2017

Barriers to Counseling Among Human Service Professionals: The Development and Validation of the Fit, Stigma, & Value Scale

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The Development and Validation of the Fit, Stigma, & Value (FSV) Scale

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Abstract

This study sought to confirm rates of attendance in counseling of human service professionals and validate a 32-item questionnaire designed to identify barriers to counseling seeking behavior among this population. Results indicated that a large percentage of human service professionals attend counseling, with males and females attending at similar rates and non-Caucasians attending at lower rates. A multivariate analysis of variance and descriptive statistics identified the most common barriers to attendance in counseling and examined demographic differences in participants' sensitivity towards barriers to attendance in counseling. A Principal Factor Analysis (PFA) revealed three subscales (*fit*, *value*, and *stigma*), which we called the Fit, Stigma, & Value (FSV) Scale. How the instrument can be used with students in human service programs, and with human service professionals, to reduce barriers to attendance in counseling and ultimately ameliorate personal problems, reduce vicarious traumatization, and limit countertransference are discussed.

Introduction

Preventing and ameliorating vicarious traumatization, compassion fatigue, and burnout among mental health professionals is critical if clients are to receive effective services (Brownlee, 2016; Corey, Muratori, Austin, & Austin, 2017; Mayorga, Devries, & Wardle, 2015; Whitfield & Kanter, 2014; Wolf, Thompson, Thompson, & Smith-Adcock, 2014). Some of the many self-care activities that have been shown to be useful in this capacity include: reading for leisure, eating well, journaling, going on vacation, having a hobby, creative writing for self-awareness, practicing relaxation techniques, meditating, exercising, practicing mindfulness, avoiding traumatic events on media outlets, seeking supervision, establishing appropriate boundaries with clients, and developing a strong support system. However, the one self-care activity that most mental health professionals agree is most critical if human service professionals are to be effective is attendance in their own personal counseling (Byrne & Shufelt, 2014; Daw & Joseph, 2007; Norcross, 2010; Norcross, Bike, Evans, & Schatz, 2008; Norcross & Guy, 2005; Neukrug, Milliken, & Shoemaker, 2001).

Personal Counseling: A Critical Self-Care Activity

Multiple reasons underlie the importance for human service professionals to seek personal counseling (Knight, 2013; Malikiosi-Loizos, 2013; Norcross, 2010; Orlinsky, Schofield, Schroder, & Kazantzis, 2011). First, counseling may help limit countertransference and thus ensure that the personal issues of professionals do not interfere with their work with clients (King & O'Brien, 2011; Murphy, 2013). Working on one's own issues in counseling tends to increase self-awareness, improve the ability to deal more effectively with one's emotions (emotional intelligence), increase the ability to be insightful concerning clients' problems, sharpen helper skills, decrease the likelihood of unethical work, and increase empathy and strengthen other working alliance skills. Also, being in one's own counseling can limit

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compassion fatigue or vicarious traumatization and thus help rejuvenate the human service professional and ensure the provision of optimal services for clients (Cole, Craigen, & Cowan, 2014; McClam & Varga, 2014). Finally, because human service professionals should be positive role models for clients, being in their own counseling can help ensure that they are presenting themselves in their best light (Neukrug, 2016).

Helpers' Rates of Attendance in Counseling

Attendance in counseling by mental health professionals tends to be high. For instance, a survey of 206 human service professionals revealed that 74.8% ($n = 154$) were either currently in, or had received, personal counseling (Neukrug, et al., 2001). Among these human service professionals, individual counseling was most common (94.7%; $n = 145$), followed by group counseling (38.7%; $n = 59$), couples counseling (26.7%, $n = 45$), family counseling (26%; $n = 40$), and "other" type of counseling (1%; $n = 4$). Further, 57.1% ($n = 88$) of these human service professionals utilized more than one type of counseling. Also, female human service professionals were more likely to attend counseling than males (77% to 65%). It was also found that 47% ($n = 73$) of human service professionals attended personal counseling services prior to receiving professional training, 41.3% ($n = 64$) attended during their training, and 31.6% ($n = 65$) attended after they had completed their training. Human service professionals attended counseling for a variety of reasons, with life transitions, (17.3%; $n = 72$), family issues (16.8%; $n = 70$), and personal growth (16.6%; $n = 69$), being the most prevalent.

Studies of related mental health disciplines have reported similar findings to that of human service professionals. For instance, McCarthy, Pfohl, & Bruno (2010) found that 44% of counselor trainees had been in counseling, while Neukrug and Williams (1993) discovered that 80% of counselors had attended personal counseling. Similarly, Holzman, Searight, and Hughes (1996) found that 75% of clinical psychology trainees utilized counseling services. Further, Dearing, Maddux, and Tangney (2005) reported that 70% of clinical psychology trainees had been in counseling before entering graduate school and 54% engaged in counseling while in graduate training. Attendance in counseling is also a common experience for psychiatrists in training with 57% of residents having utilized some form of individual treatment while in their residency (Fogel, Sneed, & Roose, 2006). Finally, Orlinsky et al. (2011) found that 87% of a variety of helpers (e.g., psychiatrists, counselors, social workers, and medical professionals) had been in personal therapy while Norcross and Guy's (2005) review of 17 studies found that of 8,000 helping professionals, close to three-fourths had been in therapy at least once.

Barriers to Attendance in Counseling

The results of survey research indicate that between 15% and 38% of Americans seek counseling for mental health problems (Flynn, 2013; Hann, Hedden, Libari, Copello, & Kroutil, 2014). Reasons why larger percentages of Americans have not sought counseling have included: lack of insurance coverage (36%), doubting that counseling would be effective (32%), being unclear about how to find a counselor (28%), not being able to find a counselor with whom they felt compatible (21%), reluctance to face their problems (19%), and concerns about social stigma (15%). In addition, gender seems to mediate attendance in counseling, with females being more likely to seek counseling than men (Lindinger-Sternart, 2015).

Studies of those in the helping professions find that they share similar reasons for not seeking counseling as those found in the general public; however, they also have some unique concerns. For instance, Holzman et al. (1996) found that of the 24% of clinical psychology

students who had never been in counseling, 56% stated they had no need for counseling and 53% stated it was a financial burden. Dearing et al. (2005) found that for psychology graduate students, the three major concerns for not seeking counseling included cost, the amount of time it consumed, and concerns about confidentiality. They also found that concerns about confidentiality, positive attitudes about therapy, and perceived importance of therapy were the best predictors of graduate students seeking help. Fleckenstein (2003) suggested that helper vulnerability and insecurity were related to reluctance to seek personal counseling by counselor trainees and novice counselors, and Norcross (2010) suggested that counselors, like members of the public, may not seek counseling due to the perceived stigma involved. As with the public, there appear to be gender differences in help-seeking behaviors with female helpers holding more positive attitudes toward counseling and seeking counseling at higher rates as compared to male helpers (McCarthy et al., 2010; Neukrug et al., 2001). Finally, helpers' theoretical orientation has been found to be related to their help seeking behaviors with 94% of psychoanalytic-oriented, 91% of humanistically oriented, and 73% of cognitive-behavioral focused therapists seeking counseling (Orlinsky et al., 2011).

Research Questions & Hypotheses

Researchers sought to answer the following research questions: 1. What is the percentage of human service professionals who seek counseling? 2. What are the most common barriers to counseling of human service professionals? 3. What is the underlying factor structure of the Fit, Stigma, and Value (FSV) scale? 4. Are there demographic differences in participants' sensitivity to barriers to counselor seeking behavior by gender, previous attendance in counseling, and professional status? The hypotheses are as follows: The frequency of counselor seeking behavior among human service professionals will be similar to the findings of Neukrug et al. (2001), an interpretable latent factor structure will emerge from the exploratory factor analysis (EFA), and statistically significant demographic differences in participants' sensitivity to barriers to counselor seeking behavior will emerge. The purpose of an EFA is to identify the fundamental factor structure (latent variables) from a data set (Mvududu & Sink, 2013). The hypotheses of the current study, therefore, are intentionally inexplicit.

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Methods

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Instrument Development and Distribution

The instrument, eventually titled the Fit, Stigma, & Value (FSV) Scale, was developed to identify the most prevalent types of barriers to counselor seeking behavior among human service professionals. Content validity for the scale was established by following procedures for instrument development noted by Leedy & Ormrod (2016) and included an expert panel review followed by a pilot study. Initially, the three researchers independently reviewed the literature on barriers to counseling-seeking behavior and identified potential items for the questionnaire. Researchers had over fifty years of combined experience in the human services and counseling fields. All researchers had clinical experience, and one researcher was an expert on assessment, having taught such a course for over 35 years, written articles, and authored a book on testing and assessment. A second researcher had taught research methodology and was an expert on factor analysis. After examining the existing literature and developing independent lists of potential barriers, the researchers met three times until a consensus was reached regarding which

items to include on the scale. A completed version of the instrument was developed after the researchers met for one final review of the items on the questionnaire.

The completed version of the instrument asked information about respondents' ethnicity/racial identity; age; level of education; major or concentration in school; gender; whether they primarily identified as a student, educator, or practitioner; and whether they had ever attended counseling. To answer this last question, respondents were provided with the American Counseling Association's (2016) definition of counseling: "Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (para 2). Initial demographic items and the attendance in counseling question were followed by 42 Likert-type items which respondents rated as to whether they perceived the item as a barrier to them seeking counseling (1= Strongly Disagree, 2 = Disagree, 3 = Neither Agree or Disagree, 4 = Agree, 5 = Strongly Agree). IRB approval was obtained through the researchers' university.

The resulting scale was pilot tested (Fowler, 2014), with 47 undergraduate students in human services and graduate students in counseling. Minor changes were made to the final instrument based on the feedback received. Specifically, some items were re-worded for clarity, roman numerals were changed to numerical digits, and the stem: "I am less likely to attend counseling because," which had preceded all items, was moved to the overall instructions, making the scale more readable. The final version of the instrument, which was comprised of seven demographic and 42 barriers-to-counseling items, was then sent to all members of the National Organization of Human Services (NOHS).

Participants

The scale was developed on Qualtrics (2017), an online survey software tool. A link to the questionnaire was then distributed to all 1,725 members of NOHS via email. A total of 628 (36%) participants responded. Following removal of 118 responses due to missing and incomplete data, the final response rate was 29.6% ($n = 510$), which is consistent with survey research on organizations (Guo, Kopec, Cibere, Li, & Goldsmith, 2016). As suggested by Field (2013), cases with less than 5% of missing data ($n = 5$) were replaced with the mean of all responses to that item. Of the final sample, 80% ($n = 410$) identified as female, 19% ($n = 97$) identified as male, 0.4% ($n = 2$) identified as other, and 0.2% ($n = 1$) identified as transgendered. Of respondents, 43.1% ($n = 220$) identified as students, 28.8% ($n = 147$) identified as educators, and 28% ($n = 143$) as practitioners. The majority of participants identified as Caucasian 50.4% ($n = 257$), followed by African American 34.3% ($n = 175$). To ensure sample sizes large enough to make group comparisons, the remainder of participants who identified with a variety of different ethnic backgrounds were aggregated into an "other ethnic" group, 15.3% ($n = 78$). Participants in this group identified as, Hispanic or Latino 6.1% ($n = 31$), Asian 1.4% ($n = 7$), American Indian or Alaska Native 1.4% ($n = 7$), Native Hawaiian or Pacific Islander 0.4% ($n = 2$), and 6.1% ($n = 31$) identified as other. This aggregation procedure is commonly used in survey research to ensure sample sizes that are sufficient for making comparisons (Kaneshiro, Geling, Gellert, & Millar, 2011).

Statistical Analyses

Based on the recommendations of prominent psychometric researchers, the factor structure of the scale was derived using a principal factor analysis (PFA) (Mvududu & Sink, 2013). An oblique rotation, direct oblimin ($\Delta = 0$) was applied. The flowing factor retention

criteria were used: factor loading > 0.40, commonality (h^2) > 0.30, and cross-loadings > 0.40 (Beavers et al., 2013). A 2 (gender) X 2 (attendance in counseling) X 3 (professional status) MANOVA was conducted as a follow-up analysis to investigate potential participant group differences across each of the derived factors. Specifically, the first independent variable (IV), gender, had the following two levels, 1. Male or 2. Female. The second IV, attendance in counseling, had the following two levels, 1. Had previously attended personal counseling and 2. Had not previously attended personal counseling. The third IV, professional status, had three levels, 1. Educator, 2. Practitioner, or 3. Student. The dependent variables (DVs) consisted of interval level scales that were constructed from summed item scores from each of the three derived factors.

Results

Attendance in Counseling

The majority of participants, 69.6% (n = 355), noted that they attended at least one session of personal counseling. Of female respondents, 68.8% (n = 282) sought counseling, while 73.2% (n = 71) of male respondents sought counseling. For attendance in counseling by professional status, 66.8% (n = 147) of students, 66.4% (n = 95) of practitioners, and 76.9% (n = 113) of educators reported attending counseling. For ethnicity, participants who identified as Caucasian reported the highest frequency of attendance in counseling (n = 190, 73.9%), followed by those who were aggregated into the "other ethnic" group" (n = 54, 69.2%), and lastly by African Americans (n = 111, 63.4%).

Item Analysis

The top five barriers to counseling among participants were as follows "1. I couldn't afford it" (M = 2.50, SD = 1.40), "2. I lack the time" (M = 2.50, SD = 1.40), "3. I would be uncomfortable because my counselor could also be a colleague" (M = 2.35, SD = 1.30), "4. My counselor may have a future professional role with me (be my colleague, supervisor, etc.)" (M = 2.26, SD = 1.24), and "5. My problems don't warrant seeing a counselor" (M = 2.24, SD = 1.15). A frequency analysis of all the barriers to counseling can be found in Table 1.

Table 1
Mean Independent Scores for Barriers

Barrier	N	Mean	Std. Deviation
17. ...I couldn't afford it.	510	2.50	1.40
19. ...I lack the time.	510	2.40	1.30
36. ...I would be uncomfortable because my counselor could also be a colleague.	510	2.34	1.24
30. ...my counselor may have a future professional role with me (be my colleague, supervisor, etc.).	510	2.30	1.24
35. ...my problems don't warrant seeing a counselor.	510	2.24	1.15
38. ...I have had a bad experience with a previous counselor in the past.	510	2.19	1.25
18. ...I lack health insurance with mental health benefits.	510	2.14	1.29
29. ...I'm afraid if I am given a diagnosis, it will impact my life negatively.	510	2.11	1.23
39. ...I prefer to talk to a religious leader about my personal issues rather than a counselor.	510	2.00	1.08

31. ...I can't trust people with private matters.	510	2.00	1.10
37. ...counseling is unnecessary because my problems will resolve naturally.	510	1.97	.98
10. ...it would indicate something is wrong with me.	510	1.94	1.14
41. ...I'm afraid if I go to counseling I will re-live past traumatic experiences.	510	1.92	1.07
7. ... it would suggest I am unstable.	510	1.91	1.14
25. ...I couldn't find a counselor with my theoretical orientation (personal style of counseling).	510	1.89	1.04
21. ...the financial cost of participating is not worth the personal benefits.	510	1.88	1.02
20. ...I would not know where to find a counselor.	510	1.84	1.03
26. ...I would feel judged by my counselor.	510	1.83	1.00
42. ...I'm afraid people at my work will find out.	510	1.82	1.03
28. ...I couldn't find a counselor who would understand me.	510	1.81	0.98
12. ...it would damage my reputation.	510	1.80	1.04
27. ...I couldn't find a counselor competent enough to work with me.	510	1.80	1.00
33. ...I would find out something about myself that I do not want to know.	510	1.79	1.00
9. ...I would feel embarrassed.	510	1.79	1.04
34. ...I don't trust a counselor to keep my matters just between us.	510	1.78	0.99
16. ...I am concerned that matters I discuss would not be kept confidential.	510	1.76	1.10
1. ...my colleagues, supervisors, professors, or classmates would think less of me.	510	1.76	0.97
3. ...it would suggest I lack the ability to be an effective helper.	510	1.75	0.98
4. ...my colleagues, supervisors, professors, or classmates would not be supportive.	510	1.74	0.88
2. ...my family would not be supportive.	510	1.74	0.94
5. ...my family would think less of me.	510	1.73	0.91
32. ...I lack the emotional preparedness to be in counseling.	510	1.70	0.88
6. ...my friends would think negatively of me.	510	1.70	0.84
24. ...it is not an effective use of my time.	510	1.66	0.88
11. ...it is a sign of weakness.	510	1.65	0.92
13. ...it would be of no benefit.	510	1.62	0.87
22. ...my counselor won't understand my sexuality.	510	1.62	0.91
14. ...I would feel badly about myself if I saw a counselor.	510	1.60	0.81
23. ...there are no counselors in my immediate area.	510	1.55	.7908
40. ...I have a disability that makes it difficult to travel to a counselor's office.	510	1.52	.7720
8. ...it is difficult for me to find transportation to a counselor's office.	510	1.49	0.77
15. ...my problems are too severe for counseling to help.	510	1.44	0.70
Valid N (listwise)	510		

Participants (*N* = 510) responded to the Likert-type questions above with higher scores indicating a greater sensitivity to barriers (1= *Strongly Disagree, 2 = Disagree, 3 = Neither Agree or Disagree, 4 = Agree, 5 = Strongly Agree*).

Inter-Item Correlations

Inter-item Pearson Product correlations were conducted between all 42 items, ranging from 0.13 to 0.85. Initial internal consistency reliability was calculated on the 42 items, producing a Cronbach's alpha of 0.92. Reliability analysis indicated that removing 10 items (2, 8, 20, 29, 30, 32, 33, 36, 39, and 42) raised the internal consistency of the measure to 0.96. The inter-item correlation matrix was re-produced with the remaining 32 items and was favorable, with all items inter-correlating $r \geq .30$ with at least half of the other items. Item commonalities were acceptable (see Table 2), ranging from 0.31 to 0.67. Bartlett's Test of Sphericity and a Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO) demonstrated that the correlation matrix was favorable for factor analysis, $B(496) = 11,221.52$, $p = 0.00$, KMO $= 0.95$.

Multiple modalities were utilized to investigate the normality of the distribution (Field, 2013). An initial inspection of histograms, skewness values, and kurtosis values indicated that the data was not normally distributed. Data were converted to z-scores and winsorized. Skewness and Kurtosis values were computed for the winsorized data. The majority of skewness and kurtosis values ($n = 25$, 78%) were within the ranges of a normal distribution ± 1. Item 23 displayed a negative skew while items 3, 14, 15, 16, 22, and 23 displayed positive skews. Researchers elected to keep these seven items in the factor analysis as normality is not required for all items when using a principal axis factor extraction method (Beavers et al., 2013). These seven items also demonstrated favorable inter-item correlations ($r \geq .30$) with at least half of the other items, suggesting that it would be valuable to keep them in the factor analysis.

Exploratory Factor Analysis and Emergent Factor Structure

A Principal Factor Analysis (PFA) with a direct oblimin rotation was conducted. The Kaiser Criterion ($\Lambda > 1.00$), scree plot, and meaningful variance accounted for ($\geq 5\%$) and were used to identify the appropriate number of factors to extract (Fabrigar & Wegener, 2011). A three factor structure emerged (see Table 2) based on these criteria. Factor 1, which was named *Fit*, accounted for 42% of the variance in the total model and involved one's sense of comfort being in counseling and trust in the process of counseling. Some examples of items that loaded on this factor included: "15. My problems are too severe for counseling to help," "38. I have had a bad experience with a previous counselor in the past," and "28. I couldn't find a counselor who would understand me." Factor 2, *Stigma*, accounted for 7.6% of the variance and referred to shame or embarrassment about being in counseling. For example, "1. My colleagues, supervisors, professors, or classmates would think less of me," "12. It would damage my reputation," "9. I would feel embarrassed" are found in this factor. Factor 3, *Value*, accounted for 5.1% of the variance in the model and is comprised of items related to the perceived benefit of counseling. For example, "24. It is not an effective use of my time," "21. The financial cost of participating is not worth the personal benefits," and "37. Counseling is unnecessary because my problems will resolve naturally" were found in this factor. The final scale was given the name Fit Stigma Value (FSV) Scale to represent these attributes. The coefficient alpha reliability of the FSV scale was high, 0.96. Reliability coefficients of each independent factor were also high, 0.92, 0.94 and 0.86, respectively for Factors 1, 2, and 3.

Table 2
Summary of Principal Factor Analysis of the "FSV" Using Oblique Rotation (N = 510)

Item	Factor 1 (*Fit*)	Factor 2 (*Stigma*)	Factor 3 (*Value*)	h^2
		Loadings		
28. I couldn't find a counselor who would understand me	**0.77**		0.11	0.67
27. I couldn't find a counselor competent enough to work with me	**0.76**		0.12	0.63
22. My counselor won't understand my sexuality.	**0.66**	0.13	0.12	0.49
25. I couldn't find a counselor with my theoretical orientation (personal style of counseling).	**0.65**		0.20	0.58
34. I don't trust a counselor to keep my matters just between us.	**0.64**	-0.12		0.57
23. There are no counselors in my immediate area.	**0.62**			0.36
40. I have a disability that makes it difficult to travel to a counselor's office.	**0.60**		0.20	0.32
26. I would feel judged by my counselor.	**0.58**	-0.15	0.17	0.63
41. I'm afraid if I go to counseling I will re-live past traumatic experiences.	**0.54**	-0.16		0.36
16. I am concerned that matters I discuss would not be kept confidential.	**0.53**	-0.12		0.44
31. I can't trust people with private matters.	**0.53**	-0.17	0.11	0.51
38. I have had a bad experience with a previous counselor in the past.	**0.50**			0.32
15. My problems are too severe for counseling to help.	**0.49**	-0.17	0.11	0.46
7. It would suggest I am unstable.		**-0.84**	0.26	0.70
10. It would indicate something is wrong with me.	0.17	**-0.81**	0.28	0.64
12. It would damage my reputation.		**-0.80**		0.67
9. I would feel embarrassed.		**-0.77**		0.65

3. It would suggest I lack the ability to be an effective helper.		**-0.74**	0.61
11. It is a sign of weakness.		**-0.73**	0.14	0.63
1. My colleagues, supervisors, professors, or classmates would think less of me.	0.17	**-0.65**		0.54
14. I would feel badly about myself if I saw a counselor.		**-0.60**	0.30	0.65
6. My friends would think negatively of me.	0.30	**-0.56**		0.60
4. My colleagues, supervisors, professors, or classmates would not be supportive.	0.33	**-0.547**		0.57
5. My family would think less of me.	0.31	**-0.52**		0.53
21. The financial cost of participating is not worth the personal benefits.			**0.71**	0.62
19. I lack the time.			**0.61**	0.41
17. I couldn't afford it.			**0.60**	0.37
18. I lack health insurance with mental health benefits.	0.20	0.18	**0.50**	0.33
37. Counseling is unnecessary because my problems will resolve naturally.		-0.17	**0.47**	0.36
35. My problems don't warrant seeing a counselor.		-0.13	**.429**	0.31
24. It is not an effective use of my time.	0.28	-0.18	**0.42**	0.54
13. It would be of no benefit	0.16	-0.26	**0.41**	0.59
Eigenvalues	13.75	2.44	1.63	
% of variance	43%	7.6%	5.1%	

Note: Factor loadings that appear in bold mark items that loaded on that particular factor. Empty cells indicate factor loadings ≤ 0.10.

MANOVA Results

A Multivariate Analysis of Variance (MANOVA) was conducted to investigate demographic differences in participants' sensitivity to the FSV barriers. Researchers ensured that the current data set met the statistical assumptions that are required to conduct a MANOVA that are outlined by Field (2013). The Skewness values for factor 1, (0.56) factor 2, (0.80) and factor 3, (0.27) and Kurtosis values for factor 1, (-0.61) factor 2, (-0.27) and factor 3, (-0.81) were all within the range of a normal distribution. The assumption of multicollinearity was met as correlations between the DVs were as follows: factor 1 and factor 2 ($r = 0.68$), factor 1 and factor 3 ($r = 0.67$), and factor 2 and factor 3 ($r = 0.61$). The assumption of independence of observations was met as it was not possible for any participant to simultaneously be in more than one group.

The results of the MANOVA revealed a statistically significant main effect for attendance in counseling $F(11, 495) = 3.10$, $p = 0.03$, $\eta_p^2 = 0.02$. A Bonferroni correction was utilized. Specifically, participants who had never attended counseling ($M = 0.18$, $SD = 0.67$) were significantly more likely to be sensitive to Factor 3: *Value*, compared to participants who had previously attended counseling ($M = -0.06$, $SD = 0.65$), $F(11, 495) = 7.70$, $p = 0.01$, $\eta_p^2 = 0.02$.

Discussion

This study confirmed the relatively high rate of attendance of human service professionals in counseling (70%), although slightly lower than Neukrug et al.'s (2001) study (75%). Differences may be due to the more precise definition of counseling provided in this study or to this study's larger sample size. In either case, it appears that human service professionals attend counseling at fairly high rates, similar to rates found by other mental health professionals, and probably a fair amount higher than the general public (Flynn, 2013; Hann, et al., 2014; Orlinksy et al., 2011). This is promising, since attendance in counseling is likely related to amelioration of personal problems, reduction of vicarious traumatization, and a decrease in the likelihood of countertransference (Harrison & Westwood, 2009; Murphy, 2013).

This study found attendance in counseling of female and male human service professionals to be nearly the same. This was somewhat surprising, since past studies have shown that as compared to males, female professionals tend to be more amenable to being in their own therapy (Lindinger-Sternart, 2015; McCarthy et al., 2010; Neukrug et al., 2001). Additionally, non-Caucasian, particularly African Americans, find the helping relationship less welcoming (Lo, Cheng, & Howell, 2013; U.S. Department of Health and Human Services, 2014). So, it is not surprising that participants who identified as Caucasian in this study reported the highest rates of attendance in counseling, followed by "other ethnic," and lastly by African Americans. These results emphasize the importance of multicultural competence to ensure that the counseling process, and the helping relationship, are viewed as inviting and rewarding to all individuals (Nuttgens & Campbell, 2010). Further, the findings from the current study have extended the literature on barriers to counseling seeking behavior among human services professionals by identifying psychometrically validated types of barriers. The final version of the FSV scale was comprised of 32 items that comprise three subscales. The first barrier, *fit*, accounted for the largest amount of variance and included 13 items. This was followed by *stigma*, which included 11 items, and *value*, which included eight items. In addition, *value* seems to be particularly important for those human service professionals who have never attended counseling.

These results raise important considerations for human service education and human service professionals in general. It would seem important for human service programs, and perhaps NOHS, to develop a directory of counselors who are "trustworthy" or specialize in working with clients who are also helping professionals. Although trustworthiness is a loose concept, students may be more likely to see a counselor who has been identified by faculty as trustworthy, and if they knew that the counselor's focus or areas of expertise included specific issues that students typically face. Similarly, human service professionals may be more likely to seek counseling by an individual identified through their national organization as being duly qualified, and if the human service professional was aware of the counselor's specialty focus and areas of expertise. This may make it easier for human service professionals to seek a counselor who specializes in the problems they might be experiencing. Such a listing by NOHS might reduce the uncertainty that can be involved with finding a qualified counselor.

Relative to stigma, it is critical that human service programs, national organizations, and ethics codes make it clear that seeking counseling will not negatively impact a person's ability to find a job, continue in their training, or work with others. In fact, programs, organizations, and ethics codes should be vehicles for promoting the importance of attendance in counseling, noting how such attendance is critical in ameliorating problems and decreasing countertransference (Cole et al., 2014; King & O'Brien, 2011; McClam & Varga, 2014; Murphy, 2013). Finally, relative to value, it is recommended that human service programs and national organizations emphasize the importance of attending personal counseling so that all human service professionals realize its benefits.

On a more practical level, the FSV scale can be used by human service programs nationally. Such an instrument can be taken by students, and within classes, and results can be discussed and used to examine why students may not be attending counseling. Although such results should be discussed in a manner that does not reveal individual responses, a wide variety of issues can still be addressed through such an assessment. For instance, if many students believe there are few, if any, counselors in their area, faculty can help identify those counselors which may be nearby. If large numbers of students believe that attending counseling is stigmatizing, faculty can discuss the importance of de-stigmatizing counseling and emphasize the importance of personal counseling in decreasing countertransference and in ensuring a positive helping relationship with clients (King & O'Brien, 2011; Murphy, 2013). If relatively large numbers of students believe they cannot afford counseling, faculty can attempt to find counselors who charge lower fees and help students identify if their medical insurance will cover the cost of counseling. With training programs being an essential vehicle for mental health professionals' attendance in counseling (McCarthy, 2008; McCarthy et al., 2010; McCarthy, Bruno, & Sherman, 2010), it is hoped that research such as this can help direct the manner in which human service programs assist their students in finding counselors and in removing barriers to seeking counseling.

Limitations and Future Research

Sampling procedures in survey research can skew results. For instance, it could be that those who seek counseling have more of a tendency to respond to such a survey as compared to those who do not seek counseling. Such self-selection could give a false sense of which barriers are primarily faced by helpers.

Another limitation of the current study is the lack of an ethnically diverse sample. The majority of participants identified as Caucasian or African American, and the remaining participants were aggregated into an "other ethnic group" to ensure sample sizes large enough for group comparisons. This aggregation procedure is commonly used as recruiting an ethnically diverse sample is a common limitation in survey research (Kaneshiro et al., 2011). It is recommended that future researchers investigate differences in counselor seeking behavior with an ethnically diverse sample using inferential statistical procedures.

Future researchers may want to further validate the emergent factor structure of the FSV scale by conducting additional confirmatory factor analyses, perhaps for other mental health professionals, and for the general population. They may also want to investigate demographic differences among helping professionals to develop a deeper understanding of why different ethnic and racial groups may avoid seeking counseling. In addition, future researchers can investigate the validity of the FSV scale for predicting individuals' attendance in counseling. For

instance, one might investigate the extent to which reductions in participants' sensitivity barriers to counselor seeking behavior predicts their actual attendance in counseling.

The multivariate results in the current study suggest that participants who have not attended counseling are more likely to be sensitive to the *value* barrier. Future research should confirm this finding with different populations. Finally, the majority of the existing studies on barriers to counselor seeking behavior among helping professionals have utilized survey research methodology. Future qualitative researchers might conduct a phenomenological study to identify mental health professionals' lived experiences in relation to barriers and solutions towards counselor seeking behavior.

Summary and Conclusion

This study sought to understand the types of barriers that may be at play when a human service student or professional is considering seeking counseling. The results of an exploratory factor analysis uncovered three subscales (*fit*, *stigma*, and *value*) that may be important in understanding why some human services professionals may be reticent to attend counseling. Further studies that confirm this factor structure are important if this instrument is to become widely used. It is hoped that the FSV scale can offer a mechanism to help understand and reduce the barriers for helping professionals who may want to seek counseling to ameliorate their problems, diminish vicarious traumatization, or reduce countertransference.

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