so should the concept of self-care. If stress is normalized as a part of life that changes over time, then psychologists might feel they have permission to discuss problems and implement self-care and prevention strategies sooner or more frequently. Just as clients are asked to participate in treatment planning, it would be novel for psychologists to implement and track their own wellness and self-care plans based on assessment and research. Moving beyond a distress orientation and toward a wellness orientation, where psychologists are developmentally informed and reinforced from the training years on, is a necessary change.

Understanding its imperative role, self-care and related variables should be assessed as any other competency. Given the changing landscape of professional psychology, it is especially important to understand the relationships between these factors over time, as this may inform more effective well-functioning strategies that are sensitive to evolving demands and resources. As the field moves toward a focus on competencies, the zeitgeist may be prime for introducing these changes (Nelson, 2007). It is clear that research needs to support a systematic effort to establish a culture that places sincere value on self-care as evidenced by standards and assessment across the career-span.

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APPENDIX A

Self-Care Assessment Worksheet

This assessment tool provides an overview of effective strategies to maintain self-care. Using the scale below, rate the following areas in terms of frequency:

5 = Frequently/Several times a week

4 = Occasionally/Several times a month

3 = Rarely/Less than once a month

2 = Never

1 = It never occurred to me

Physical Self-Care

Eat regularly (e.g. breakfast, lunch and dinner)

Eat healthy

Exercise

Get preventative medical care

Seek medical care when needed

Take time off when needed

Get massages

Engage in physical activity that you consider fun (dance, swim, walk, run, playsports)

Sex/intimacy

Get sufficient sleep

Contribute to your appearance

Take vacations

Take day trips or mini-vacations

Take time away from telephones, email, etc.

Psychological Self-Care

Take time for self-reflection (thoughts, judgments, beliefs, attitudes, and feelings)

Have your own personal psychotherapy

Write in a journal

Read literature that is unrelated to work

Actively decrease stress in your life

Engage your intelligence in areas outside of psychology

Allow yourself to receive from others

Say “no” to extra responsibilities sometimes

Emotional Self-Care

Spend time with others whose company you enjoy

Stay in contact with important people in your life

Give yourself affirmations/praise

Identify and seek out comforting activities, objects, people, or places

Allow yourself to feel and express emotion

Spiritual Self-Care

Spend time with nature

Engage in religion/spirituality

Meditate

Pray

Identify what is meaningful to you and notice its place in your life

___ Contribute to causes in which you believe (social advocacy, letters, donations, etc)

Workplace or Professional Self-Care

___ Take a break during the workday (e.g. lunch)

___ Take time to chat with co-workers

___ Make quiet time to complete tasks

___ Identify projects or tasks that are exciting and rewarding

___ Set limits with your clients and colleagues

___ Balance your caseload so that no one day or part of a day is “too much”

___ Arrange your work space so it is comfortable and comforting

___ Get regular supervision or consultation

___ Negotiate for your needs (benefits, pay raise, etc.)

___ Have a peer support group

Balance

___ Strive for balance within your work-life and workday

___ Strive for balance among work, family, relationships, play, and rest

APPENDIX B

Perceived Stress Scale - 14

INSTRUCTIONS:

The questions in this scale ask you about your feelings and thoughts during **THE LAST MONTH**. In each case, you will be asked to indicate your response by placing an "X" over the circle representing **HOW OFTEN** you felt or thought a certain way (Never, Almost Never, Sometimes, Fairly Often, Very Often). Although some of the questions are similar, there are differences between them and you should treat each one as a separate question. The best approach is to answer fairly quickly. That is, don't try to count up the number of times you felt a particular way, but rather indicate the alternative that seems like a reasonable estimate.

1. In the last month, how often have you been upset because of something that happened unexpectedly?
2. In the last month, how often have you felt that you were unable to control the important things in your life?
3. In the last month, how often have you felt nervous and "stressed"?
4. In the last month, how often have you felt that you were effectively coping with important changes that were occurring in your life?
5. In the last month, how often have you felt confident about your ability to handle your personal problems?
6. In the last month, how often have you felt that things were going your way?
7. In the last month, how often have you found that you could not cope with all the things that you had to do?
8. In the last month, how often have you been able to control irritations in your life?
9. In the last month, how often have you felt that you were on top of things?
10. In the last month, how often have you dealt successfully with day to day problems and annoyances?
11. In the last month, how often have you been angered because of things that happened that were outside of your control?

12. In the last month, how often have you found yourself thinking about things that you have to accomplish?
13. In the last month, how often have you been able to control the way you spend your time?
14. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

APPENDIX C

Coping Self-Efficacy Scale

When things aren't going well for you, or when you're having problems, how confident or certain are you that you can do the following:

Cannot Moderately Certain

1 2 3 4 5 6 7 8 9 10

For each of the following items, write a number from 1 - 10, using the scale above.

When things aren't going well for you, how confident are you that you can:

1. Keep from getting down in the dumps.
2. Talk positively to yourself.
3. Sort out what can be changed, and what can not be changed.
4. Get emotional support from friends and family.
5. Find solutions to your most difficult problems.
6. Break an upsetting problem down into smaller parts.
7. Leave options open when things get stressful.
8. Make a plan of action and follow it when confronted with a problem.
9. Develop new hobbies or recreations.
10. Take your mind off unpleasant thoughts.
11. Look for something good in a negative situation.
12. Keep from feeling sad.
13. See things from the other person's point of view during a heated argument.
14. Try other solutions to your problems if your first solutions don't work.
15. Stop yourself from being upset by unpleasant thoughts.
16. Make new friends.
17. Get friends to help you with the things you need.
18. Do something positive for yourself when you are feeling discouraged.
19. Make unpleasant thoughts go away.
20. Think about one part of the problem at a time.
21. Visualize a pleasant activity or place.
22. Keep yourself from feeling lonely.
23. Pray or meditate.
24. Get emotional support from community organizations or resources.
25. Stand your ground and fight for what you want.
26. Resist the impulse to act hastily when under pressure.

Chesney MA, Neilands TB, Chambers DB, Taylor JM, Folkman S. A validity and reliability study of the coping self-efficacy scale. *Br J Health Psychol* 2006 Sep; 11(3): 421-37.

<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1602207>. We appreciate copies of manuscripts or conference presentations generated from the use of this scale to help us stay current with its use and to assess its validity and reliability in other populations. Please address correspondence to Margaret A. Chesney, PhD, Deputy Director, National Center for Complementary and Alternative Medicine, National Institutes of Health, 31 Center Drive, Room 2B11, MSC2182, Bethesda, MD 20892-2182, USA (e-mail: chesneym@mail.nih.gov)

APPENDIX D

Outcome Questionnaire (OQ-45)

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the items that best describe your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.

0=Never 1=Rarely 2=Sometimes 3=Frequently 4=Almost always

1. ___ I get along well with others.
2. ___ I tire quickly.
3. ___ I feel no interest in things.
4. ___ I feel stressed at work/school.
5. ___ I blame myself for things.
6. ___ I feel irritated.
7. ___ I feel unhappy in my marriage/significant relationship.
8. ___ I have thoughts of ending my life.
9. ___ I feel weak.
10. ___ I feel fearful.
11. ___ After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never").
12. ___ I find my work/school satisfying.
13. ___ I am a happy person.
14. ___ I work/study too much.
15. ___ I feel worthless.
16. ___ I am concerned about family troubles.
17. ___ I have an unfulfilling sex life.
18. ___ I feel lonely.

19. ___ I have frequent arguments.
20. ___ I feel loved and wanted.
21. ___ I enjoy my spare time.
22. ___ I have difficulty concentrating.
23. ___ I feel hopeless about the future.
24. ___ I like myself.
25. ___ Disturbing thoughts come into my mind that I cannot get rid of.
26. ___ I feel annoyed by people who criticize my drinking (or drug use). (If not applicable, mark "never").
27. ___ I have an upset stomach.
28. ___ I am not working/studying as well as I used to.
29. ___ My heart pounds too much.
30. ___ I have trouble getting along with friends and close acquaintances.
31. ___ I am satisfied with my life.
32. ___ I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never").
33. ___ I feel that something bad is going to happen.
34. ___ I have sore muscles.
35. ___ I feel afraid of open spaces, of driving, or being on busses, subways, and so forth.
36. ___ I feel nervous.
37. ___ I feel my love relationships are full and complete.
38. ___ I feel that I am not doing well at work/school.
39. ___ I have too many disagreements at work/school.
40. ___ I feel something is wrong with my mind.

41. ___ I have trouble falling asleep or staying asleep.

42. ___ I feel blue.

43. ___ I am satisfied with my relationships with others.

44. ___ I feel angry enough at work/school to do something I might regret.

45. ___ I have headaches.

APPENDIX E

Demographic Questionnaire

Please provide the following information regarding demographics:

Age, Gender, Ethnicity, Degree (Ph.D., Psy.D., Ed.D.), Discipline (Clinical, Counseling, School, or combined), Primary Setting (university, private practice, hospital, community mental health clinic, school), Primary Function (research, psychotherapy, teaching, assessment), State, Career Stage (early, mid, late), Years in the Field, Theoretical Orientation

Approximately how many hours a week do you spend engaged in self-care activities?

Do you (or another entity) regularly evaluate your self-care practices?

Which of the following has most informed your self-care activities? (Choose 3)

Faculty/Supervisors/Advisors_____

Peers/Colleagues_____

Program/Coursework_____

Research_____

Culture (ethnicity) _____

Family/Friends_____

None_____

Other_____

Which of the following has most reinforced your self-care activities? (Choose 3)

Faculty/Supervisors/Advisors_____

Peers/Colleagues_____

Program/Coursework_____

Research_____

Culture (ethnicity) _____

Family/Friends_____

None_____

Other_____

APPENDIX F

Participant Recruitment Email

Dear Dr. _____ :

I am a doctoral student in the Counseling Psychology Ph.D program at Seton Hall University. Under the supervision of Dr. Laura K. Palmer, I am conducting my dissertation research exploring self-care habits across the career-span of licensed, doctoral level psychologists.

I am contacting you in hopes that you will take a few minutes to complete the brief assessment as well forward my call for participants to other eligible psychologists.

If you would like to contact me, the principal investigator, I can be reached at Krista.Dettle@student.shu.edu or (201)-787-6939.

Thank you in advance for your consideration, time and assistance.

Sincerely,

Krista L. Dettle, M.A., Principal Investigator
Laura K. Palmer, Ph.D., ABPP
Counseling Psychology Ph.D. Program
Seton Hall University
400 South Orange Ave
South Orange, NJ 07079

APPENDIX G

Informed Consent

Dear Participant,

Thank you for your interest in this survey. As a counseling psychology doctoral student at Seton Hall University, I recognize many of the challenges of our field. While there is much to explore on the experiences of psychologists, there is relatively little published research on our patterns of self-care across the career-span. The present study aims to add knowledge to a field that may ultimately improve our well-being!

I understand that your time is very valuable. In the interest of time, I have compiled a survey consisting of several brief measures that will take a total of **15 minutes** or less to complete.

If you are a licensed, doctoral level psychologist currently working in the field of psychology, I invite you to take part in this survey. Participation in this study is completely voluntary and anonymous. You will not be asked for any identifying information and you are free to withdraw at any time without penalty. Additionally, data gathered from the study will be described collectively so that no one person's responses will be reported. Completed responses will be stored in a secure location on a USB memory key and will be accessible only to myself and my research advisor, Dr. Laura Palmer.

This project has been reviewed and approved by the Seton Hall Institutional Review Board (IRB) for Human Subjects Research. Questions about the research subject's rights should be directed to the Director of the IRB at Seton Hall University, Dr. Mary F. Ruzicka, Ph.D. at (973) 313-6314. Your comments or questions regarding this study are encouraged and welcomed; please feel free to write, e-mail, or call. We know your time is valuable. We appreciate your consideration and are hopeful you will participate.

Should you agree to participate, you may click on the following web link:

<http://asset.tlrc.shu.edu:80/servlets/asset.AssetSurvey?surveyid=3995>

You may create a username of your choosing. The password is "asset." Your consent will be implied by clicking "Next" to proceed with the survey. Thank you for your time and consideration.

Sincerely,

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