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Self-Care, Anticipated Stigma, and Personal Therapy in Mental Health Professional Trainees

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ABSTRACT

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Self-care has increasingly become encouraged as a means for maintaining well-being for mental health professionals; yet, there exists an unsettling lack of research and guidance on this topic for those within the field (Callan et al., 2021; Colman et al., 2016; Norcross & VandenBos, 2018). This has led to call for change and reform to recognize the importance of self-care as an ethical imperative and to incorporate it within the education and training of mental health professionals (Barnett et al., 2007; Barnett & Cooper, 2009; Wise & Reuman, 2019; Zahniser et al., 2017). These calls for reform and the increased importance of self-care have only grown given the realities of the strains included within the work that mental health professionals do and the increased stress placed on the field from the COVID-19 worldwide pandemic (El-Ghoroury et al., 2012; Posluns & Gall, 2020; Sciberras & Pilkington, 2018). Given the need for research on self-care and ways to implement it combined with the lack of prior research, the current research set out to contribute quantitative research on areas related to self-care for mental health professional trainees. The first purpose was to determine how much of the variation in the five factors of self-care was explained by anticipated stigma and attendance in personal therapy. The second purpose was to determine the contribution of both anticipated stigma and personal therapy separately on the variation within self-care. The third purpose was to determine if there was a difference in self-care between mental health professional trainee groups who had

experienced personal therapy. In the current study, the Self-Care Assessment for Psychologists was used (Dorociak, Rupert, Bryant, et al., 2017). The other variables of interest anticipated stigma and attendance in personal therapy were measured by the Anticipated Stigma Scale (Quinn & Chaudoir, 2009; Quinn et al., 2014) and having participants detail their therapy experience similarly to what prior researchers had done (Bike et al., 2009; Byrne & Ost, 2016; Byrne & Shufelt, 2014; Geller et al., 2005; Kalkbrenner & Neukrug, 2019; Kalkbrenner et al., 2019; Norcross, 2005; Norcross et al., 2008; Orlinsky et al., 2011; Ziede & Norcross, 2020). A multivariate multiple linear regression was used to analyze the data of 100 participants (Keith, 2019; Remler & Van Ryzin, 2015; Rencher & Christensen, 2012). The results did not provide any evidence that anticipated stigma and personal therapy explained a significant amount of the variation within self-care for mental health professional trainees; no evidence was found for either of the variables separately nor was there evidence found for a difference between groups of those who did and did not attend therapy. Theoretical, research, and clinical implications are discussed suggesting how further inquiry might be conducted to better understand self-care for the mental health trainee population.

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CHAPTER I

INTRODUCTION

Introduction

Self-care has increasingly become disseminated as a model of promoting physical and mental health and overall well-being among the general populace and professionals in a multitude of fields. Research and discussion showed the adoption of self-care into professional fields of every kind. Largely, counseling psychologists and other mental health professionals have been at the forefront of promoting self-care and the well-being for others (Dattilio, 2015; Lee & Miller, 2013). Despite being at the forefront of promoting self-care and the vast amount of literature focused on the large stress and psychological toll of working in the field (Engle et al., 2017), the literature was also resplendent with how mental health professionals ironically failed to apply these same practices to their own overall well-being (Ziede & Norcross, 2020). In fact, the research as applied within the psychological field about self-care was rather limited when compared to the literature that existed within other fields for self-care (Dorociak, Rupert, Bryant, et al., 2017).

The lack of research and discussion on self-care within the field has been called "an unsettling paucity" (p. 1) by well-renowned authors of the most comprehensive text on psychotherapist self-care, Norcross and VandenBos (2018). Lack of research and application has also led to calls from many researchers and professionals for systemic change within the field that addresses self-care and well-being more fully for current and future mental health professionals (Barnett et al., 2007; Swords & Ellis, 2017; Wise et al., 2012; Wise & Reuman,

2019). These calls for change were especially pertinent to those professionals who adhered to the counseling psychology values and principles. As noted by many authors (American Psychological Association [APA], 2017; Clauss-Ehlers et al., 2019; Scheel et al., 2018; Wise et al., 2012), the core values of counseling psychologists aligned with the systemic incorporation of self-care on all levels of the professional spectrum to better promote lifelong competence and flourishing. These core values also ran counter to the paucity of research surrounding awareness of self and the lack of incorporation of a self-care intervention strategy that was preventative and positive in nature (Norcross & VandenBos, 2018). More research needs to be conducted on how to effectively implement these changes in a manner that maximizes the ability of these changes to have a long term and widespread impact.

To those within the mental health field, self-care is more than a personal prerogative toward healthy functioning and well-being; it is an ethical imperative for all professionals that calls for, "implementing the systemic changes needed in our education and training systems" (Barnett et al., 2007, p. 606). Norcross and VandenBos (2018) noted that every ethical code of mental health professionals included a provision that stated the need for self-care. Despite these provisions about the need for self-care, or perhaps partially because of them, a dearth of research and discussion exists around dealing with stress, distress, and other topics potentially ameliorated by self-care. Zerubavel and Wright (2012) theorized that lack of discussion and research was part of a social conspiracy of silence within the field; silence makes professionals and trainees feel as though only secrecy around wounds or other stigmatizing identities protects them from stigma and judgement within the mental health field. As noted by many researchers, professionals within the mental health field are far from immune to the effects of stigma (Crowe et al., 2017; Kalkbrenner et al., 2019). More research is needed to better understand the impact stigma has on

self-care within those current and future professionals in the mental health field as the majority of research is theoretical, limited in scope, or only addresses limited self-care behaviors.

Although there are many calls for systemic change regarding self-care in the field, little research exists on how to implement such changes. The suggested beginnings of addressing such issues start with the education of mental health professionals in graduate programs due to the higher rates of burnout, less vigor, and lack of guidance these trainees experience (Bamonti et al., 2014; Swords & Ellis, 2017; Wise & Reuman, 2019). Suggestions given by research focused on the incorporation of self-care into education to help combat the known rigors and psychological toll of working as a professional in the field (Engle et al., 2017; Sciberras & Pilkington, 2018; Wise et al., 2012). Incorporation of these suggestions is especially pertinent to counseling psychologists as a whole; counseling psychologists have an active role all throughout the various stages in the development of mental health professionals. Counseling psychologists not only exist in the roles of teachers to those who are beginning to develop interest in the field, but also serve trainees or professionals within the field in the roles of supervisor, consultant, mentor, therapist, and researchers. Incorporation of self-care is fundamental in establishing a framework that better meets guidelines surrounding the core values of counseling psychologists in the development of mental health professionals by optimizing growth towards full potential, maintaining a holistic and contextual perspective that respects diversity, promoting social justice, and fostering a communitarian perspective (Wise & Reuman, 2019). Such values should be incorporated in the developmental areas that counseling psychologists are involved in and efforts that encourage such values should be promoted.

A well-known self-care behavior for those within the mental health field that has many researched positive benefits to the person of the therapist is personal therapy (Kalkbrenner &

Neukrug, 2019). Despite the well-known benefits, many of the recent conceptualizations of treatment efficacy and subsequent modalities have attempted a removal of the importance the person of the therapist contributes to personal therapy. Such conceptual dismissal of importance has coincided with the state of personal therapy being used less within the mental health field's training and education of trainees as a method of self-care and more to ameliorate problematic behaviors (Dorociak, Rupert, Bryant, et al., 2017; Norcross & VandenBos, 2018). Such use within the mental health field was noted by Orlinsky et al. (2011) to be a major contributor to the small percentage of negative or harmful outcomes of therapy by trainees. Improper uses that contributed to harmful or negative outcomes ran directly against the core values and ethics of counseling psychologists and need to be rectified by professionals in the field (APA, 2017). Inclusion of counseling psychologist values that take a preventative- and strengths-based focus into personal therapy for mental health professional trainees might be one way of meeting the calls for systemic educational change to incorporate better self-care (Drew et al., 2017; Scheel et al., 2018; Ziede & Norcross, 2020). It is imperative as well that counseling psychologists, who hold roles that are involved throughout the developmental process of mental health professionals, assure the usage of personal therapy is consistent with their values and prevents harm to those within the field (APA, 2017). A greater understanding of the contribution personal therapy plays in self-care is needed to help accomplish systemic changes and incorporate uses of personal therapy that prevent harm in the education and training of mental health professionals.

Background

Over the years, the knowledge and subsequent competencies encompassed by mental health professionals have steadily increased and adapted to an ever-changing society that consistently has new scientific discoveries and steadily makes progress. While increases in

knowledge benefit society and help in the progression of developing more effective treatment, they have increased the knowledge, skills, and competencies these mental health professionals need to accumulate to effectively operate within the field as well (Piotrowski, 2012). There is a high level of acknowledged stress for those within the mental health field and those preparing to enter the field (Sciberras & Pilkington, 2018; Swords & Ellis, 2017). Stress and related tolls of working within the mental health field are not new; yet despite the vast literature surrounding these stressors and tolls and the increased access to it, there is a stark absence of correlated coping strategies for mental health professionals and trainees in dealing with stress (Engle et al., 2017). As many authors in the literature have described, there exists a need for change in the support of current and future mental health professionals on a system-wide basis for the mental health field that includes preventative training and education to handle the stress more aptly from working in the field and promote professionals who flourish (Bamonti et al., 2014; Colman et al., 2016; Dorociak, Rupert, & Zahniser, 2017; Wise & Reuman, 2019). To effectively incorporate changes, more research needs to be conducted on self-care for mental health professionals as research on self-care and its measurement is still in its infancy and includes many gaps such as lack of a specific theoretical basis (Jiang et al., 2020). In line with recommendations from previous authors (Bamonti et al., 2014; Barnett & Cooper, 2009; Colman et al., 2016; Jiang et al., 2020; Norcross & VandenBos, 2018; Santana & Fouad, 2017; Wise & Reuman, 2019), further research on self-care for trainees within the mental health profession needs to address a variety of areas. Self-care should be taken from a preventative viewpoint and potential methods or means of engaging in such self-care, like personal therapy, and the impact of personal therapy on self-care need to be better understood. Other important avenues discussed about incorporating

such changes into the education and training of mental health professionals included cultural changes in this training like reducing anticipated stigma.

All throughout history, there has existed the idea of the healer healing themselves and the problems contained within doing so. Whether it be Greek mythology, shamanistic traditions, or religious stories, the idea of the healer needing to heal oneself is prevalent throughout history (Conchar & Repper, 2014; Kirmayer, 2003). Despite such traditions, cultural examples, and the importance of the person of the therapist being repeatedly pointed to in the literature (Barnett et al., 2007; Norcross & Lambert, 2018), the mental health field is still in a position where it largely has left its future and current professionals without adequate guidance on caring for themselves (Bamonti et al., 2014). Research showing that professionals within the field cannot just naturally manage their stress or are somehow impervious to it has been largely ignored (Dattilio, 2015; Rudaz et al., 2017). The failings of previous system-wide attempts at addressing the lack of adequate self-care and subsequent silence further highlight the need of additional study for self-care (Barnett et al., 2007). As shown by previous research, an uncoordinated promotion or vague response that some sort of self-care should be the remedy was also not the answer needed nor effective for current and future mental health professionals (Bamonti et al., 2014; Bloomquist et al., 2016; Colman et al., 2016; Zahniser et al., 2017). The lack of an organizational response is exemplified in that self-care is still not specifically stated as an ethical mandate despite over at least a decade of it being argued as such (APA, 2017; Barnett et al., 2007); self-care is still only able to be argued as ethically imperative due to theory around the importance of the person of the therapist to efficacy outcomes around competence for psychologists (Norcross & Lambert, 2018; Wise et al., 2012).

Self-Care

Literature on self-care is rather vast and has been ever present in some form throughout history (Haug et al., 1989). As evidenced by the small amount of literature in the context of mental health professionals, it is in its application or context to certain fields or peoples that generally tend to be lacking (Bamonti et al., 2014; Barnett et al., 2007; Colman et al., 2016; Dorociak, Rupert, Bryant, et al., 2017; Norcross & VandenBos, 2018). Self-care in the context of current and future mental health professionals becomes ever more important due to the nature of the work mental health professionals do and that they are the tool being used in the process (Lasky, 2005; Santana & Fouad, 2017). Wise et al. (2012) echoed previous literature and authors by delineating how self-care became an ethical imperative for professionals in the mental health field through competency. The importance of self-care for mental health professionals cannot be overstated (Mahoney, 1997; Owens-King, 2019; Posluns & Gall, 2020).

When focused within the context of mental health professionals and applied with models of systemic change for the mental health field, the literature highlighted the importance of self-care as something that is flexible and focused on wellness (Bamonti et al., 2014; Dreison et al., 2018; Wise & Reuman, 2019). The literature on such a form of self-care within the mental health field was fragmented and lacking but consistent themes on areas of importance emerged (Dorociak, Rupert, Bryant, et al., 2017; Norcross & VandenBos, 2018; Richards et al., 2010; Santana & Fouad, 2017; Ziede & Norcross, 2020). These areas were summarized into the five factors of professional support, professional development, life balance, daily balance, and cognitive awareness in a comprehensive assessment of self-care by Dorociak, Rupert, Bryant, et al. (2017); the Self-Care Assessment for Psychologists (SCAP) was made for the comprehensive assessment of self-care that incorporates factors pertinent to those within the mental health field.

As noted, incorporation of self-care is important due to the propensity that professionals in the mental health field have toward not adequately addressing their own self-care because they are prioritizing the care of others. To address the lack of self-care, systemic cultural changes are needed within the field that begin with the education and training of mental health professional trainees (Bamonti et al., 2014; Dorociak, Rupert, Bryant, et al., 2017; Dreison et al., 2018; Wise & Reuman, 2019). The subsequent focus on trainees and their education within the field followed ideals aimed at creating lasting change that affected the entirety of the field (Wise & Reuman, 2019). Such focus followed current research suggestions not only on the importance of incorporating self-care for the mental health professional trainee population but also followed findings about the higher levels of risk, burnout, lack of vigor, and stress than comparable groups (Barnett, 2007; Kalkbrenner & Neukrug, 2019; Swords & Ellis, 2017). The promotion of self-care within the field needs to be focused on incorporating these ideals and further investigating areas that are important to enacting change.

Personal Therapy

Historically, professionals within the psychological field have engaged in many forms of self-care (Barnett et al., 2007). One such technique, strategy, or method that has historical roots within the mental health field is personal therapy (Norcross & VandenBos, 2018). Personal therapy has been intertwined throughout the histories of psychology in all its different forms (Benziman et al., 2012; Kirmayer, 2003). In looking at the history of current professional and organized therapeutic practices, Freud is a commonly known historical figure of eminence within the field. Not only was personal therapy or psychoanalysis a requirement of entering into the profession, it was also something practitioners submitted themselves to without shame periodically (Steiner, 2005). Personal therapy as a requisite to engaging in their own practice is

no longer required for mental health professionals and is often used as a central way of addressing trainee impairment (Drew et al., 2017; Kalkbrenner & Neukrug, 2019; Norcross & VandenBos, 2018; Ziede & Norcross, 2020). Reviews of the literature showed an approximately combined range of 70-90% of professionals, dependent on theory, had attended personal therapy (Bike et al., 2009; Ziede & Norcross, 2020). The range spanned both international and American studies. Americans were reported to have low/high ranges from 44%–66% for behaviorists and 82%–100% for psychoanalytic orientations. The rate of having attended personal therapy for mental health professional trainees was roughly 50% (Kalkbrenner & Neukrug, 2019; Kalkbrenner et al., 2019).

It is important to highlight that these rates reflected having ever attended therapy and not something else like having attended recently. Though there might be any number of many diverse reasons for the attendance rates for trainees, literature highlighted stigma, ability to seek services, the deemphasis on the importance of the person of the therapist, and characteristic qualities of those within the field as some of the reasons (Barnett et al., 2007; Kalkbrenner et al., 2019; Norcross & Lambert, 2018; Norcross & VandenBos, 2018). As reflected by prior literature and past traditions (Byrne & Shufelt, 2014; Drew et al., 2017; Norcross & VandenBos, 2018; Ziede & Norcross, 2020), perhaps engaging in personal therapy as part of the education and training of mental health professional trainees to facilitate the incorporation of suggested self-care warrants further research and consideration in any future educational changes implemented.

In reference to those trainees who do not seek personal therapy, Byrne and Shufelt (2014) stated, “Trainees may find themselves in the false position of recommending services about which they have insufficient understanding or offering services as underprepared practitioners.” (p. 185). Trainee practitioners not attending their own therapy might also promote questions

about non-attendance and skepticism about the efficacy of treatment modality when the field's own practitioners do not use it. To address the issue of whether or not personal therapy works, a wide and vast database of literature pointing to its efficacy exists (Kalkbrenner & Neukrug, 2018). It is common knowledge within the field that personal therapy has a host of benefits (e.g., improved emotional and mental functioning, improved self-esteem and work functioning, improvements in social life, increased genuineness, increased empathy, increased self-awareness, better alliance with clients, and improved management of countertransference). Much like other concepts, mental health professionals and trainees are not immune to these benefits. In fact, they receive many professional and personal benefits from personal counseling (Byrne & Shufelt, 2014; Norcross, 2005; Orlinsky et al., 2011). Pertaining to the earlier question of why practitioners do not engage in their own personal therapy, recent literature was engaged in looking at barriers to counseling for professionals (Kalkbrenner & Neukrug, 2019; Kalkbrenner et al., 2019) and provided some answers to these questions. Kalkbrenner and Neukrug (2019) built upon previous research that suggested areas around resources such as time, the value and benefits from counseling, and stigma (Byrne & Shufelt, 2014). Fit, stigma, and value were conceptualized as three areas that were barriers to mental health professional trainees (Kalkbrenner & Neukrug, 2019). Plenty of evidence exists that supports the benefits of personal therapy and its value (Norcross & VandenBos, 2018), leaving the area of stigma as the seemingly unexplored barrier. Given stigma is also a barrier to engaging in other strategies or behaviors that increase self-care and is known to impact correlates of well-being, the overlap suggests further research might provide more insight and knowledge about the relationship anticipated stigma has with self-care and personal therapy.

Attendance in their own personal therapy by around half of trainees (Kalkbrenner & Neukrug, 2019) was also raised as a concern by authors Norcross and VandenBos (2018) who viewed personal therapy as, “the epicenter of the educational and self-care universe for psychotherapists” (p. 194). When Norcross and VandenBos discussed personal therapy, they highlighted its importance by stating how it is a vital emotional and professionally nurturing experience. These authors went so far as to state it should be a prerequisite to conducting psychotherapy and a co-requisite of professional self-care throughout the professional lifespan. Such a strong statement was due in part to the large evidence that existed for the benefits of personal therapy for professionals and trainees within the field as well as the educational benefits that existed from a multitude of learning and psychological theories. Many of the benefits experienced were also integral to conceptualizations of models that had incorporated system wide changes surrounding mental health professional self-care (Aponte et al., 2009; Bamonti et al., 2014; Lee & Miller, 2013; Niño et al., 2015; Wise et al., 2012; Wise & Reuman, 2019). The implicated evidence that personal therapy is important to informing and implementing systemic change around integrating self-care is strong, but more research on the benefits therapy has regarding to self-care is lacking. Due to a gap in the research literature around attendance in personal therapy and its impact on self-care along with the implications for the importance of personal therapy in the training and education of mental health professional trainees, more research on the impact of attendance in personal therapy on self-care is needed.

Anticipated Stigma

Stigma is interwoven within the history of psychology and the treatment of mental health issues. Its presence can be seen throughout the history of humankind with its treatment toward the mentally ill. Stigma, itself, is a word derived from the mark given when slaves or criminals

were branded in Ancient Greece (Rössler, 2016). It is a broad term that encompasses many different conceptualized areas, but it can also be reduced to specific contexts and terms (Pescosolido & Martin, 2015). A broad focus of the term taken but applied first to the specific population of mental illness allows for the easiest elaboration of the topic. Humans diagnosed with mental illness have a long history of negative treatment that ranged from being tortured and burned at a stake, to being chained up their entire lives, or to the current social exclusion and rampant homelessness (Comer & Comer, 2018). The negative repercussions of mental illness and the associated stigma are well known and taught to those professionals within the mental health community. Perhaps in part due to these well-known stigmas and the fact that professionals are not immune to viewpoints and cultures they exist within, stigma impacts mental health professionals and trainees (Barnett et al., 2007; Crowe et al., 2017; Dattilio, 2015; Kleespies et al., 2011).

Because mental health professionals are not immune to stigmas prevalent within society, it is worth noting the impact of these prevalent stigmas within the field. Outside of the field, stigma has been noted in preventing individuals from disclosing distress (Kahn et al., 2012), contributing to the felt need to conceal potentially stigmatizing identities (Budge et al., 2017; Quinn et al., 2014), unequal treatment, having poorer health outcomes (Newheiser & Barreto, 2014), and reduction of seeking help personally and professionally (Parcesepe & Cabassa, 2013; Rössler, 2016; Vogel et al., 2006, 2009). Inside the field, it is worth first to dispel the myth that mental health professionals are free from stigma and its correlates (Rössler, 2016). Stigma exists within the field and has been identified as a barrier to self-care behaviors and a contributor to the silence within the field surrounding psychological wounds and self-care (Kalkbrenner et al., 2019; Zerubavel & Wright, 2012). Stigma also impacts self-care through cognitive dissonance

that buoys invulnerability and other myths and misconceptions such as those stated by Barnett et al. (2007) that led professionals in the field to not engage in self-care. Stigma within the mental health professional population and context carries a particularly profound weight as professionals are also tasked with gatekeeping other current and future professionals in the field. Disclosure of any potentially stigmatizing condition by those within the field has a very real potential of inviting negative correlates and consequences of stigma to profoundly impact both their personal and professional life negatively (Cain, 2000).

Although research on stigma within the field was more prevalent than earlier constructs, there still exists much to be done and understood. Stigma is a vast construct with many layers of differentiation and complexity. The given population of future and current mental health professionals also presents many other complexities around stigma due to the general makeup of those who choose to work within the field; these characteristics make anticipated stigma one of the more prevalent forms of stigma likely to be experienced by those in the field (Aponte & Kissil, 2014; Barnett, 2007; Ivey & Partington, 2014; Swords & Ellis, 2017). Stigma in general and specifically anticipated stigma are topics that need further research and understanding in order to implement effective systemic change in the field around incorporating self-care. More specifically, there seems to be a lack of research on the impact of anticipated stigma and personal therapy on self-care within the mental health trainee population. A better understanding is important to know how to approach having a field that actively addresses the issues surrounding self-care and creating a training and education system that promotes lifelong flourishing in its professionals.

Theoretical Framework

The underpinnings of calls for the incorporation of self-care for current and future mental health professionals are related to theory on the importance of the person of the therapist. At their core, such calls acknowledge the importance of the therapist's well-being and consequently the importance of the person of the therapist. Put quite simply, the POTT theory highlights the importance of the therapist's person in contribution to the quality of therapy (Aponte & Kissil, 2016; Aveline, 2005; McConnaughy, 1987; Norcross & VandenBos, 2018). Recent literature highlighted again how the person of the therapist is inextricably intertwined with efficacious treatment (Norcross & Lambert, 2018).

The person of the therapist (POTT) is a theory that emphasizes the person or individual who is the mental health professional and considers the therapist's humanity and well-being within the therapeutic relationship and treatment (Kissil & Niño, 2017). Person of the therapist theory views the self or person of the therapist as a necessary element in the education and training of mental health professionals (Aponte et al., 2009). Research supported the POTT theory and focus with findings that the person of the therapist is a contributing and essential factor to the efficacy of therapeutic treatment (Norcross & Lambert, 2018). In fact, the research reviewed by Norcross and Lambert (2018) found the person of the therapist contributed more than the treatment method and accounted for 5%-8% of the treatment outcome. These authors concluded it was impossible to mask the person and contribution of the therapist despite efforts to the contrary (e.g., the person of the therapist being largely ignored in research, not being a training focus, omission from treatment guidelines), and that POTT theory effects were strong and ubiquitous.

Person of the therapist theory incorporates research on the importance of the therapist by focusing on the person of the therapist and using the self within therapy (Aponte et al., 2009). Person of the therapist theory emphasizes clinical growth through self-access, self-knowledge, and self-management (Aponte & Kissil, 2016). Knowledge and use of the self is predicated by exploration of signature themes (i.e., elements of emotional woundedness) for the therapist. Person of the therapist theory holds the premise that we are all wounded healers (Aponte & Kissil, 2014; Niño et al., 2015) and that by embracing our own vulnerable humanity, we can better understand and connect to others. Emphasis on the importance of self-care within the education and training of mental health professionals is prioritized within POTT theory (Kissil & Niño, 2017).

Regarding self-care, Kissil and Niño (2017) noted that POTT theory had many similarities to self-care strategies for psychotherapists promoted within the field (Norcross & VandenBos, 2018). Kissil and Niño determined that POTT theory constituted engaging in self-care and noted that several themes were consistently associated with increased self-care: (a) an increased understanding, openness, and acceptance of self; (b) relational changes that allowed acknowledgement and discussion of elements of woundedness; and (c) themes of seeking personal growth and addressing change. These themes were uniquely relevant to this study in that all the variables (i.e., self-care, anticipated stigma, and personal therapy) are encompassed in POTT theory. Self-care is valued and emphasized in POTT theory; it is also an outcome of implementing POTT theory into the education and training of mental health professionals. Anticipated stigma is attended through the discussion of signature themes, embracement of vulnerability and humanity, assumptions of woundedness and stigma, empathizing with the struggle of others, and the need to address the culture of silence concerns noted by Zerubavel and

Wright (2012). Within POTT theory, Aponte and Kissil (2016) noted that much of the work included work similar to therapy and might even be therapeutic at times. Aponte and Kissil elaborated that the aim is different from personal therapy work and consequently leads many to do their own personal work to further address issues and continue personal growth. As illustrated, POTT encompasses all the relevant variables in a multitude of ways and suggests these variables are important to enhancing self-care for those within the mental health field.

The person of the therapist theory is used as the lens through which the construct of self-care is related and understood. To begin to adequately understand self-care within the population of interest, it is necessary to incorporate the most pertinent literature that explains the specific construct of self-care within the field and said field's lack of incorporating it. Due to the population being mental health professional trainees with an adherence to a multitude of theoretical orientations, only an integrative perspective of self-care would prove adequate for all trainees within the mental health field. In fact, Norcross and VandenBos (2018) reviewed their own decades of research and other literature in the field to conclude that a broad, flexible, and integrative principle-based approach to self-care should be used. They highlighted that a broad, flexible, and integrative principle-based conceptualization of self-care stemmed from theory on the person of therapist and stated the need to value the person of the therapist. A broad, flexible, principle-based, and integrative conceptualization of self-care was used within this study to characterize and explain self-care within the context of mental health professional trainees.

With regard to the lack of self-care and relative silence within the field, the wounded healer conceptualization used by POTT theory (Kissil & Niño, 2017) contains relevant explanations for the stigma surrounding a culture of silence and why people in the field might not adequately engage in self-care (Zerubavel & Wright, 2012) as well as ways to begin

addressing this silence and self-care. The wounded healer construct provides a backdrop for a better historical and current understanding about relevant characteristics of those within the field.

Using POTT theory to explain the constructs of self-care, personal therapy, and anticipated stigma as well as to unpack the unique considerations for the trainee population within the field of mental health allows for a more comprehensive view that uses theory to highlight the importance of self-care. Valuing the person of the therapist, as is done within POTT theory, emphasizes the need to effect changes that incorporate self-care into the education and training of mental health professionals through means like reducing stigma and promoting self-care strategies like personal therapy. Using POTT theory also allows for a better understanding of how valuing the person of the therapist might impact the field and emphasizes the importance of further exploring anticipated stigma, personal therapy, and self-care. Utilization of POTT theory also allows for greater support to be lent on current models that emphasize the person of the therapist in education and training.

Rationale and Need of Study

Due to the increased call to create a systemic change to the education and training within the mental health field that better incorporates self-care for professionals, many researchers have begun looking to incorporate self-care within graduate training programs for mental health professionals (Colman et al., 2016; Dattilio, 2015; Wise & Reuman, 2019). Little literature currently exists within the field on self-care for mental health professional trainees, much less on the factors contributing to said self-care. The mental health field's lack in addressing self-care is concerning given that self-care is conceptualized as an ethical imperative (Barnett et al., 2007; Wise et al., 2012). Lack of guidance on how to incorporate self-care into the education of future mental health professionals and effective measures of doing so are also concerning issues that

need further research (Bamonti et al., 2014). The lack of research makes it difficult to know the long-term benefits of incorporating self-care into the education and training for mental health professionals as well. To create a mental health professional education system that promotes lifelong flourishing as suggested by Wise and Reuman (2019), more than incorporation of self-care is needed (Zahniser et al., 2017). A better understanding of self-care and what contributes to it within the mental health professional trainee population is required ~~t~~o begin to better address the stated need to incorporate self-care changes within the field. As noted by many authors in the literature (Bamonti et al., 2014; Barnett & Cooper, 2009; Posluns & Gall, 2020; Wise & Reuman, 2019), there exists a dire need for action and change in the self-care of current and future professionals within the field in order to meet the rising demands of working in the field.

Purpose of Study

The purpose of this research was primarily threefold. The first purpose was to determine how much of the variation in self-care was explained by anticipated stigma and attendance in personal therapy. The second purpose was to determine the contribution of both anticipated stigma and personal therapy separately on the variation within self-care. The third purpose was to determine if there was a difference in self-care between mental health professional trainee groups who had experienced personal therapy. It was hoped this research would help promote future research and inform methods on the incorporation of self-care within the education and training of mental health professionals. A greater understanding of anticipated stigma, attendance in therapy, and self-care along with their relationships might allow for implications for better implementation of systemic change in the education and training of mental health professional trainees to incorporate self-care and attendance in therapy throughout the curriculum. A better understanding might also allow changes that positively address stigma for this population. The

hope is this research contributed toward further research and an educational and training system that promotes flourishing mental health professionals who are better able to engage in self-care and personal therapy to meet the rising demands of the field.

Research Questions

Q1 How much of the variation in self-care is explained by anticipated stigma and previous personal therapy in mental health professional trainees?

Q2 What is the contribution of anticipated stigma in explaining the variation within self-care for mental health professional trainees?

Q3 What is the contribution of previous personal therapy in explaining the variation within self-care for mental health professional trainees?

Q4 Is there a statistically significant difference between the groups of those mental health professional trainees who engage in personal therapy and those who do not on self-care?

Definition of Terms

Anticipated Stigma. The definition from Quinn and Earnshaw (2013) was used to define anticipated stigma: "The negative treatment people with concealable stigmatized identities (CSIs) believe they might receive if others know of their identity" (p. 3). Participants were provided with relevant definitions and examples. In this study, anticipated stigma was measured by the Anticipated Stigma Scale (Quinn & Chaudoir, 2009).

Mental Health Professional Trainees. Mental health professional trainees are described as any trainees in a graduate program who are preparing to enter the mental health field as professionals who will provide mental health services as therapists or counselors. The list might include mental health trainees in various graduate training programs such as counseling, counseling psychology, marriage and family therapy, and counselor

education and supervision. Participants were screened for meeting the above criteria with basic questions before taking the survey.

Personal Therapy. Personal therapy was defined based on APA's (2007) definition of psychotherapy, the American Counseling Association's (2010) definition of counseling, and Norcross and VandenBos's (2018) definition of personal therapy. The definition was that personal therapy is a generic term used to encompass a range of possible collaborative treatments with a mental health professional to work through mental health problems and/or accomplish mental health and other goals to live a happier, healthier life. Personal therapy consisted of any personal therapy, analysis, or counseling that the mental health professional trainee had completed that comprised of at least one session. For this study, a survey was created asking participants the number of counseling sessions they had had and related information.

Self-Care. The definition of self-care is based upon the definition and Self-Care Assessment for Psychologists (SCAP) developed by Dorociak, Rupert, Bryant, et al. (2017) for specific application of those within the mental health field. As noted by the authors, "The SCAP adopts a preventative perspective on self-care, with items reflecting strategies or behaviors that may be integrated into one's professional and personal life on a more ongoing basis to promote well-functioning" (p. 332). The definition incorporates significant themes, areas, and domains throughout the field to create an integrative construct that defines self-care and marks its goal to promote professionals who flourish both personally and professionally. Self-care is defined specifically as "a multidimensional, multifaceted process of purposeful engagement in strategies that promote healthy functioning and enhance well-being" (p. 326). Self-care is determined

by the five factors of professional support, professional development, life balance, daily balance, and cognitive awareness. In this study, self-care was measured by the SCAP (Dorociak, Rupert, Bryant, et al., 2017).

Systemic Change. Systemic change within this study referred to what Barnett et al. (2007) stated when discussing self-care changes that needed to be made within the mental health field: "implementing the systemic changes needed in our education and training systems" (p. 606) and "global, systemic action by the profession of psychology" (p. 609).

Limitations

Within the psychological field and study of psychological constructs, self-report measures are often employed due to the nature of study and constructs being studied. Regardless of the pervasiveness of use, the use of self-report measures inherently includes unavoidable limitations such as social desirability, self-selection, and misunderstanding questions. These limitations become of even more concern when the topic or questions include areas that might be more sensitive or secretive. The use of self-report measures includes limitations in the accuracy of results. These could come about because of social desirability or using known politically or otherwise correct responses to appear better. A final note on limitations of self-report within the current population is how current and future mental health professionals likely have a copious number of ways and methods by which they minimalize their own need to engage in self-care due to various reasons (Barnett et al., 2007; Engle et al., 2017).

It needs to be noted that this study used self-report measures throughout and the areas covered might have involved topics that might be sensitive in nature (e.g., participation in counseling and areas involving stigma). To combat these limitations as much as possible, every possible step was taken to ensure the anonymity of the participants. Qualtrics, which was used to

conduct the survey, allowed for many anonymity measures such as not recording Internet Protocol (IP) addresses. All these methods were employed and data were separately collected from any specific possible identifying information like email addresses.

This study was a non-experimental design type study from which only correlations should be drawn. The recruitment methods were largely convenience based and the known response rate for surveys within similar populations has shown to be lower than 25% (Dorociak, Rupert, & Zahniser, 2017; Drew et al., 2017; Singh et al., 2010). Self-selection to engage in the study impacted the generalizability of results and might subject the results to responder's bias. An incentive was offered in order to help overcome these limitations but due to the previously stated limitations, the sample participants were not representative of the entire population and the generalizability was limited. Professionals who were no longer trainees were also not included to limit the scope of this research.

This research was conducted during a time when COVID-19 made a significant impact on the mental health field and world at large. The effects of COVID-19 on research and studies conducted during pandemic time have not been quantified but it should be noted that COVID-19 and the relevant changes experienced in daily life (e.g., social distancing) likely impacted self-care practices and behaviors. It was also likely COVID-19 and these changes additionally might have impacted mental health professionals and trainees through various ways including the myriad of changes the mental health field made to meet the subsequent demands from COVID-19. The impact of all these different processes is unknown and might introduce a further limitation to this study in that the results from this study might not be generalizable outside of the context of the specified time period.

Summary

There are numerous calls within the field to implement systemic changes within the mental health field around incorporating self-care for current and future mental health professionals (Bamonti et al., 2014; Colman et al., 2016; Dorociak, Rupert, & Zahniser, 2017; Niño et al., 2015; Richards et al., 2010; Wise & Reuman, 2019). The calls for change are due to increased need within the field and within graduate programs to bolster well-being and its related constructs through methods like self-care and attendance in personal therapy (Swords & Ellis, 2017). An unsettling paucity of discussion, research, and guidance surrounds self-care in general and on methods with which to incorporate self-care and other determinants of well-being within the mental health field (Norcross & VandenBos, 2018). The ways in which to theoretically begin addressing the problem of self-care have been debated within the field, and there exists a need for more study on how to promote flourishing future professionals (Wise & Reuman, 2019). The purpose of this research was to address the gap of knowledge and research about self-care, personal therapy, and anticipated stigma within future mental health professionals. It was hoped this research would begin to fill the gap on how anticipated stigma and personal therapy affect self-care for mental health trainees and help prompt discussion and change within these areas. This research might help guide future attempts at incorporating systemic changes regarding self-care within the field and show the contribution that anticipated stigma and personal therapy have on self-care within this context.

CHAPTER II

LITERATURE REVIEW

Introduction

This chapter provides a detailed review of the guiding theory and factors used in the current study. Using the theory of the person of the therapist (POTT) allowed for a framework that highlighted the importance the contribution the therapist's person or therapist effects has in therapy and the importance of the development and self-care of the individual or person of the therapist (Kissil & Niño, 2017; Norcross & Lambert, 2018). The person of the therapist is a theoretical framework that focuses on the impact the therapist (i.e., the actual individual; not some interchangeable provider) has on the therapeutic process and how therapists use the self within the clinical context (Aponte & Kissil, 2016; Aponte et al., 2009). Such a framework then lends theoretical and researched credence to the importance of the therapist's overall self-care and subsequent well-being (Wise et al., 2012). The POTT theoretical framework is ideally suited for meeting the calls for systemic change within the education of future mental health professionals due to the focus on the person of the therapist that would promote professionals who flourish both professionally and personally (Wise & Reuman, 2019). The person of the therapist framework also addressed the other variables within this study and incorporated them.

The variables of self-care, personal therapy, and stigma within the context of this study are also explored in the current chapter. Self-care and its meaning for those within the field were analyzed while the limited literature was reviewed. The deep historical roots of personal counseling within the field are investigated and summarized for incorporation into modern times.

Literature reviewing the connections to and the importance of personal therapy within the education of future mental health professionals is also detailed. Stigma and its subsequent research are also reviewed. Pertinent issues are derived to detail the impacts it has within the field and this research. In the end, everything is drawn together in a complete picture that could help increase the knowledge in the field concerning self-care for future mental health professionals.

Theory

The recent shift in literature that recognizes that importance of the person of the therapist and its contribution to the efficacy of mental health treatment is nothing new (Norcross & VandenBos, 2018). Perhaps some of the methods at providing evidence in support of the importance of the therapist theory are newer (i.e., meta-analysis data) but the idea that the person of the therapist is important is itself not new and can be seen throughout the history of all mental health traditions (Benziman et al., 2012; Wampold, 2015; Wampold & Serlin, 2014). The person of the therapist theory emphasizes the person or individual who is the mental health professional and considers the therapist's (i.e., individual who is providing therapeutic services) humanity and well-being within the therapeutic relationship and treatment (Kissil & Niño, 2017). Active use of self necessitates the therapist has knowledge of self, access to self, and management of self (Aponte & Kissil, 2016). Such a turn back to the historical importance of self within the therapeutic encounter highlights what Norcross et al. (2009) defined as the necessary components of effective practice in embracing the treatment method, the individual therapist, the therapy relationship, the patient, and their optimal combinations.

If the person of the therapist was not an essential component to effective therapy as the theory around it suggests, there would be no need for mental health organizations to have

regulations surrounding the self-care of their professionals and self-care would not be an ethical imperative (Wise et al., 2012). In fact, the most recent iteration of the APA study on evidence-based psychotherapy by Norcross and Lambert (2018) stated:

> Although efficacy research has gone to considerable lengths to eliminate the individual therapist as a variable that might account for patient improvement, the inescapable fact of the matter is that it is simply not possible to mask the person and the contribution of the therapist. (p. 306)

Such a strong statement highlights the importance of the person of the therapist and it should be considered within the same breath as theory and technique.

Such a concentration on theory and technique with little attention to the person of the therapist is well exemplified in the training and education of mental health professionals (Dorociak, Rupert, & Zahniser, 2017; Zahniser et al., 2017). The lack of concentration on the person of the therapist has contributed to calls for systemic reformation to the ways in which future mental health professionals are trained (Bamonti et al., 2014). Indeed, as noted by Norcross and VandenBos (2018), such calls might be a "nostalgic throwback to the 1970s and 1980s" (Location 311) that brings in sweeping reforms to the educational process. In fact, many of the fields have begun incorporating such reforms by building frameworks or models that highlight the importance of the person of the therapist (Aponte & Kissil, 2016; Wise & Reuman, 2019). Training models that emphasize the importance of the therapist such as the POTT model have been found to increase measures of and activities pertaining to self-care, increased self-reflection and awareness, prompt seeking personal therapy to continue growth, and reduce determinants of stigma (Kissil & Niño, 2017). Counseling psychology as a field should not be left behind when it comes to implementing these systemic changes for the betterment of mental

health professionals and the clients they serve. As noted by Mahoney (2003), counseling psychologists have the special opportunity to work with current and future mental health professionals throughout their development and hold a sacred duty toward them as clients. Counseling psychologists should be at the forefront of implementing and advocating for changes that benefit their clients. The involvement counseling psychologists have throughout the span of mental health professionals' lives necessitates a duty as a field to research and integrate educational and treatment changes that promote flourishing throughout the lifespan.

Norcross and VandenBos (2018) also spoke to the rich history the importance of the person of the therapist has throughout the mental health field. The importance was exemplified by the literature surrounding the wounded healer paradigm that focuses on the individual's own wounds that have been cured as part of the process of them becoming healers themselves (Benziman et al., 2012; Jackson, 2001). Examples can be seen throughout different cultures and traditions that relate to the wounded healer paradigm (Kirmayer, 2003). In Greek mythology, the wounded healer paradigm is exemplified by Chiron who heals others but can never heal himself. The wounded healer paradigm is seen repeatedly throughout other cultures as well including Norse tales, Arthurian legends, Hebrew lore, Chinese teachings, Babylonian myth, India beliefs, Islamic history, the Jewish Talmud, Christian myth and religion, and shamanistic traditions (Benziman et al., 2012; Stone, 2008). At some point after Freud, the mental health field lost the perspective that valued the tradition of the wounded healer and shifted to one that more closely matched a medical model where practitioners could not suffer from the same ailments as their clients (Barnett et al., 2007). Whether the lack of self-care resulted from ignoring the wisdom of past traditions or from the inherent caretaker qualities from those professionals within the field, it would seem Freud's admonition that psychologists engage in their own care with no shame has

been pushed into the background (Steiner, 2005). Perhaps a historical throwback is just what the field needs.

Self-Care

Self-care is a vast concept that spans a wide variety of professions, application, and research. It is only within context that self-care begins to become more specific and applicable. What might constitute self-care in one context does not necessarily constitute self-care in another. For example, consider Orem's Self-Care Model within the context of nursing (Sitzman & Wright Eichelberger, 2015). Here, self-care is defined as "what people plan and do on their own behalf to maintain life, health, and well-being" (chapter 14, para. 4) and focuses primarily on physical aspects of well-being. Such a conceptualization is pointedly different from how it is conceptualized for mental health professionals. As defined by Dorociak, Rupert, Bryant, et al. (2017), self-care is a process specifically defined as a "a multidimensional, multifaceted process of purposeful engagement in strategies that promote healthy functioning and enhance well-being" (p. 326). Such self-care focuses on the five factors of professional support, professional development, life balance, cognitive awareness, and daily balance. The wide discrepancy based on context is another major reason why the dearth of research on self-care within mental health professionals is so concerning. Without the proper specific contextual knowledge of self-care, a major determinant of well-being and a method for dealing with the inherent rigors of the mental health field are being ignored within the field and the field's education and training of future professionals (Bamonti et al., 2014; Dorociak, Rupert, & Zahniser, 2017; Wise & Reuman, 2019; Ziede & Norcross, 2020).

In order to develop programs that produce mental health professionals who engage in self-care throughout their lifespan, more research needs to be done around how to implement

effective methods of incorporating self-care within their education and training (Bamonti et al., 2014; Wise & Reuman, 2019). Past research overall supports the value of self-care within these settings but research on methods of incorporating self-care are fragmented and disjointed at best (Dorociak, Rupert, Bryant, et al., 2017; Zahniser et al., 2017). Incorporation of self-care becomes ever more important when the context of who tends to enter the mental health professional field is taken into consideration. As noted by much of the research in the field, the field tends to be made up of individuals who have experienced a wound of some sort themselves in their lives (Barnett, 2007). Whether that wound be a loss, some other experience of hardship, or a signature theme, it is often these things that draw people to the field (Aponte & Kissil, 2014, 2016; Barnett, 2007; Jackson, 2001). In fact, Mander (2004) noted that applicants to the field without some aspect of overcoming a wound are viewed with suspicion and are less likely to be chosen. Having a field comprised of individuals who have likely suffered a wound makes engaging in self-care all the more important due to the ambiguous nature of recovery trajectories and the associated stigma that comes with such identities (Conchar & Repper, 2014; Howard, 2006; Regehr et al., 2001).

Self-care is not only important at the beginning but also throughout the lifespan of the mental health professional due to the nature of the work (Sciberras & Pilkington, 2018; Wise & Reuman, 2019). Although there are many benefits to working in the mental health field, there are also a myriad of hardships and stressors that occur as well. Professionals working within the field often come up against their own limitations and those of the mental health system, reminding them of the prevalence of hopelessness and powerlessness that exists within the field (Goodman et al., 2004). Professionals are constantly working with people who are at low points in their lives. Any workday might bring with it dealing with trauma, depression, suicide, loss, racism,

and many other emotionally taxing and stressful issues. Coming into consistent contact with these issues is known to increase the prevalence of secondary traumatic stress, burnout, and decreased overall well-being—all of which have been shown to be linked to the adequacy of self-care (Dreison et al., 2018; Owens-King, 2019; Posluns & Gall, 2020; Swords & Ellis, 2017). Those within the field need to maintain their resilience to the stressors that come with working in the mental health field in order to provide effective services and have a fulfilling life (Lakioti et al., 2020) and self-care is increasingly becoming a method that is highlighted in doing so (Dorociak, Rupert, & Zahniser, 2017; Engle et al., 2017).

Echoing the message of fostering resilience and the promotion of well-being, self-care within the mental health field is theorized to include five factors of measurable areas (i.e., professional support, professional development, life balance, cognitive awareness, and daily balance) that work to enhance well-being both professionally and personally (Dorociak, Rupert, Bryant, et al., 2017). These five factors were consistent with the self-care literature within the field and matched the definition set forth by being positively correlated with measures of enhanced well-being and health functioning (Dattilio, 2015; Dorociak, Rupert, & Zahniser, 2017; Lee & Miller, 2013; Wise et al., 2012; Ziede & Norcross, 2020). The factors were developed by Dorociak, Rupert, Bryant, et al. (2017) by examining relevant frameworks of self-care to generate an item pool that identified all facets of self-care. Items were then analyzed by experts and run through two studies to confirm final items, factor structure, and measures of validity and reliability. The factor of professional support focused on the importance of support from colleagues and avoiding isolation. Professional development emphasized the importance of engaging in enjoyable work activities and staying current in the profession. Life balance underscored the importance of having both a personal and professional identity and having

support outside of the work environment. Cognitive awareness highlighted psychological self-care and monitoring of self-awareness around feelings and needs. Daily balance covered smaller-scale or misfocused strategies that are incorporated throughout the workday to manage demands and maintain awareness.

Although none of these factors covered physical self-care, Dorociak, Rupert, Bryant, et al. (2017) noted the exclusion of the area of physical self-care did not denote an unimportance of the physical area. The exclusion was due to the fact that it could not be quantified and appropriately assessed through a small number of items. The inability to appropriately quantify and measure physical self-care was a result of the complexity and personalized nature of self-care. For example, consider the wide diversity of sleep or dietary needs for different people and how that varies for the same individual across their lifespan. Such diversity precludes question specificity and the individual needs prohibit broad generalization in a relatively few number of items. Thus, the importance of physical self-care should not be minimized or not discussed as it is important to self-care (Posluns & Gall, 2020). Physical self-care should be assessed and planned in consultation with a medical professional as needed to fit the individualized needs of the person.

In support of how the five-factor conceptualization incorporated the requisite areas within the context of mental health professionals, areas like daily balance, professional development, and life balance were highlighted in research from Lakioti et al. (2020) through related theoretical conceptualizations and areas of impact. Their research focused on things such as deriving meaning from work and having positive relationships as being particularly important in maintaining mental health and functioning for professionals within the field. These foci were conceptualized within the areas of self-care for mental health professionals in the factors of

professional support, professional development, and life balance. Defining and conceptualizing self-care is just the beginning of understanding self-care within the mental health field and more research needs to be done around understanding and incorporating self-care.

Further examination regarding the incorporation of self-care for professionals within the mental health field led to inevitable ideas that self-care changes with and is dependent on the many different theoretical orientations held by those within the mental health field. As noted by Norcross and VandenBos (2018) in their comprehensive guide to implementing self-care for mental health professionals, their decades of research on self-care led to a broad principle-based approach that was flexible. The principles were 13 areas of focus that were based on first valuing the person of the therapist. The focus on the importance of the person of the therapist brings the research full circle to implementing systemic changes of self-care that first begin to value and then grow the person of the therapist. As mentioned by many researchers, the ideal place to begin these changes starts with the education and development of mental health professionals (Bamonti et al., 2014; Barnett et al., 2007; Wise & Reuman, 2019; Zahniser et al., 2017). The beginning point of development is the ideal place due to the many problems and lower efficacy in addressing the common negative outcomes (e.g., burnout, increased stress, and professional impairment) of the field after the fact (Lakioti et al., 2020) and the literature that suggested stress carried over when transferring into a professional role in the field (Robins et al., 2018). Given such, building a training culture that actively promotes and focuses on the value of the mental health professional's self-care to mitigate many of the negative effects of working within the mental health field is imperative. To make such changes, more knowledge is needed on the development and incorporation of self-care for mental health professional trainees.

Personal Therapy

Personal therapy is historically intertwined with professionals in the mental health profession and is a generic term that refers to psychological treatment by means of various theoretical orientations and formats (Norcross & VandenBos, 2018). Mental health professionals have historically sought their own personal therapy throughout many different cultures and traditions. The healer seeking their own healing is epitomized through the wounded healer paradigm within various cultures and histories in that the healer cannot heal themselves and seeks healing in some form from another healer. American psychology is not exempt from the tradition in that it was irrevocably impacted by Sigmund Freud after the Second World War (Woody & Viney, 2017). Freud himself was well known for undergoing his own period psychoanalytic analyses or personal therapy as it were and subjecting all those who wished to be into the field to analysis as well (Steiner, 2005). Having personal therapy or analysis, as it was called, as a necessary element to the education and training of mental health professionals changed slowly as different schools of thought and practice continued to evolve in American psychology (Norcross & VandenBos, 2018). The rates of attendance in the United States are such that roughly half of trainees attend personal therapy (Kalkbrenner & Neukrug, 2019) even though research like Orlinsky et al. (2011) found, "Personal therapy, analysis or counseling is subjectively rated as highly influential on psychotherapists' professional development" (p. 830); Byrne and Shufelt (2014) found roughly 75% of trainees believed personal therapy should be a prerequisite for clinical work; and Barnett and Cooper (2009) indicated training directors had recommended since 1998 that graduate programs should require personal therapy. Perhaps self-care practices have been always lacking in the field but the proliferation of ideas that diminished the importance of the therapist were evident in the literature leading up to and around the 21st

century (Norcross & VandenBos, 2018). The diminishment on the importance of the therapist might only be one of many potential reasons for the lack of self-care and its related activities like personal counseling becoming more prominent historically, but it is telling that even important historical figures like Carl Rogers (2004) were not exempt from lacking self-care. Reportedly, Carl Rogers admitted he was always better at caring for others than himself. Unfortunately, inadequate attention toward self-care of professionals in the field at large has continued to the current state where the field is now well known to be lacking in adequate self-care and many calls in the literature for change existed (Bamonti et al., 2014; Barnett et al., 2007; Wise & Reuman, 2019; Zahniser et al., 2017).

The current state of the mental health field for current and future professionals is one in which the work has often been linked to burnout, distress, vicarious traumatization, secondary traumatic stress, emotional exhaustion, increased stress, elevated risk for suicide, and mental disorders (Dreison et al., 2018; Kleespies et al., 2011; Lakioti et al., 2020; Meichenbaum, 2007; Owens-King, 2019; Robins et al., 2018; Sciberras & Pilkington, 2018). Although such negative outcomes combined with only a modest monetary reward might seem surprising at first glance, further exploration of the different areas that comprise the work within the mental health field revealed just how unsurpirsing these outcomes actually were. Taken into consideration first was the area of clientele; mental health professionals work largely with a population who shares with them their intense suffering, traumatic experiences, abuse, mental illness, suicidality, human cruelty, death, and behavioral problems (Lakioti et al., 2020; Meichenbaum, 2007; O'Brien, 2011). It is unsurprising that the experience of bearing witness to all of these things from their clientele would affect mental health professionals. The negative outcomes are also evident when consideration is given to the environment in which mental health professionals work. These

environments often lack funding, adequate staffing, power to affect change, job stability, emphasis on clinician mental health, and resources (Dreison et al., 2018; Kleespies et al., 2011; Sciberras & Pilkington, 2018). The fundamental nature of the work also includes a one-way relationship in which the mental health professional has no expectation of reciprocal caring, compassion, or empathy that they put into relationships (Posluns & Gall, 2020). Given the many negative outcomes and contributers to those outcomes, it is no wonder the field is in a state where there exist so many calls for change to incorporate increased self-care other determinants of enhanced well-being (Bamonti et al., 2014; Dattilio, 2015; Rupert & Dorociak, 2019; Ziede & Norcross, 2020).

In looking closer at the reduction of their own personal therapy as a possible contributor to the reduced self-care, noting the trends of attendance over the professional lifespan of those within the mental health profession provide some interesting data. Trainees reportedly attended their own personal therapy roughly at rates of 50% (Kalkbrenner & Neukrug, 2019) and professionals had attendance rates around roughly 80% (Bike et al., 2009; Kalkbrenner et al., 2019; Orlinsky et al., 2011). In a study of self-care across the professional lifespan, Dorociak, Rupert, and Zahniser (2017) noted the finding that late-career psychologists might engage in more self-care and experience greater well-being. The measure of well-being falls as the career point becomes earlier. Mid-career psychologists were shown to experience middle well-being levels that were between the high well-being of late-career and the low well-being of early-career psychologists. The relationship of attendance in therapy rates and related measures of self-care and other determinants of well-being are unknown; yet, the prominent tradition of healers going through their own healing process in order to become healers in many cultures reinforces the notion that something important might be overlooked with the current rates of personal therapy

and its incorporation into the education and training for mental health professional trainees (Benziman et al., 2012; Jackson, 2001; Kirmayer, 2003). Norcross and VandenBos (2018) further reinforced the notion with a statement on the cumulative results of decades of research stating, “The cumulative results argue that personal therapy is an emotionally vital and professionally nourishing experience” followed by the statement that personal therapy is viewed, “as a prerequisite to conducting psychotherapy and as a corequisite of self-care over one’s professional lifespan” (p. 195). Such a strong statement is in large part due to the educational growth and known benefits that attendance of personal therapy has for those within the field (Bike et al., 2009; Byrne & Shufelt, 2014; Drew et al., 2017; Kalkbrenner et al., 2019; Orlinsky et al., 2011).

The benefits of personal therapy for future and current mental health professionals were well documented in the literature. Authors like Bike et al. (2009), Norcross et al. (1988, 1992), Orlinsky et al. (2005), and others documented the host of benefits that personal therapy has toward enhancing clinical effectiveness. There are even more benefits when the personal benefits gained from positive outcomes of therapy are considered. Studies on professionals within the field noted 90% reported beneficial results and over three-quarters found it to have a strong positive influence on their development as a psychotherapist (Geller et al., 2005; Norcross, 2005). Negative outcomes were reported at around 1% to 5% in the United States and 3% to 7% internationally (Ziede & Norcross, 2020). Further examination revealed the negative outcomes mainly came when personal therapy was viewed as mandated (Orlinsky et al., 2011), which is typically a product of the remediation process (Drew et al., 2017; Kallaugher & Mollen, 2017; Vacha-haase et al., 2019). Noting when negative outcomes are experienced is important because work of the nature that caused harm is fundamentally different from what occurs in personal

therapy that is adherent to the core values of counseling psychologists and work that is centered on the person of the therapist and growth (Aponte & Kissil, 2016; Aponte et al., 2009; Kissil & Niño, 2017; Niño et al., 2015).

To better understand the attendance rates of personal therapy within mental health professional trainees, the barriers to personal therapy need to be understood. In their review of literature and subsequent assessment of barriers to personal therapy for trainees within the mental health field, Kalkbrenner and Neukrug (2019) found fit, stigma, and value to be the main barriers to personal therapy for mental health professional trainees. Value measured the reluctance to seeking personal therapy due to the belief that attending therapy would not be beneficial. As shown by the prior research, the value barrier is either ill-conceived or a product of ignorance and is best addressed by systemic changes that address cost, availability, and education among future mental health professionals. The fit barrier measures hesitation due to a mistrust of the counselor and the process of counseling. Fit is also best remedied on a systemic level by increasing available resources for trainees. The final barrier of stigma is defined as hesitation due to feelings of embarrassment or shame and was noted by the authors to have several limitations and further areas of study. To address the barrier of stigma, systemic changes in the culture of training programs as called for by the literature are needed (Bamonti et al., 2014; Barnett et al., 2007; Barnett & Cooper, 2009; Colman et al., 2016; Dorociak, Rupert, & Zahniser, 2017; Niño et al., 2015; Richards et al., 2010; Wise & Reuman, 2019). A greater understanding of the relevant stigmas within the population of mental health professional trainees would also be beneficial toward guiding these called for changes.

Anticipated Stigma

Stigma has long been viewed broadly as a barrier to mental health services and fundamental cause of inequalities in the health of the population (Hatzenbuehler et al., 2013). Multiple ways contributing to stigma have been conceptualized, operationalized, and defined. Among the different conceptualizations of stigma exist various forms that pertain to mental health; self-stigma, public-stigma, experienced stigma, and anticipated stigma were the major forms in the literature (Chaudoir & Quinn, 2016; Mullen & Crowe, 2017; Parcesepe & Cabassa, 2013; Quinn & Chaudoir, 2009; Quinn et al., 2014; Tucker et al., 2013; Vogel et al., 2006, 2009). Although different forms have been identified, clarity between them is murky and debate within the field exists even on these broad terms; Tucker et al. (2013) illustrated how easily the forms of stigma become entangled. The murkiness around stigma might be partly to blame for why researchers have only recently begun to examine the effect of stigma within mental health professionals and trainees and how they cope with the stressors inherent to working within the field (Kalkbrenner & Neukrug, 2019; Kalkbrenner et al., 2019; Mullen & Crowe, 2017). Anticipated stigma specifically has yet to be applied to mental health professional trainees despite the vast literature suggesting its applicability to the population (Barnett, 2007; Ivey & Partington, 2014; Meichenbaum, 2007; Zerubavel & Wright, 2012). Anticipated stigma was defined by Quinn and Earnshaw (2013) as "the negative treatment people with concealable stigmatized identities believe they might receive if others know of their identity" (p. 3). Anticipated stigma has been identified as a main contributor to other forms of stigma and to a lower sense of belonging; it has also been shown to be a stronger predictor of psychological distress than other forms of stigma, making it ideal to study with mental health professional

trainees (Hing & Russell, 2017; Newheiser & Barreto, 2014; Quinn et al., 2014). To understand anticipated stigma more fully, an understanding of the literature around stigma is necessary.

Pescosolido and Martin (2015) noted that stigma, in the research literature, is a global referent category that is not a singular entity, static phenomenon, or an either/or experience. The scope of stigma research was therefore broad across many areas of study because of the conceptual ambiguity that did not limit the argued scope and applicability of stigma. The basic conceptual definition of stigma is a mark, condition, or status that is subject to devaluation; it is derived from ancient Greece where criminals or slaves were branded with the stigma mark (Rössler, 2016). Within the context of psychology, stigma has been known to negatively impact psychological well-being and life satisfaction (Markowitz, 1998), be a barrier to seeking professional help (Vogel et al., 2006, 2009), act as a fundamental cause of health inequalities (Hatzenbuehler et al., 2013), and negatively impact the lives of those with mental illness in a myriad of ways (Parcesepe & Cabassa, 2013). Stigma has long played a large part in how those with mental illness of any sort were treated and ranged from the systemic hunting down, torture, and public burning of individuals (Broedel, 2013) to mass rates of incarceration and hospitalization of the mental ill in terrible conditions (Woody & Viney, 2017). Although such active forms of negative treatment are not used today, current consequences of stigma for the mental ill still involve many negative consequences such as mass avoidance and banishment to homelessness seen today (Comer & Comer, 2018).

Considering the aforementioned and other past treatment that has resulted from the many different kinds of stigma, it is no wonder individuals often conceal any form of identities that could be stigmatized. Such identities are known as concealable stigmatized identities (CSIs) and are defined as any socially devalued identity that can be hidden from others (Quinn et al., 2014).

For example, one might conceal the part of their identity that is sexual orientation in certain contexts for fear of negative treatment. The extent to which pieces of or whole identities are concealable and stigmatized varies across cultural groups and situations. These identities could range from a recovery of mental illness to sexual orientation or even having lived through abuse (Quinn & Earnshaw, 2013). In fact, CSIs cover such a large range of identities that Quinn et al. (2014) indicated most people will experience or care for someone who has one at some point. Every person has different identities and attributes that construct and impact their identities. As shown in the literature, CSIs often exist before entering the field (e.g., previous depression or other mental illness, sexual and gender orientation, childhood trauma, abuse, etc.) or might develop while working within the field through things like vicarious trauma, secondary traumatic stress, depression, burnout, imposter syndrome, psychological distress, and grief (Barnett, 2007; Ivey & Partington, 2014; Meichenbaum, 2007; Owens-King, 2019; Quinn et al., 2014; Wheeler, 2007). Such intersectionality is a characteristic of identity that needs to be accounted for when discussion about areas are likely to be impacted by the potential stigma future and current mental health professionals face (Clauss-Ehlers et al., 2019).

Current and future professionals within the mental health field are not somehow immune to stress and other common occurrences of life nor do they possess a presence of mind that makes them insusceptible to stigma and other forms of erroneous thought (Barnett et al., 2007). In fact, it is well documented that mental health professionals are impacted by and hold stigmas, even about mental illnesses they treat (Byrne & Shufelt, 2014; Crowe et al., 2017; Kalkbrenner et al., 2019; Kleespies et al., 2011; Mullen & Crowe, 2017). Much of the previous work around stigma has focused on the impact such self-stigma of mental illness has on help seeking behaviors (Choi & Miller, 2018; Crowe et al., 2017; Mullen & Crowe, 2017; Vogel et al., 2006).

Generally, self-stigma is defined as a reduction in one's self-esteem or self-worth and the internalization of negative public attitudes and beliefs to their self-concept (Mullen & Crowe, 2017; Tucker et al., 2013; Vogel et al., 2006). Tucker et al. (2013) suggested that self-stigma of mental illness and self-stigma on help seeking behaviors are different constructs that are mixed into many of the assessments on self-stigma. Not only does such a mixture present conceptual problems in differentiating between what is being assessed but neither forms of self-stigma offer explanations to further the knowledge and understanding of why there exists silence within the mental health field.

Anticipated stigma conceptually accomplishes the task of explaining why there exists silence within the mental health field around discussion of woundedness and lack of self-care with literature that shows individuals choose to hide concealable stigmatized identities in the workplace due to expectation that revealing it would have a negative impact (Newheiser & Barreto, 2014). If stigma research is combined with literature surrounding the uncertainty of recovery trajectories (Conchar & Repper, 2014; Howard, 2006; Regehr et al., 2001), the social conspiracies of silence Zerubavel and Wright (2012) identified within the mental health field that prevented discussion around the wounds professionals have or obtain as a result of working as a mental health professional become ever clearer (Callahan & Dittloff, 2007; O'Brien, 2011). The lack of dialogue and guidance for addressing issues of mental health for current and future professionals within the mental health field has led to the calls for systemic change by many (Bamonti et al., 2014; Colman et al., 2016; Dorociak, Rupert, & Zahniser, 2017; Niño et al., 2015; Richards et al., 2010; Wise & Reuman, 2019). More research into the relevant stigmas that impact mental health professional trainees needs to be done to adequately address it.

As many of these calls for change focused on addressing the training and education of future mental health professionals, examination of stigma around concealable stigmatized identities becomes even more relevant due to the characteristics of this population (Barnett, 2007). The literature around relevant stigma illustrated many different types of stigmas but again highlighted the role anticipated stigma plays (Quinn et al., 2014). Highlighted importance is due to the found associations of anticipated stigma; anticipated stigma is associated with poorer recovery trajectories, self-stigma and less help seeking behavior, psychological distress, lowered sense of belonging, and impairment of social interactions (Chaudoir & Quinn, 2016; Choi & Miller, 2018; Hing & Russell, 2017; Mullen & Crowe, 2017; Newheiser & Barreto, 2014; Quinn et al., 2014). Negative treatment in the context of mental health professionals carries even more weight as they are at a heightened risk for potential serious ramifications from disclosing, and the risk is even more increased for trainees (Zerubavel & Wright, 2012). Gaining a greater understanding and knowledge of anticipated stigma and its impact on mental health professional trainees are critical to guiding calls for changes and incorporating increased self-care within the education and training of these trainees.

Although many of the changes to the education and training of mental health professional trainees suggested by the research incorporated changes and research that were meant to address stigma, few actually mentioned stigma directly throughout their recommendations (Bamonti et al., 2014; Colman et al., 2016; Dorociak, Rupert, & Zahniser, 2017; Wise et al., 2012; Wise & Reuman, 2019; Zahniser et al., 2017). Awareness that stigma is a problem was shown by incorporation of research and changes that addressed it, but more research is needed that directly addresses stigma in their recommendations (Barnett et al., 2007; Norcross & VandenBos, 2018; Zerubavel & Wright, 2012; Ziede & Norcross, 2020). Further investigation into stigma,

specifically anticipated stigma, is needed to address the gap in the literature if the field intends to truly make changes to the culture of self-care surrounding the education and development of mental health professionals.

Anticipated Stigma, Personal Therapy, and Self-Care

By using theory on the person of the therapist, it is possible to lend theoretical and research support that highlights the importance of the therapist. Theory surrounding the importance of the therapist highlights that the person of the therapist is important to the efficacy of any therapeutic endeavor. Otherwise, the therapist's well-being and therefore self-care would be unimportant regarding the efficacy of treatment outside of just being capable to go through the indicated manual or treatment. In other words, POTT theory is the essential linchpin to all research, evidence, statements, changes, etc. that regard the therapist as important in some form to therapeutic success. The person of the therapist theory highlights the person behind the professional and treatment to focus on factors that are important in relation to the individual (Allen, 2018; McConnaughy, 1987). An individual focus allows for study on concealable stigmatized identities and the anticipated stigma that one might feel from having these identities or their pieces of identities known.

Anticipated stigma is known to have many detrimental effects on well-being determinants, to contribute to other forms of stigma, and decrease the likelihood of help seeking behaviors (Chaudoir & Quinn, 2016; Choi & Miller, 2018; Hing & Russell, 2017; Mullen & Crowe, 2017; Newheiser & Barreto, 2014; Quinn et al., 2014). Detrimental effects are experienced in part due to lowered sense of belonging, actual social rejection, and higher levels of experienced distress (Chaudoir & Quinn, 2016; Quinn & Chaudoir, 2009; Quinn & Earnshaw, 2013). Anticipated stigma's impact on self-care has not been researched. The previous statement

is especially true within mental health professional trainees despite the significant amount of research pointing toward the higher population density of concealable stigmatized identities this population holds (Barnett, 2007; Jackson, 2001; Mander, 2004; Wheeler, 2002, 2007). Relevant also is that stigma has been shown to be a barrier to the attendance in personal therapy (Kalkbrenner et al., 2019). Within the context of future mental health professionals that exists within a described culture of silence and lesser power, anticipated stigma is theorized to be even more relevant (Hing & Russell, 2017; Mullen & Crowe, 2017; Quinn & Earnshaw, 2013; Quinn et al., 2014; Zerubavel & Wright, 2012).

The de-emphasis on the importance of personal therapy as a development and educational tool is likely in part due to the attempts within the field to deemphasize the importance of the person of the therapist (Norcross & Lambert, 2018). Person of the therapist theory and models highlight the importance of the person of the therapist and address this culture of silence by having trainees discuss and work through their signature themes (i.e., elements of emotional woundedness); such addressing of stigma and the importance of the therapist has shown to increase self-care within trainees and shift the culture of the training and education of mental health professionals (Kissil & Niño, 2017). Many of the self-care benefits experienced by those within the POTT model are similar to those gained from personal therapy, and such theory encourages the use of personal therapy much like what was suggested by Norcross and VandenBos (2018) as a result of the focus on the person of the therapist's wellbeing, use of self, knowledge of self, and management of self (Aponte & Kissil, 2014, 2016; Kalkbrenner & Neukrug, 2019; Kissil & Niño, 2017; Ziede & Norcross, 2020). To meet these calls of incorporating self-care within the training and education of mental health professional trainees,

more research on anticipated stigma, personal therapy, and self-care needs to be done (Bamonti et al., 2014; Barnett et al., 2007; Wise & Reuman, 2019; Ziede & Norcross, 2020).

Summary

Stress and other negative outcomes of working within the field have overflowed to the point that the lack of adequate self-care has increasingly become an area of research and concern (Dorociak, Rupert, Bryant, et al., 2017; Sciberras & Pilkington, 2018; Swords & Ellis, 2017; Wise et al., 2012). Recent calls in the literature highlighted a need for systemic change that incorporates self-care into the education and training of mental health professionals (Bamonti et al., 2014; Barnett et al., 2007; Norcross, 2005; Norcross & VandenBos, 2018). Such renewed focus on the importance of the person of the therapist highlighted the need to better understand what contributes to the development of self-care within mental health professionals to guide changes that promote professionals who flourish (Wise & Reuman, 2019). Relevant self-care literature pointed to the importance of personal therapy in the education and development of mental health professionals and as a method of self-care (Norcross & VandenBos, 2018). Specific barriers to personal therapy for those within the mental health field like anticipated stigma and other things that contributed to a culture of silence are areas that require more research and understanding within this population (Aponte & Kissil, 2016; Kalkbrenner & Neukrug, 2019; Quinn & Earnshaw, 2013; Ziede & Norcross, 2020). The purpose of this study was to begin to fill the gap in the literature, contribute to furthering research on the importance of mental health professional trainee self-care, and provide preliminary guidance for systemic changes to incorporate self-care within the education and training of mental health professionals.

CHAPTER III

METHODOLOGY

Research Design

This study was a non-experimental correlational research design (Remler & Van Ryzin, 2015). The primary investigator examined the impact of attendance in personal therapy and anticipated stigma on self-care in mental health professional trainees. Calls within the current literature for the education and training of mental health professionals looked at incorporating self-care into programs as a method to address the stress within the field and promote professionals who flourish (Bamonti et al., 2014; Barnett et al., 2007; Barnett & Cooper, 2009; Colman et al., 2016; Dorociak, Rupert, & Zahniser, 2017; Niño et al., 2015; Richards et al., 2010; Wise & Reuman, 2019). Anticipated stigma is thought to be a deterrent to many forms of self-care (Hatzenbuehler et al., 2013) and to interact with many of the elements constituting self-care and other determinants of well-being for similar populations (Quinn & Earnshaw, 2013; Quinn et al., 2014). Theory and models that highlighted the importance of the person of therapist prioritized and promoted self-care within trainees, and incorporation of strategies and principles to increase self-care such as having discussions around stigmatizing identities was used within models that followed this theory (Aponte & Kissil, 2016; Kissil & Niño, 2017; Norcross & VandenBos, 2018). Little research exists on the impact of anticipated stigma and personal therapy on self-care for mental health professional trainees. Thus, there is a need for such more knowledge to guide systemic change around incorporating self-care within the education of mental health professional trainees; the current study aimed to fill the gap in the literature.

Specifically, this study aimed to investigate if there was a difference in self-care for those trainees who engaged in personal therapy and to assess the impact of personal therapy and anticipated stigma on self-care.

Procedure

Participants

Upon Institutional Review Board approval (see Appendix A), the researcher sought participants primarily from various graduate programs via email, dissemination, and snowball sampling by emailing the director or members of programs that fit the population criteria and were identified from various state education departments, regional chapters of the Association for Counselor Education and Supervision, and internet search for psychology departments that had APA)/Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredited programs. Over 500 programs were identified using the APA and CACREP sites; then 50 sites of each accreditation were chosen at random via a random number generator to be contacted for participation in the study. Due to the number of APA accredited programs that responded with policies of not participating in research requests, further participants were sought through use of the Council of University Directors of Clinical Programs. All recruitment media followed the outline and information as shown in Appendix B that included (a) type of participants looked for, (b) general aim of the study, (c) information on incentive, (d) estimated time to take, and (e) link to survey's informed consent and subsequent survey. The included link directed participants to the survey's informed consent page (see Appendix C). After completion of the survey, participants indicated if they wanted to be included in the raffle and were redirected to a separate unlinked page where they could enter in an email address of their choice to be entered into a raffle for the incentive of four $50 amazon gift cards.

The separate page consisted of a simple question asking them to enter in the email address they would like to have the incentive sent to if they won. Participants were informed prior that their answers were anonymous and the email address provided would not be able to be linked to any participant data. Participants who do not meet the demographic criteria to participate in the survey were screened using simple screening questions such as asking if they are in a graduate training program to become a mental health professional who will provide mental health services (see Appendix D). Proper screening questions increased research efficiency and precluded participants from wasting their time if they were not within the target population. Screening questions used survey logic to automatically proceed to an alternate end of the survey for participants who did not meet inclusion criteria. The end of survey for these individuals included a message thanking them for their interest and explaining that they were not included within the population of interest for purposes of this survey. Those participants who met the inclusion criteria continued to the next portion of the survey.

Sample Size

The necessary number of participants was computed prior to engaging in research using G*Power 3.1 MacOS. G*Power is a software program used to compute statistical power analyses, effect sizes, and other variables for wide variety of statistical tests; it is recommended for use in the behavioral sciences (Faul et al., 2009). G*Power calculates the needed sample size given the number of predictors, power level, level of significance or type 1 error, and effect size. The standard power for these types of analysis within the psychological research is 0.8, and an alpha error (i.e., type 1 error) of .05 or .01 is also commonly used (Cohen, 1988; Cohen et al., 2015).

To determine the needed sample size for this study, consideration also was given to estimates that roughly 50% of trainees were reported to have attended therapy for the selected demographics (Byrne & Shufelt, 2014; Kalkbrenner & Neukrug, 2019; Orlinsky et al., 2011). This rate varies across reported studies due to sample characteristics such as time in program and program type. To gather the most accurate picture possible, more than the minimum number of participants was sought. A medium effect size standard power and alpha of .05 resulted in needing a minimum of 68 participants for the multivariate multiple regression analysis. The response rate for similar populations of graduate mental health program trainees varies from reported rates of 10% to 20% (Crowe et al., 2017; Drew et al., 2017; Singh et al., 2010). Obtaining the required sample number of respondents should have been readily possible given such response rates. If the requisite sample size was not obtained in a timely manner, reminders in the form of a secondary email and further dissemination on multiple fronts were to be used.

Demographics

After answering the screening questions, participants were then be asked to fill out a demographics questionnaire (see Appendix E) that included questions around age, ethnicity, gender, sexual orientation, and other standard demographic questions. Demographics such as ethnicity, gender, and sexual orientation included an area that allowed participants to self-identify; doing so provided recognition of the power of words and better captured a more complete picture of the individual. This was in line with APA's multicultural guidelines for mental health professionals in research and practice (Clauss-Ehlers et al., 2019). Because previous research indicated that differences in demographics did not impact stigma and counseling attendance within the mental health trainee population, none of these were included as independent variables for the analysis (Choi & Miller, 2018; Kalkbrenner & Neukrug, 2019;

Quinn & Chaudoir, 2009). After the demographics portion, participants continued to the rest of the survey that included the measures and associated primers and definitions.

Instrumentation

Personal Therapy

The first variable covered on the survey was attendance in personal therapy. Prior research outlined the methodology and questions commonly used to determine attendance in personal therapy (Bike et al., 2009; Byrne & Ost, 2016; Byrne & Shufelt, 2014; Drew et al., 2017; Geller et al., 2005; Kalkbrenner & Neukrug, 2018, 2019; Kalkbrenner et al., 2019; Norcross, 2005; Norcross et al., 1988, 2008; Orlinsky et al., 2011). Attendance in personal therapy was measured as a categorical dichotomous independent variable (i.e., yes or no) to the basic question stem, "Have you ever had personal therapy" (Bike et al., 2009), which contained no qualifiers (Bike et al., 2009; Byrne & Ost, 2016; Byrne & Shufelt, 2014; Geller et al., 2005; Holzman et al., 1996; Kalkbrenner et al., 2019; Norcross et al., 1988, 2008; Orlinsky et al., 2011) and used the qualifier of at least one session (Geller et al., 2005; Kalkbrenner & Neukrug, 2018, 2019; Norcross, 2005; Norcross & Guy, 2007). Only one study (Drew et al., 2017) used a frequency qualifier of more than one session. This included the following as a qualifier: a minimum of eight 50–60-minute sessions attended while in graduate school to qualify. For this study, participation in personal therapy/counseling was measured by answering Yes or No to the following questions: I currently am attending personal therapy/counseling and/or I attended personal therapy/counseling in the past (please indicate how long ago; see Appendix F). The results were then coded 0 for not attending and 1 for attending personal therapy. Personal therapy was defined based on APA's (2007) definition of psychotherapy, the American Counseling Association's (2010) definition of counseling, and Norcross and VandenBos's (2018) definition

of personal therapy. Personal therapy was defined as a generic term used to encompass a range of possible collaborative treatments with a mental health professional to work through mental health problems and/or accomplish mental health and other goals to live a happier, healthier life. Personal therapy consisted of any personal therapy, analysis, or counseling that the mental health professional trainee has completed that comprised of at least one session. The wording to measure attendance in personal therapy was similar to what was used in Orlinsky et al.'s (2011) nationwide survey with the addition of the qualifier of at least one session coming from the work compiled in Geller et al. (2005) and other authors in the literature that measured attendance in personal therapy for mental health professionals (Kalkbrenner & Neukrug, 2018, 2019; Kalkbrenner et al., 2019; Norcross, 2005; Norcross & Guy, 2007).

Participants were then asked whether they had attended or were attending their own personal therapy, counseling, or other form of therapy. If a yes was answered to either question, further questions regarding type, reasons for entering therapy, and perceived level of outcomes (positive and/or negative) were collected and compiled as additional descriptive data. The inclusion of negative outcomes was due to the small literature that existed concerning possible negative outcomes within certain training contexts (Orlinsky et al., 2011). The descriptive data gathered were consistent with previous research (Bike et al., 2009; Byrne & Ost, 2016; Byrne & Shufelt, 2014; Geller et al., 2005; Norcross et al., 1988, 2008; Orlinsky et al., 2011) and could be used in additional research to explore the experience of personal therapy.

Anticipated Stigma

The second measure was on anticipated stigma (see Appendix G). The definition from Quinn and Earnshaw (2013) was used to define anticipated stigma: "the negative treatment people with concealable stigmatized identities (CSIs) believe they might receive if others know

of their identity" (p. 3). The anticipated stigma scale developed by Quinn and Chaudoir (2009) and Quinn et al. (2014) was used to measure anticipated stigma due to its concentration on less visible stigmas. The anticipated stigma scale has been used to predict psychological distress and underutilization of health care services (Quinn & Chaudoir, 2009; Quinn et al., 2014). It was constructed by Quinn and Chaudoir using items from previous discrimination measures and incorporated items that captured current types of social devaluations likely to be faced by the population to construct a model of psychological distress. The anticipated stigma scale has been used in college student samples and diverse community samples. No other found scale was as up to date or measured the conceptualized area of anticipated stigma without confounding it with other measures of stigma or conflating it with several types of belief. It has high reported internal consistency rates of approximately α=.95 across different samples, has been shown to be applicable to diverse populations, and is differentiated from other types of stigma (Chaudoir & Quinn, 2016; Quinn & Chaudoir, 2009; Quinn et al., 2014). Anticipated stigma has also been shown to mediate the relationship between stigma type (personal and associative) and psychological and physical well-being. This 15-item measure utilizes a 1 (*not at all likely*) to 7 (*very likely*) Likert scale that totals scores at the end for a maximum score of 105; higher scores indicate increased anticipated stigma. The mean scale score for college student samples tended to be close to 3 while community samples tended to be almost an entire point higher. The anticipated stigma scale included items that measured things such as being "treated with less respect than other people," "people acting as if they think you are not as good as they are," and "friends avoiding or ignoring you."

Self-Care

The final construct measured was self-care (see Appendix H). Self-care for this study was defined as a conceptualization that is a "multidimensional, multifaceted process of purposeful engagement in strategies that promote healthy functioning and enhance well-being" (Dorociak, Rupert, Bryant, et al., 2017, p. 326). To operationalize self-care for this population, it was essential to pay attention to the five specified factors of self-care. Such self-care was measured by the Self-Care Assessment for Psychologists (SCAP) as it is the only known available empirically based psychometrically sound and comprehensive measure of self-care for those within the field and was made synthesizing key themes for mental health professionals in general (Dorociak, Rupert, Bryant, et al., 2017). As reviewed by Jiang et al. (2020) in their review of all self-care measures for those within the field, the SCAP was the only measure to have excellent validity constructs and met all other available methodological quality standards. Other measures failed to take into account multiple areas efficiently, suffered from weak or non-existent correlations to well-being and other validity factors, and contained non-collection of demographic data (Santana & Fouad, 2017). The SCAP was developed through a multistage process where the authors first synthesized the self-care literature in the mental health professional field to develop an operational definition and item pool (Dorociak, Rupert, Bryant, et al., 2017). The initial items were then reviewed by experts to complete the first item pool for study. A first study was done on these items to explore factor structure, retain or delete items, optimize scale length, and determine validity measurements; a second study was completed to confirm these results. Both studies were comprised of samples of psychologists. The SCAP was significantly correlated to all measures of external validity (e.g., well-being outcomes and levels of stress) as hypothesized, met the definitional criteria, contained only conceptualized process

items, and contained factors consistent with important themes identified in the literature. The results confirmed a five factor, 21 item sample structure for self-care. This oblique five factor structure model fit better than unidimensional, higher order, and bifactor models (Dorociak, Rupert, Bryant, et al., 2017).

The self-care assessment for psychologists was shown to have alpha ranges of α = .69 - .83 while measuring five different factors. The final five factors were identified as Professional Support (i.e., five items: I cultivate professional relationships with my colleagues, I avoid workplace isolation, I share work-related stressors with trusted colleagues, I share positive work experiences with colleagues, and I maintain a professional support system; α = .85), Professional Development (i.e., five items: I participate in activities that promote my professional development, I connect with organizations in my professional community that are important to me, I take part in work-related social and community events, I find ways to stay current in professional knowledge, and I maximize time in professional activities I enjoy; α = .79), Life Balance (i.e., four items: I spend time with people whose company I enjoy, I spend time with family or friends, I seek out activities or people that are comforting to me, and I find ways to foster a sense of social connection and belonging in my life; α = .80), Cognitive Awareness (i.e., four items: I try to be aware of my feelings and needs, I monitor my feelings and reactions to clients, I am mindful of triggers that increase professional stress, and I make a proactive effort to manage the challenges of my professional work; α = .71), and Daily Balance (i.e., three items: I take breaks throughout the workday, I take some time for relaxation each day, and I avoid over commitment to work responsibilities; α = .69. In total, it is a 21-items assessment that is measured on a 7-point Likert scale ranging from 1 (*never*) to 7 (*almost always*). Self-care is best conceptualized and assessed as a multidimensional construct.

> In employing the scale, it is not appropriate to compute a total self-care score, as individuals may vary in terms of their needs, preferences, and engagement in the various domains of self-care. Rather, individual subscale (factor) scores are more meaningful in describing and understanding self-care. (Dorociak, Rupert, Bryant, et al., 2017, p. 332)

This is important to the process of recognizing self-care as a multidimensional process.

The above five factors were consistent with previous literature on what areas are important to a self-care for within those who work within the mental health field (Jiang et al., 2020; Lee & Miller, 2013; Wise & Reuman, 2019); the Life Balance, Cognitive Awareness, and Daily Balance subscales were shown to be most associated with lowering stress and burnout. Professional support emphasizes supportive colleagues and strategies that emphasize strong relationships with them. Professional development demonstrates the importance of enjoyable work and professional activities and staying current with professional knowledge. Life balance highlights the importance of having a personal identity with social support. Cognitive awareness emphasizes psychological self-care and monitoring, having an approach to challenges, and maintaining awareness. Daily balance encompasses micro-focused strategies that can be incorporated to manage daily demands while maintaining awareness and replenishing. The items on the survey were randomized as the authors did not present the items in factor blocks as shown in their published overview of the SCAP. Grouping into factors was done to better illustrate the factors and easily show the items within each factor.

Completion

Upon completion of the survey, participants were taken to the end of survey message thanking them for their time and a question that asked if they would like to enter an email address for the incentive drawing. They were reminded that their data were not associated with

the email if they chose to enter. Upon selecting yes, the participants were forwarded to a separate page that allowed them to enter their preferred email for the drawing of the incentive.

Data Analysis Procedures

To test all the hypotheses and answer the research questions, one main statistical analysis with multiple assumption analyses was needed. All data analysis was conducted through IBM SPSS version 25 on Windows 10 and R Studio on MacOS. These data analyses included all relevant steps of a multivariate multiple linear regression (MMLR) analysis as outlined below (IBM, 2017; Laerd Statistics, 2015). Other descriptive information and basic statistical analyses of the sample characteristics were also analyzed using these systems to allow for outputs that contained descriptive information. Qualtrics was used to host the survey online. G*Power 3.1 on Mac OS was used to compute a priori analysis to determine the appropriate minimum sample size.

An MMLR can be used to predict multiple outcome variables using two or more predictor variables or determine the numerical relationship between these sets of variables. For this analysis, the dependent variables (DVs) were the five factors of self-care and the independent variables (IVs) were attendance in personal therapy and anticipated stigma. An MMLR was chosen as the statistical analysis due to there being multiple DVs and IVs in which the numerical relationships were being determined. The MMLR accounted for multiple DVs in its statistical analyses (e.g., confidence intervals, significance tests).

Assumptions

Assumptions for an MMLR were as follows. Assumption 1 was there were multiple continuous DVs. Meeting this assumption was accomplished through having the continuous DVs of the five factors of self-care. Assumption 2 was there were more than one or more IVs.

Assumption 2 was met through design study in having multiple IVs (i.e., attendance in personal therapy and anticipated stigma). Assumption 3 was there were no repeated measures. Because this was not measuring variables for the same group at multiple points in time, the study qualified for this assumption. Assumption 4 was there was linearity between the variables. This assumption was checked via residuals vs. fitted plotting and simple regression to determine if there was a linear relationship between the variables. The studies included DVs (i.e., the five factors of self-care) shown to have a relationship in prior research (Dorociak, Rupert, Bryant, et al., 2017). Assumption 5 was there were no outliers. Outliers were checked for via Mahalanobis Distance. Assumption 6 was there was homogeneity of covariance matrices. Homogeneity was checked for by Box's M. Assumption 7 was there was equality of error variances, which was checked for by Levene's test of equality of error variance and spread vs. level plot. Assumption 8 was there was no multicollinearity. Multicollinearity was checked for via examination of correlations of the IVs and variance inflation factor (VIF) values. These assumptions for a MLLR were tested and met, which are explained in further detail in Chapter IV.

Research Questions and Hypotheses

The following research questions and hypotheses were used to guide this study:

Q1 How much of the variation in self-care (as measured by the Self-Care Assessment for Psychologists) does anticipated stigma (as measured by the Anticipated Stigma Scale) and personal therapy explain in mental health professional trainees? (Multivariate Multiple Linear Regression)

H1 Anticipated stigma (as measured by the Anticipated Stigma Scale) and personal therapy will explain a significant amount of the variation within self-care (as measured by the Self-Care Assessment for Psychologists) for mental health professional trainees. (Multivariate Multiple Linear Regression)

Q2 What is the contribution of anticipated stigma (as measured by the Anticipated Stigma Scale) in explaining the variation within self-care (as measured by the Self-Care Assessment for Psychologists) for mental health professional trainees? (Multivariate Multiple Linear Regression)

H2 Anticipated stigma (as measured by the Anticipated Stigma Scale) will explain a significant amount of the variation within self-care (as measured by the Self-Care Assessment for Psychologists) for mental health professional trainees. (Multivariate Multiple Linear Regression)

Q3 What is the contribution of personal therapy in explaining the variation within self-care (as measured by the Self-Care Assessment for Psychologists) for mental health professional trainees? (Multivariate Multiple Linear Regression)

H3 Personal therapy will explain a significant amount of the variation within self-care (as measured by the Self-Care Assessment for Psychologists) for mental health professional trainees. (Multivariate Multiple Linear Regression)

Q4 Is there a statistically significant difference between the groups of those mental health professional trainees who engage in personal therapy and those who do not on self-care (as measured by the Self-Care Assessment for Psychologists). (Multivariate Multiple Linear Regression)

H4 There will be a significant difference between the groups of those mental health professional trainees who engage in personal therapy and those who do not on self-care (as measured by the Self-Care Assessment for Psychologists). (Multivariate Multiple Linear Regression)

Summary

The purpose of this research was primarily threefold. The first purpose was to determine how much of the variation in the five factors of self-care is explained by anticipated stigma and attendance in personal therapy. The second purpose was to determine the contribution of both anticipated stigma and personal therapy separately on the variation within the five factors of self-care. The third purpose was to determine if there is a difference in the five factors of self-care between mental health professional trainee groups who have experienced personal therapy. It was hoped the results of this study would help future researchers in informing methods on the incorporation of self-care within the mental health professional trainee population. A greater understanding of these constructs and their relationship would allow for better implementation of systemic change in the education of trainees toward a system that promotes flourishing professionals who are better able to manage self-care in all areas. The researcher answered the

research questions through the multivariate multiple linear regression and provided other basic statistical analyses for consideration. The participants were recruited primarily from various American graduate programs via email, dissemination, and snowball sampling by emailing the director or members of programs that fit the population criteria and were identified from various state education departments, regional chapters of the Association for Counselor Education and Supervision, and internet search for psychology departments that have APA/CACREP accredited programs. Participants were primarily sought from APA and CACREP accredited sites from which 50 sites of each accreditation were chosen at random. Further participants were sought through use of the Council of University Directors of Clinical Programs. These data were collected from May to August 2021.

CHAPTER IV

RESULTS

This nonexperimental examination intended to study the contribution of anticipated stigma and attendance in personal therapy on the five factors of self-care in mental health professional trainees. The SPSS Version 25 (IBM, 2017) was used to conduct all statistical analyses. The results of this study are described in this chapter including information regarding the descriptive statistics of the sample, reliability of the instruments used, and analyses run on the data to answer the research questions and hypotheses. The data were organized and cleaned as necessary and noted below.

Descriptive Statistics and Preliminary Analyses

Demographics

After data cleaning, this study consisted of a sample of 100 participants who were doctoral- (71%) and master- (29%) level mental health professional trainees who were on average three years into their program and 27 years of age. Seven participants were removed from the sample beforehand due to not finishing the survey; this resulted in the sample consisting of 100 participants. The sample consisted of participants from programs accredited by APA, CACREP, and the Commission on Accreditation for Marriage and Family Therapy Education accredited programs at 68%, 31%, and 1%, respectively. Table 1 includes the rest of the listed demographic data:

Table 1

Demographics for All Participants

Demographic Variables	*N*
Gender	
Male	18
Female	76
Transgender	1
Non-binary/third gender	4
Prefer not to specify	1
Relationship Status	
Single	40
Married	24
Divorced	1
Partnership	32
Prefer to self-describe	3
Program	
Counseling	19
Counseling Psychology	22
Couples, Marriage, Family Therapy	7
Counselor Education and Supervision	3
Clinical Psychology	43
School Psychology	6
Age	
22-25	34
26-30	51
31-47	15
Ethnicity	
African American	1
Asian	8
Hispanic/Latina/o	11
White/Caucasian	72
Multiple Ethnicities	7
Middle Eastern/North African	1
Sexual Orientation	
Heterosexual	68
Gay/Lesbian	3
Bisexual	15
Asexual	1
Pansexual	4
Prefer not to specify	1
Queer	7
Questioning	1

Table 1, *Continued*

Demographic Variables	*N*
Social Economic Status	
Upper Class	6
Upper Middle Class	35
Lower Middle Class	38
Working Class	19
Poor	1
Prefer not to specify	1
Year In Program	
1st – 2nd	38
3rd – 4th	42
5th – 6th	19
8th	1

Note. Participant number and percent are the same as *n*=100.

Descriptive Statistics

Descriptive statistics were run on the data for this sample to help show a more complete picture of the data. The data appear in Tables 2 and 3. Table 2 shows descriptive statistics for the variables related to attendance in therapy and anticipated stigma. Table 3 shows variables related to self-care.

The mean and median for the number of sessions attended were 58 and 23, respectively with the lowest being 0 or 1 (for those who attended) and the highest being 800. Thirteen percent of participants had not attended personal therapy, 42% were currently attending, and 45% had attended in the past. Anticipated stigma values ranged from 0 to 93 out of a total possible of 105 with higher numbered scores indicating higher levels of anticipated stigma. Nineteen percent of respondents reported they had no CSI and, therefore, did not feel anticipated stigma. Twenty-eight percent of participants thought it likely they would experience negative treatment if others knew of their CSI.

Table 2

Descriptive Statistics on Attendance to Personal Therapy

Descriptive Variables	*N*/%
Attendance in Therapy	
Current Attendance	42
Past Attendance	45
No Attendance	13
Number of Sessions Attended	
0	13
1-10	21
11 - 20	16
21 - 50	20
51 - 100	19
101 - 200	9
600	1
800	1
Reason for Attendance of Most Recent Therapy	
Anxiety	24
Depression	19
PTSD/Trauma	9
Eating Disorder	2
Life Transition/Academic	22
Did Not Answer	11
Did Not Attend	13
Rating of Most Recent Therapy	
Very helpful	42
Somewhat helpful	38
Neutral	7
Did Not Attend	13
Licensure of Therapy Provider	
Licensed Professional Counselor	37
Licensed Psychologist	27
Licensed Clinical Social Worker	14
Psychiatrist	1
Do not know	2
Counseling Trainee	1
Licensed Marriage and Family Therapist	3
Licensed Mental Health Counselor	1
Psychiatric Nurse Practitioner	1
Did Not Attend	13
Anticipated Stigma Levels	
No Anticipated Stigma (i.e., 0)	19
Unlikely to Occur (18 – 29)	11
Neither Likely nor Unlikely (32 – 60)	42
Likely to Occur (61 – 75)	21
Very Likely to Occur (77 – 93)	7

Table 3 includes the means and other descriptive data for the five factors of self-care: Professional Support, Professional Development, Life Balance, Cognitive Strategies, and Daily Balance. The total possible score for each of the areas respectively was 35, 35, 28, 28, and 15.

Table 3

Descriptive Statistics for Self-Care

Self-Care Factor	*M*	*SD*	Min	Less Than Half %	More Than Half %	Most of the Time%
Professional Support	23.62	5.78	9	30	58	12
Professional Development	20.43	6.13	5	44	54	3
Life Balance	21.02	5.06	8	23	47	30
Cognitive Strategies	21.35	3.80	10	13	67	20
Daily Balance	13.54	4.07	4	35	52	13

Preliminary Internal Reliability

All the instruments used for the research were checked for proper internal consistency via a Cronbach's Alpha. Each measurement instrument used met the recommended minimally acceptable level of $\alpha = .70$ for research purposes (Remler & Van Ryzin, 2015). In addition, each internal consistency level or Cronbach's Alpha computed on the instruments with this sample showed similar α levels to what has previously been reported for these instruments with other experiments and samples (Dorociak, Rupert, Bryant, et al., 2017; Quinn & Chaudoir, 2009). The

Cronbach's Alpha levels were as follows for the instruments used in this research: Anticipated Stigma Scale α=.92; the five factors of self-care professional support α=.82, professional development α=.83, life balance α=.86, cognitive awareness α=.71, and daily balance α=75.

Factor Analysis

A factor analysis was run on both the Anticipated Stigma Scale and the SCAP given that neither had been used exclusively on the mental health professional trainee population. The results are contained below in Tables 4 and 5, respectively.

An exploratory factor analysis (EFA) was conducted on the Anticipated Stigma Scale using principal axis factoring (PAF) extraction. The suitability of an EFA was assessed prior to analysis. Inspection of the correlation matrix showed all variables had at least one correlation coefficient greater than 0.32 (Tabachnick & Fidell, 2013). Visual inspection of the scree plot indicated two components should be retained (Cattell, 1966). The overall Kaiser-Meyer-Olkin (KMO) measure was 0.839 with individual KMO measures all greater than 0.7 and classifications of 'middling' to 'meritorious' according to (Kaiser, 1974). Bartlett's test of sphericity was statistically significant ($p < .0001$), indicating the data were likely factorizable. Table 4 contains the EFA using a PAF extraction of the Anticipated Stigma Scale.

Table 4

Pattern Matrix for Exploratory Factor Analysis with Principal Axis Factoring Extraction and Oblique Rotation

Anticipated Stigma Item	Factor Loading	
	1	2
Factor 1: Day to Day Discrimination		
Friends avoiding or ignoring you	**0.926**	
Current friends stop hanging out with you	**0.840**	
People not wanting to get to know you better	**0.749**	
People not wanting to get involved in a relationship with you.	**0.693**	
Roommates wanting to move out of apartment or house	**0.652**	
People not wanting to date you.	**0.619**	
People acting as if they think you are not as good as they are	**0.460**	0.344
People acting as if they think you are not smart	**0.412**	0.362
Factor 2: Social Devaluation		
People threatening or harassing you		**0.869**
People calling you names or insulting you		**0.805**
Getting poorer service than others do at restaurants or stores		**0.753**
Treated with less respect than other people	0.338	**0.607**
Treated with less courtesy than other people	0.398	**0.575**
People acting as if they think you are not to be trusted	0.376	**0.504**

The SCAP (Dorociak, Rupert, Bryant, et al., 2017) was checked via factor analysis due to the model being used previously only with psychologists and the current study being the first known study to utilize this self-care assessment in further quantitative research. A PAF was run

on the SCAP according to what the authors of the SCAP had determined in their own article. The suitability of PAF was assessed prior to analysis. Inspection of the correlation matrix showed all variables had at least one correlation coefficient greater than 0.3. The overall Kaiser-Meyer-Olkin (KMO) measure was 0.809 with individual KMO measures all greater than 0.6, classifications of 'middling' to 'meritorious' according to Kaiser (1974). Bartlett's test of sphericity was statistically significant ($p < .001$), indicating the data were likely factorizable. The factor loadings are contained in Table 5 with only one item (i.e., I make a proactive effort to manage the challenges of my professional work) loading differently.

Table 5

Rotated Structure Matrix for Principal Axis Factoring with Oblique Promax Rotation of Five Forced Components

Self-Care Items	Factor Loading				
	1	2	3	4	5
Factor 1: Professional Development					
I participate in activities that promote my professional development.	**0.889**	0.407	0.364	0.084	0.222
I find ways to stay current in professional knowledge.	**0.779**	0.251	0.247	0.182	0.299
I maximize time in professional activities I enjoy.	**0.728**	0.517	0.366	0.155	0.181
I take part in work-related social and community events.	**0.603**	0.518	0.323	0.025	0.089
I make a proactive effort to manage the challenges of my professional work.	**0.601**	0.475	0.562	0.326	0.398
I connect with organizations in my professional community that are important to me.	**0.540**	0.298	0.310	0.110	0.194
Factor 2: Professional Support					
I maintain a professional support system.	0.493	**0.762**	0.457	0.180	0.332
I share work-related stressors with trusted colleagues.	0.253	**0.711**	0.440	0.209	0.316
I share positive work experiences with colleagues.	0.520	**0.668**	0.354	0.147	0.280
I cultivate professional relationships with my colleagues.	0.478	**0.621**	0.468	0.374	0.331

Table 5, *Continued*

Self-Care Items	Factor Loading				
	1	2	3	4	5
Factor 3: Life Balance					
I spend time with people whose company I enjoy.	0.336	0.513	**0.841**	0.378	0.378
I spend time with family or friends.	0.392	0.549	**0.787**	0.241	0.138
I find ways to foster a sense of social connection and belonging in my life.	0.467	0.552	**0.769**	0.434	0.329
I seek out activities or people that are comforting to me.	0.263	0.323	**0.739**	0.512	0.514
Factor 4: Daily Balance					
I take breaks throughout the workday.	0.157	0.260	0.448	**0.776**	0.482
I take some time for relaxation each day.	0.088	0.175	0.429	**0.732**	0.398
I avoid over-commitment to work responsibilities.	0.036	0.095	0.151	**0.640**	0.130
Factor 5: Cognitive Strategies					
I monitor my feelings and reactions to clients.	0.267	0.205	0.251	0.237	**0.742**
I am mindful of triggers that increase professional stress.	0.253	0.501	0.408	0.536	**0.593**
I try to be aware of my feelings and needs.	0.140	0.433	0.364	0.517	**0.593**

Table 6 shows the intercorrelations of the different factors of self-care.

Table 6

Correlation Matrix for Self-Care Factors

	Professional Support	Professional Development	Life Balance	Cognitive Strategies	Daily Balance
Professional Support	1.000	.527	.563	.520	.205
Professional Development	.527	1.000	.421	.427	.106
Life Balance	.563	.421	1.000	.542	.390
Cognitive Strategies	.520	.427	.542	1.000	.427
Daily Balance	.205	.106	.390	.427	1.000

Assumptions

An MMLR requires that a number of assumptions are met before the data can be interpreted and used. As outlined previously, the first three assumptions were met by the design of the study given that an MMLR requires both multiple independent (i.e., anticipated stigma and attendance in personal therapy) and multiple dependent variables (i.e., the five factors of self-care) and the nature of the variables used. The fourth assumption of linearity was partially met by research design of the DVs but also by further analysis of residual plots and a partial regression. Assumption 5 used Mahalanobis Distance to determine if there were multivariate outliers. Four sets of data were flagged as being outliers. Upon further inspection, these data sets did not show as being influential or violating Cook's Distance tests; thus, the data sets were retained. Homogeneity of variance, or assumption 6, was shown through Box's M test having a

significance value of .08, signifying the null hypothesis that the observed covariance matrices of the dependent variables are equal across groups should be retained. Assumption 7 used Levene's Test of Equality of Error Variances, which had a value of greater than .05 on all values, signifying there was no reason to believe the equal variances assumption was violated for these variables. Assumption 8 was there would be no multicollinearity. Multicollinearity was checked for via examination of correlations of the IVs and VIF values; none of the independent variables had correlations greater than 0.7 and all tolerance values were above .01 and VIF values were below 10. All assumptions for this data were met, signifying the data analysis could be conducted.

Data Analysis

An examination of the research questions was conducted through an MMLR analysis, which was useful as it could accommodate intercorrelations between variables while also reducing Type I and Type II errors (Lutz & Eckert, 1994). Blackmon and Thomas (2014) noted that MMLR could also accommodate multiple independent and dependent variables. An MMLR was used in the current study because the outcomes of interest consisted of multiple intercorrelated factors (i.e., the five factors of self-care: professional development, professional support, life balance, daily balance, and cognitive strategies) and there were multiple IVs (anticipated stigma and attendance in personal therapy) of interest (Rencher & Christensen, 2012). The MMLR analysis allowed for the current study to incorporate the multiple DVs and the multiple IVs to be analyzed in one analysis while reducing the chance for Type I and Type II errors.

Research Question 1

Research Question1 sought to determine how much of the variation in self-care anticipated stigma and personal therapy was explained in mental health professional trainees. The results of the MMLR were used to determine the amount of variation explained by using the partial eta squared statistic. Larger values of the partial eta squared indicated the independent variable controls for a larger amount of variation in the dependent variable(s); these values ranged from 0 to a maximum of 1. The partial eta squared value for this analysis (attendance * anticipated stigma) was .014 as shown in Table 7.

H1 Anticipated stigma (as measured by the Anticipated Stigma Scale) and personal therapy will explain a significant amount of the variation within self-care (as measured by the Self-Care Assessment for Psychologists) for mental health professional trainees.

The results of the MMLR showed anticipated stigma and attendance in personal therapy did not explain a significant amount of the variation within self-care as shown in Table 7. More specifically, the result of the MMLR Pillai's Trace was $F(5, 92) = .265$, $p > .05$, Pillai's Trace = .014, partial $\eta 2 = .014$.

Table 7

*Attendance in Personal Therapy * Anticipated Stigma*

Test	Value	*F*	df	Error df	Sig.	Partial Eta Squared
Pillai's Trace	0.014	.265[b]	5	92	0.931	0.014
Wilks' Lambda	0.986	.265[b]	5	92	0.931	0.014
Hotelling's Trace	0.014	.265[b]	5	92	0.931	0.014
Roy's Largest Root	0.014	.265[b]	5	92	0.931	0.014

b. Exact statistic

Research Question 2

Research Question 2 examined the contribution of anticipated stigma in explaining the variation within self-care for mental health professional trainees. The MMLR revealed that the partial eta squared value for anticipated stigma was .012 as illustrated in Table 8.

H2 Anticipated stigma (as measured by the Anticipated Stigma Scale) will explain a significant amount of the variation within self-care (as measured by the Self-Care Assessment for Psychologists) for mental health professional trainees.

The results of the MMLR analysis showed the anticipated stigma did not explain a significant amount of the variation within self-care as shown in Table 8 below. More specifically, the result of the MMLR Pillai's Trace was $F(5, 92) = .244$, $p > .05$, Pillai's Trace = .012, partial $\eta 2 = .012$.

Table 8

Anticipated Stigma

Test	Value	*F*	df	Error df	Sig.	Partial Eta Squared
Pillai's Trace	0.012	.224[b]	5	92	0.951	0.012
Wilks' Lambda	0.988	.224[b]	5	92	0.951	0.012
Hotelling's Trace	0.012	.224[b]	5	92	0.951	0.012
Roy's Largest Root	0.012	.224[b]	5	92	0.951	0.012

b. Exact statistic

Research Question 3

Research Question 3 examined the contribution of personal therapy in explaining the variation within self-care for mental health professional trainees. Use of the MMLR revealed that the partial eta squared value for attendance in therapy was .023.

H3 Personal therapy will explain a significant amount of the variation within self-care (as measured by the Self-Care Assessment for Psychologists) for mental health professional trainees.

The results of MMLR analysis showed that attendance in therapy does not explain a significant amount of the variation within self-care as shown in Table 9. More specifically, the result of the MMLR Pillai's Trace was $F(5, 92) = .429$, $p > .05$, Pillai's Trace = .023, partial $\eta 2 = .023$.

Table 9

Attendance in Personal Therapy

Test	Value	*F*	df	Error df	Sig.	Partial Eta Squared
Pillai's Trace	0.023	.429[b]	5	92	0.827	0.023
Wilks' Lambda	0.977	.429[b]	5	92	0.827	0.023
Hotelling's Trace	0.023	.429[b]	5	92	0.827	0.023
Roy's Largest Root	0.023	.429[b]	5	92	0.827	0.023

b. Exact statistic

Research Question 4

Research Question 4 sought to determine if there was a statistically significant difference between the groups of those mental health professional trainees who engage in personal therapy and those who do not on self-care.

H4 There will be a significant difference between the groups of those mental health professional trainees who engage in personal therapy and those who do not on self-care (as measured by the Self-Care Assessment for Psychologists).

The MMLR revealed no difference in self-care between those groups of mental health professional trainees who do and do not attend personal therapy. More specifically, the result of the MMLR Pillai's Trace was $F(5, 92) = .429$, $p > .05$, Pillai's Trace = .023, partial $\eta 2 = .023$ for the variable of attendance in therapy. A finding of non-significance for this variable meant any

further analysis would be non-significant. A simple contrast procedure that compares the mean of each level to the specified group's mean (i.e., group 1 attendance in therapy) within the MMLR was also explored to better illustrate the differences among levels of the factor. The significance values were .53, .73, .70, .98, .28 for the five factors of self-care (i.e., professional support, professional development, life balance, cognitive strategies, and daily balance) showing the level of non-significance among all levels of the factors as illustrated in Table 10.

Table 10

Attendance in Therapy Contrast

Variable	Sig.	Contrast Estimate	Standard Error
Professional Support	.53	1.64	2.58
Professional Development	.73	-0.95	2.76
Life Balance	.67	-0.98	2.28
Cognitive Strategies	.98	0.05	1.70
Daily Balance	.48	-1.31	1.83

Summary

This chapter first presented the statistical results of the demographic and descriptive analysis of all the data for this study. Subsequently, the reliability analyses of all measures were reported and shown to meet the suggested level of $\alpha = .70$ for use in research purposes (Remler & Van Ryzin, 2015). The assumption tests for the multivariate multiple linear regression were then reported and shown to have been met. Finally, all research questions and hypotheses were tested and the results presented. As was shown for each research question and hypothesis, none of the data analyses yielded significant results for the research questions and hypotheses. Chapter V

discusses the findings as well as addresses the implications of the study. Limitations and future directions are also discussed.

CHAPTER V

DISCUSSION AND IMPLICATIONS

The purpose of the current research was primarily threefold. The first purpose was to determine how much of the variation in self-care was explained by anticipated stigma and attendance in personal therapy. The second purpose was to determine the contribution of both anticipated stigma and personal therapy separately on the variation within self-care. The third purpose was to determine if there was a difference in self-care between mental health professional trainee groups who had experienced personal therapy.

The intent of the current research study was to contribute quantitative research on the area of self-care for mental health professional trainees. It was hoped the current study could be used to inform further areas of research and inquiry in the matter of incorporating self-care into the training and education of mental health professionals by examining how much variation the variables of anticipated stigma and attendance in personal therapy explained self-care. Although the results were not significant, the current study was an additional step in gathering quantitative information on self-care for the mental health professional trainee population.

Discussion of the Results

Internal reliability reports for the assessments used were close to the reported Cronbach's Alpha levels that had been shown in prior research with samples (Quinn & Chaudoir, 2009; Rupert & Dorociak, 2019), suggesting the internal consistency and validity of the assessments were comparable. The alpha levels were all above the .7 level suggested for use in research purposes, which indicated all the results could be used with the measurements as they were.

Research Question 1

Q1 How much of the variation in self-care does anticipated stigma and personal therapy explain in mental health professional trainees?

H1 Anticipated stigma and personal therapy will explain a significant amount of the variation within self-care for mental health professional trainees.

The results of the current study did not provide any evidence that anticipated stigma and attendance in personal therapy explained a significant amount of the variation within the five areas of self-care for the sample of mental health professional trainees. Prior research into self-care within mental health professionals hypothesized that the effect of any single self-care strategy was rather modest and multiple strategies were needed (Norcross & VandenBos, 2018). The results from the current quantitative study showed the effect of the two variables of anticipated stigma and attendance in personal therapy were not enough to statistically explain a significant amount of the variation within self-care.

The results of the current study indicated the model of having a concealable stigmatized identity with anticipated stigma and attendance in personal therapy did not significantly explain the variation within the five factors of self-care in mental health professional trainees. Inability to significantly explain the variation within self-care meant that the model of attendance in personal therapy and anticipated stigma was insufficient and these variables might not be suitable for a future model of explaining the variation within self-care. More research needs to be conducted on what should be included in a model explaining the variation within self-care for the population of mental health professional trainees as the current research suggested anticipated stigma and attendance in personal therapy alone were insufficient.

It is possible the results did not support the hypothesis that anticipated stigma and personal therapy would explain a significant amount of the variation within self-care for mental

health professional trainees because of measurement issues. For the anticipated stigma measure, the differences in the sample of the current study and the Quinn and Chaudoir (2009) samples of different population might have impacted the results. The sample of the current study was comprised of doctoral- (71%) and master- (29%) level mental health professional trainees who were on average three years into their program and the mean age was 27 years of age (range = 22-47, *SD* = 4.13). The Quinn and Chaudoir study included a sample of 300 undergraduate students from introductory psychology classes with a mean age of 18.59 years (*SD* = 1.08) and a sample of 235 undergraduate students with a mean age of 18.87 years *(SD* = 1.38). It is possible the experience of anticipated stigma and CSI was dissimilar for undergraduate and graduate students in mental health programs due to different developmental stages. It is also possible the results were different from those hypothesized because of the measure used for self-care. The SCAP (Dorociak, Rupert, Bryant, et al., 2017) was built from a sample of licensed psychologists, mean age of 51.55 years (*SD*=13.21) and mean years since licensure was 18.13 years (*SD*=12.04 years). In addition, the reduction of the complex process of personal therapy to a single response of "Yes" "No" to personal therapy might have introduced mono-operation bias and negatively impacted the power of analyses within the current study (Laerd Statistics, 2015).

Research Question 2

Q2 What is the contribution of anticipated stigma in explaining the variation within self-care for mental health professional trainees?

H2 Anticipated stigma will explain a significant amount of the variation within self-care for mental health professional trainees.

The results did not provide any evidence that anticipated stigma by itself explained a significant amount of the variation within self-care for mental health professional trainees. Although stigma has played a significant role within the mental health field and help-seeking

behavior for mental health, the results of the current study did not provide any evidence that having a concealable stigmatized identity with anticipated stigma explained a significant variance within the five factors of self-care.

For the current study, the definition from Quinn and Earnshaw (2013) was used to define anticipated stigma as "the negative treatment people with concealable stigmatized identities (CSIs) believe they might receive if others know of their identity" (p. 3). Nineteen of the participants (19%) did not identify as having a CSI and therefore had zero anticipated stigma. Approximately 65% of those who did identify as having a CSI had an average anticipated stigma level that was below the level of believing it was likely to occur and they would experience the negative treatment described in the measure. This was on a Likert Scale of 1-7 with 1 being very unlikely and 7 being very likely. The current study found no evidence that anticipated stigma explained a significant variance within the five factors of self-care.

The finding of no evidence for anticipated stigma with CSIs affecting the variation within the five factors of self-care might be a beneficial one in that it could tentatively suggest that mental health professional trainees did not find anticipated stigma to be a variable that impacted the five factors of self-care as conceptualized for the current study. The reasons for this could be many with the ideal reason being programs addressed and/or normalized CSIs to the extent that anticipated stigma was no longer a significant barrier to self-care and relevant self-care areas as hypothesized and demonstrated in previous literature about other correlates of well-being like self-care (Kalkbrenner & Neukrug, 2019). It is possible the hypothesis was not supported due to measurement issues. Research Question 1 included comments on measurement issues for the Anticipated Stigma Scale and the self-care measure, SCAP.

Research Question 3

Q3 What is the contribution of personal therapy in explaining the variation within self-care for mental health professional trainees?

H3 Personal therapy will explain a significant amount of the variation within self-care for mental health professional trainees.

The results did not provide any evidence that attendance in personal therapy explained a significant amount of the variation within self-care for mental health professional trainees. Attendance in personal therapy for mental health professional trainees has shown to have a host of benefits for over 90% of those who attended, ranging from having a first-hand opportunity to observe clinical methods to improvement of mental and emotional functioning (Ziede & Norcross, 2020). Despite the positive benefits and the subsequent derived hypothesis for the current study, the results did not provide any evidence for attendance in personal therapy explaining significant variation within self-care's conceptualization and measurement for this study. The result of attendance in therapy not explaining a significant variation within the construct of self-care for this current study also mirrored what was described in recently published literature. Callan et al. (2021) discussed how engagement in personal therapy as a self-care method was found to have no significant correlations to other wellness constructs and self-care efficacy.

Personal therapy in this study was defined as a generic term used to encompass a range of possible collaborative treatments with a mental health professional to work through mental health problems and/or accomplish mental health and other goals to live a happier, healthier life. Attendance in personal therapy consisted of any personal therapy or counseling the mental health professional trainee had completed that was comprised of at least one session for the purpose of the current study. The decision to measure personal therapy with a "Yes" "No" response to

attending or having attended therapy was based on previous literature. Specifically, Norcross and various affiliated authors have measured attendance since 1988 within their questionnaire of the Processes and Outcomes of Mental Health Professionals' Personal Therapy with a dichotomous categorical variable, yes or no (Norcross, 2005; Norcross et al., 1988, 2008, 2009). This variable was then used in analyses of various other outcomes and processes of mental health professionals' use or non-use of personal therapy. Byrne and other associates also used an adapted form of the Norcross questionnaire for graduate students called the Counseling Experience Assessment, which also used attendance to therapy as a dichotomous categorical variable (Byrne & Ost, 2016; Byrne & Shufelt, 2014). In another study of the utilization of personal therapy in six English speaking countries, Orlinsky et al. (2011) noted the Development of Psychotherapists Common Core Questionnaire also measured attendance in therapy as a yes no dichotomous categorical variable. An advantage of using a yes no question is it is a straightforward and brief way for respondents to answer.

Despite the precedence set in previous research on measuring the variable of attendance in therapy as a dichotomous categorical variable, there were limitations. The process of coding and grouping data could result in a loss of information in data due to simplification and grouping processes; the process might also impact the power of assessments and the analyses able to be run on the data (Miller & Lovler, 2020). Within the current study, it was possible the reduction of the complex process of attendance in personal therapy might have introduced mono-operation bias and negatively impacted the power of analyses (Laerd Statistics, 2015). Mono-operation bias represents the single operationalization of a construct that might potentially under-represent the construct being measured and impact its construct validity (Cook & Campbell, 1979). While

measuring a construct using a single measure, as in the current study, is not uncommon (Laerd Statistics, 2015), it might have possibly introduced threats to construct validity.

The benefits of having used this construct as a dichotomous categorical variable were that the current study used previously established measurement methods from peer-reviewed articles and professionals within the field. It is possible that using a dichotomous categorical variable to measure attendance in therapy negatively impacted the current study in considerations of power and construct validity despite its use in previous research. Other methods of assessment for this construct were not found despite an exhaustive search and it was beyond the scope and resources of the current research to develop a new assessment method. Evidence for the use of qualifiers to the question was also lacking such as a minimum number of sessions, which would be counter to the current research within the field and ignore the benefits from initial or few sessions noted in the literature (Glover et al., 2016; Howard, 2006; Zhang, 2021). Further investigation of personal therapy for mental health professional trainees would most likely benefit from qualitative investigation with in-depth interviews rich in data. Research of such qualitative nature would likely provide greater insight into the use of personal therapy within the mental health trainee population and how personal therapy is used and conceptualized as self-care or something other than self-care. Therefore, qualitative research might provide more detail and depth on how to more accurately measure attendance in therapy.

When results are non-significant, as was the case in the current study in relation to self-care and personal therapy, it is important to consider the role of variance (Laerd Statistics, 2015). Variance is a measure of variability that explains the spread of scores in a distribution. A large variance indicates individual scores differ substantially from the mean or there are outliers (Miller & Lovler, 2020). Too much variability could dramatically reduce statistical power during

hypothesis testing. Statistical power is the probability that a test will detect a difference or an effect that exists (Cohen, 1988). The number of sessions for participants in the current study varied from one to hundreds. Roughly 35% of participants attended therapy for more than 50 sessions. Therapy in the current study was measured as a dichotomous variable. Specifically, participants responded "Yes or No" to having attended or attending therapy or not. Collecting information on number of sessions was asked for descriptive statistic purposes and not as a variable for the statistical analyses of the hypotheses. Therefore, in terms of statistical analysis, number of sessions would not play a role. However, it is theoretically possible the number of sessions might have impacted whether participants perceived therapy as self-care. At this point with the limited research on self-care for mental health professional trainees, it would be speculation to theorize there was a difference for those who attended more sessions to perceive it as self-care as compared to those who had less sessions, or vice versa. Qualitative research with in-depth interviews might shed some light on the question of number of sessions and the role it might play in participant perceptions of self-care.

Because attendance in personal therapy is known for having many benefits on well-being and has historically been used within the field since the time of Freud to promote personal growth (Steiner, 2005; Ziede & Norcross, 2020), it was hypothesized these benefits and growth from attendance in personal therapy would also explain a significant amount of the variance within self-care as measured in this study. The current study found no evidence for supporting the hypothesis for Research Question 3.

Research Question 4

Q4 Is there a statistically significant difference between the groups of those mental health professional trainees who engage in personal therapy and those who do not on self-care.

H4 There will be a significant difference between the groups of those mental health professional trainees who engage in personal therapy and those who do not on self-care.

The results did not provide any evidence of a significant difference between groups of those mental health professional trainees who did and did not engage in personal therapy on self-care. The reason could potentially be due to not having a high enough participant number of those who did not engage in personal therapy as only 13% did not attend personal therapy in the current study. Despite the analysis used being able to incorporate unbalanced models and the data meeting all assumptions, statistics relied on having an adequate sample size to obtain a satisfactory power to give significance to results. When a sample size is either too great or small, the results could be skewed to finding or not finding significance (Rencher & Christensen, 2012). Given that the current research met the requisite assumptions and its findings were consistent to recent findings from other authors that attendance in personal therapy had no significant correlations related to self-care efficacy, it is likely an increased sample number within a comparable range would not have found different results (Callan et al., 2021).

The *Ethical Principles of Psychologists and Code of Conduct* (APA, 2017) clearly stated that psychologists ought to refrain from activities that might impact their work in a negative manner and take precautions if personal problems interfered with the quality of their work (APA, 2017). The APA (2017) created the Advisory Committee on Colleague Assistance with the mission to offer resources to prevent professional distress. Based on the results of this study, that there was no difference in self-care as defined by the five factors (professional support, professional development, life balance, daily balance, and cognitive awareness) between those mental health trainees who reported not attending therapy (13%) and those who did attend (87%), it seems recommending therapy would not be a resource to prevent professional distress

for trainees. Questions continue to be raised how ought psychologists be trained to competency in practicing self-care? While the finding that attending therapy did not make a difference in self-care might be surprising, it pointed in the direction of looking at other self-care methods.

A systematic review of 21 papers identified by Callan et al. (2021) on training psychologists in self-care, which looked at doctoral-level clinical and counseling psychology programs, found 19.05% studies focused and advocated for creating a culture of self-care within clinical and counseling psychology programs. Results indicated program self-care culture was significantly positively associated with professional self-care. Furthermore, significant relationships existed between students' perceptions of programmatic emphasis on self-care and self-care utilization and quality of life (Goncher et al., 2013; Roth, 2015). Continuing the review of papers by Callan on self-care and psychologists, 9.5% of the studies focused on personal therapy as self-care and found no significant associations. Of the 21 studies (38.10%), most of the studies included in the Callan et al. (2021) review were focused on self-care interventions that included a didactic self-care training component. Interventions had a didactic component in common and they varied in the techniques used in the training. For example, the Integral Life Practice was used (Burkhart, 2014); a secondary traumatization prevention perspective was incorporated (Patel, 2017); a stress reduction approach was used (Bistricky et al., 2016), and Focusing Practice techniques (Lowe, 2012) were included. Half of the studies on interventions were based on mindfulness (Hemanth & Fisher, 2015; Killebrew, 2012; McMahon, 2016; Simons, 2015). The duration and intensity of trainings varied from one 2-hour training period (Patel, 2017) to weekly meetings for several semesters (Lowe, 2012). From the remaining studies (28.57%), workbook and training tools were included as a didactic component to training in self-care. Types of training tools varied; Castineiras (2016) included self-compassion related

exercises, Santana and Fouad (2017) created a self-monitoring tool to measure self-care competency progress, and Hotmer (2017) and Weinstein (2013) created a curriculum that included a variety of self-care practices. It was interesting to note that 67% of all the studies in the metanalysis by Callan et al. (2021) were doctoral dissertations and the research on self-care training appeared exclusively in the last 10 years. It is suggested that in view of the above findings of different methods of self-care used in clinical and counseling doctoral programs, it would be too early to conclude that any one self-care training method is more effective than any other. The literature is still considered to be in its infancy and more rigorous methodological studies need to be conducted.

In summary, the intent of this research was to contribute quantitative research on the area of self-care for mental health professional trainees. This research aimed to contribute to areas that could potentially impact self-care in the education and training of mental health professionals. It was hoped this research could be used to inform further areas of research and inquiry in the matter of incorporating self-care into the training and education of mental health professionals. The purpose of this research was primarily threefold. The first purpose was to determine how much of the variation in self-care ess explained by anticipated stigma and attendance in personal therapy. The second purpose was to determine the contribution of both anticipated stigma and personal therapy separately on the variation within self-care. The third purpose was to determine if there was a difference in self-care between mental health professional trainee groups who had experienced personal therapy. The results for this study did not provide any significant evidence for any of the purposes or questions of this study. The findings of the current study indicated no statistical significance to explain a significant amount of the variation separately or together for personal therapy and anticipated stigma within self-

care. The results might have not been significant due to limitations in only having the two variables when a more complex model could adequately account for the variation within self-care (Norcross & VandenBos, 2018). Variables indicated in the recent literature around incorporation into a more complex model of self-care included a measure of perceptions of culture of self-care within trainee programs; perceptions of a didactic self-care training component within the graduate program; physical variables of self-care (e.g., sleep, nutrition, etc.); having nurturing relationships; boundaries; and receiving quality mentorship and supervision (Callan et al., 2021; Collins & Cassill, 2021; Guler & Ceyhan, 2021; Wong & White, 2021; Ziede & Norcross, 2020).

Errors related to measurement might have influenced the results of the study. The reduction of the complex process of personal therapy to a single response of "Yes" "No" might have introduced mono-operation bias and negatively impacted the power of analyses within the current study (Laerd Statistics, 2015). Mono-operation bias represents the single operationalization of a construct that might potentially under-represent the construct being measured and impact its construct validity (Cook & Campbell, 1979). The process of coding and grouping data could have resulted in a loss of information in data due to simplification and grouping processes; the process might have also impacted the power of assessments and limited the analyses able to be run on the data (Miller & Lovler, 2020). Error related to measurement of attendance in therapy might have negatively impacted the results by impacting construct validity, loss of information, lowered power, and limiting the analyses to be used.

It is also possible the results were different from those hypothesized because of the measure used for self-care. The SCAP was built from a sample of licensed psychologists (Dorociak, Rupert, Bryant, et al., 2017). The sample of the current study was comprised of

mental health professional trainees in graduate school who were not licensed and not practicing as psychologists. Specifically, the sample of trainees was comprised of doctoral- (71%) and master- (29%) level trainees who were on average three years into their program and 27 years old (*SD*=4.3). The stressors trainees experience differ from licensed psychologists in development, available support, and coping abilities (Swords & Ellis, 2017). It might be that the use of the SCAP with mental health professional trainees negatively impacted significance for anticipated stigma and did not support the hypothesis. The same case could be made for the other hypothesis that was not supported, specifically that personal therapy would explain a significant amount of the variation within self-care.

The non-significant findings of the current study around attendance in personal therapy and self-care, despite the shown benefits of attendance in personal therapy, could be due to the null hypothesis being accurate in that personal therapy did not explain a significant amount of variation with the five factors of self-care for this population. The hypothesis that personal therapy was not correlated with self-care for this population has recently been supported by a systematic review of the research (Callan et al., 2021). It might also be that personal therapy and self-care are perceived differently by mental health professional trainees. Initial qualitative research about attendance in personal therapy for mental health professional trainees has shown some common themes of negative impact on the trainee (Grimmer & Tribe, 2001; Kumari, 2011). The negative themes identified by these authors centralized around issues of additional stress, trainees becoming too focused on their own emotional turmoil, inadequate resolution of problems, negative impacts on relationships, and difficulties with the therapist. Considering these perceived negative effects of therapy by trainees, it intuitively made sense that personal therapy would not be perceived as self-care, which implies protecting oneself from further stress. Given

that graduate school for mental health professional trainees is known as a significant source of stress and burnt out (Swords & Ellis, 2017), it would make sense the trainees would not perceive attendance in therapy as self-care. Another reason as to why personal therapy was not seen as self-care for this population could be due to the negative association of personal therapy during graduate school with remediation/impairment or due to the idea that going to therapy constituted failure (Vacha-haase et al., 2019; Ziede & Norcross, 2020). Other things like population characteristics (e.g., stage of life and development, levels of personal awareness and insight, coping mechanisms, and other relevant features) could preclude mental health professional trainees from viewing personal therapy as self-care.

Issues related to the sample might have impacted the results of the study given the sample contained sampling bias such as volunteer bias and convenience sampling. Maybe unknown characteristics of the sample due to volunteer bias caused the results to turn out differently than expected. It was of concern that having collected data at the time of the pandemic might have somehow influenced results; self-care might have a different meaning for trainees coping with COVID-19 related distress.

Finally, it is worth mentioning that finding non-significant results and discussing reasons why they might not have been in relation to what was hypothesized did not imply the results were not important. While there is room for improvement in terms of measures and conceptualization as was explained above, it is important to consider that personal therapy might be a mixed situation for trainees in terms of self-care and therefore the results were not significant. It is important to consider that trainees perceived therapy as both helpful and as taking away from their time, money, and energy while they were in training/graduate school. Personal therapy might have been seen as causing emotional turmoil and not be perceived as

self-care. It would be important to continue research on the topic of self-care and personal therapy using different research methods such as qualitative research. The purpose would be to explore with in-depth interviews the perceptions and experiences of mental health trainees on the topic of self-care and personal therapy, the advantages and disadvantages, the benefits, and costs. Self-care might be qualitatively a different experience than therapy at a time when trainees have academic and training demands placed on them. It is also important to consider that self-care might look very different during the time of COVID-19 in comparison with other times for mental health professional trainees.

Interpretations were provided for the results and relevant current literature was integrated in the discussion of results. The following sections discuss information on descriptive statistics, implications, and conclusion.

Discussion on Descriptive Statistics

Descriptive statistics for this sample included a wealth of information that clarified and described the information collected for this research. For this research, 87% of participants had attended personal therapy for more than one session. Previous results showed attendance rates for mental health professional trainees at 50% (Kalkbrenner & Neukrug, 2019), 73% (Byrne & Ost, 2016), 61% (Byrne & Shufelt, 2014), and 73% (Holzman et al., 1996). The numbers of those participants who had attended personal therapy were higher compared to previous publications. Participants for this study also identified attending therapy on average 58 sessions with those who had not attended therapy included. This number jumped to an average of 67 times if only those participants who had attended therapy were considered. Only one identified study used a population considered similar to this studies of mental health professional trainees. Holzman et al. (1996) used graduate students from APA-accredited clinical programs for the

sample and found the students had attended psychotherapy for an average of 79 sessions. It should be noted that most (42%) of those who sought therapy sought it from someone from a psychodynamic-orientated therapist in Holzman et al.'s (1996) study. Although the literature on personal therapy for mental health professional trainees was sparse (Byrne & Ost, 2016), the number of those that sought therapy seemed higher in the current study. The number of sessions were harder to evaluate given only one other study looked at the number of sessions attended for similar samples. In the current study, 92% of the participants who attended therapy (80 out of 87 participants) reported it was a good experience, 42% reported it as very helpful, and 38% as somewhat helpful.

Other descriptive statistics gathered in this study seemed congruent with findings from previous samples. Reasons for seeking personal therapy were mainly 24% anxiety related, 19% depression related, and 22% academic/life transition focused. The most comparable data (Byrne & Ost, 2016) cited stress and anxiety at 26%, depression at 13%, other at 13%, relationships at 13%, and self-understanding at 12%. The satisfaction or rating of therapy also seemed consistent with previous results having an above 80% (i.e., 90%) rating of being helpful or beneficial (Bike et al., 2009; Byrne & Shufelt, 2014; Mahoney, 1997; Ziede & Norcross, 2020).

The ratings of self-care and anticipated stigma had no similar comparison groups. It was interesting to note 19% of respondents reported they had no CSI and therefore did not feel anticipated stigma. Twenty-eight percent of participants thought it likely they would experience negative treatment if others knew of their CSI. In looking at the variance within the context of only 28% participants answering that they were likely to experience anticipated stigma, the variance would be narrow.

Variance is a measure of variability and variability describes how much scores differ in a sample (Adams & Lawrence, 2019). Too narrow of variance could negatively impact power and validity (Miller & Lovler, 2020). In measuring just likely or very likely to occur for anticipated stigma, the variance in scores would be narrow and the score range would be 32 for 28 participants. Having such a narrow variability and limited sample size would violate assumptions for most analyses (Laerd Statistics, 2015) and not meet requisite sample sizes using standard power and error (i.e., n=31) to show correlation for a multiple regression with even a large effect size (Faul et al., 2009). The sample in this case would be biased as Adams and Lawrence (2019) defined sampling bias as "the sample does not represent the population" (p. 114). Remler and Van Ryzin (2015) noted sampling bias generally was due to the way in which the data were collected including sample selection bias, coverage bias, nonresponse bias, and volunteer bias. Using the above 28 participants would include all the above due to selecting the sample, not fully covering the population, a low response rate, and using those who volunteered. The results of the 28 participants could and should not be generalized as the results would not accurately represent the population or meet assumptions for analysis.

However, in the current study, the total Anticipated Stigma Scale score was measured as a continuous variable within the analysis and computed using all the items and corresponding scores from all 81 participants who completed it. The scores of participants who endorsed the item that "I have a concealable stigmatized identity (CSI)" were used in the analysis. Nineteen participants did not indicate they had a CSI from which to feel anticipated stigma about and were screened from taking the survey. The screening happened similarly to Quinn and Chaudoir (2009) who did not include those who did not endorse having a CSI for anticipated stigma.

For those participants who completed the Anticipated Stigma Scale, their overall score was calculated with higher scores, indicating increased anticipated stigma. The continuous variable of anticipated stigma within the current study's sample was normally distributed as assessed by Shapiro-Wilk's test ($p > .05$) and did not contain significant values of skewness or kurtosis (absolute z-score was < 1; the cutoff for .01 significance requires absolute z-score < 2.58; Laerd Statistics, 2015). The findings of normal distribution for the sample with the anticipated stigma scores and no violations in assumptions for the analysis indicated the sample results would be generalizable within context and noted limitations to generalizability. Issues related to sampling bias that would still pertain were nonresponse bias, volunteer bias, and sample selection bias.

Counseling psychology doctoral program faculty and training directors need to consider how students with concealable stigmatized identities, meaning having an identity that could be kept hidden from others because of negative attributes or stereotypes attached that could result in a loss of status and/or discrimination (Link et al., 2017; Quinn & Earnshaw, 2013), impact mental health trainees. It is possible some identities were more concealable than others out of fear that if faculty and/or other trainees knew, it would create anticipated stigma. The current study did not ask specifically what those concealable identities were. Further research could explore what identities were still concealed in graduate level mental health trainees.

Implications

Theoretical Implications

Person of the therapist (POTT) theory defines self-care as "the application of a range of activities with the goal of being well-functioning" (Kissil & Niño, 2017. p.527) and has several components. Person of the therapist provided the theoretical orientation for the current study.

The POTT theoretical framework focused on the self (i.e., the person of the therapist) in that it aimed to have the therapist be able to use the self effectively in therapy by increasing personal growth and normalizing/attending to signature themes (i.e., wounded humanity) within the trainee program (Aponte et al., 2009). As noted by Aponte and Kissil (2014) and Niño et al. (2015), the POTT model and training affected personal change and growth within mental health professional trainees that had many similarities of self-change from trainees in areas that would constitute self-care; these areas would fall under the self-care factors of life balance, cognitive strategies, and daily balance. The authors then highlighted a change in attitude within the professional realm that would meet items on the self-care factor of professional support and development. Hypothetically in the current study, it was thought the benefits and growth experienced from personal therapy that included similar changes in self would significantly explain factors of self-care within the trainee population. At the same time, it was hypothesized anticipated stigma would similarly explain the area of professional factors. It was hoped these two variables combined would then explain significant variation within self-care. Despite the findings of non-significance for this study, all calls or ideas aimed at increasing self-care had an underlying theme that acknowledged and granted importance to the person of the therapist. It might be, however, that the person of the therapist theory or model might not be supported by constructs such as anticipated stigma and attendance in personal therapy as conceptualized and measured in the current study in relation to self-care. The challenge in finding an underlying and unifying theory for self-care research at this time was that self-care research is still in its infancy (Callan et al., 2021). The lack of research was such that other authors resorted to creating their own theories or methodologies of self-care like Guler and Ceyhan (2021) with the model of multi-dimensional structure of self-care for counsellors. Other authors used behavioral prediction

frameworks, specifically the theory of planned behavior, to underpin their research into self-care (Wong & White, 2021). Depner et al. (2021) even explored a theoretical model of mindful self-care using structural equational modeling. Moving forward, it is likely that theory will branch between behavioral, interpersonal, and self-orientated theories as the most recent review of the literature suggested areas within each orientation (Callan et al., 2021). Self-care is an important competency for trainees to develop at any time. During this time, prioritizing self-care to manage COVID-19 related distress is even more important (Callan et al., 2021). Trainees have unique concerns such as meeting training requirements during this global pandemic (Desai et al., 2020). Attending to self-care and seeking professional and personal support could be especially helpful during this time for trainees in the mental health profession (Callan et al., 2021).

Practice Implications

For practice purposes, the current research did not find evidence that attendance in personal therapy or anticipated stigma significantly explained the variation within self-care and its five factors. When considering why personal therapy would not be significant to self-care, it is important to revisit the definitions of these constructs and why it would be considered as significant. Self-care was defined in this study as "a multidimensional, multifaceted process of purposeful engagement in strategies that promote healthy functioning and enhance well-being" (Dorociak, Rupert, Bryant, et al., 2017, p. 326). Personal therapy/counseling in the current study was defined for participants as a collaboration with a mental health professional to work through mental health concerns to accomplish mental health and goals to live a happier, healthier life. Theoretically, the two constructs of self-care and personal therapy/counseling seemed similar and overlapping. It was surprising that in the current study the two constructs did not relate significantly. Therefore, it seemed important to revisit the literature around personal therapy as it

related to self-care. Norcross and many associates throughout the literature (Norcross & Guy, 2007; Norcross & VandenBos, 2018; Ziede & Norcross, 2020) recommended personal therapy as 1 out of 13 "broad self-care strategies tailored to psychologists and those in training" (Ziede & Norcross, 2020, p. 2). The reasons given by Ziede and Norcross (2020) that made personal therapy important for graduate students were related to how much they juggled, while also developing in their career, to name a few challenges: academic responsibilities, financial concerns, imposter syndrome, countertransference, and a heavy workload. While these are important considerations, there was a lack of empirical studies and asking graduate students themselves what they thought of the connection between personal therapy and self-care. Ziede and Norcross (2020) recommended enhancing and publicizing systems of self-care in the psychology profession by "encouraging research, including dissertations, on psychologist self-care and development" (p. 610). A meta-analysis of 17 studies on the efficacy of self-care among graduate students in professional psychology (Colman et al., 2016) revealed self-care strategies as mainly associated with reductions in student distress and increases in self-compassion and personal accomplishments. It would be important to research further whether personal therapy is perceived by graduate students as associated with decreasing distress, increasing self-compassion, and assisting in reaching personal accomplishments.

Norcross and VandenBos (2018) suggested personal therapy might be more suitably conceptualized as modus for promoting personal and professional growth and a process for professional identity development rather than as a self-care strategy that promotes healthy functioning and enhances well-being. Personal therapy might rather be viewed by trainees as a part of the educational process that at times might even cause additional stress in a time when they are already experiencing high levels of burnout and stress (Swords & Ellis, 2017). Another

possibility noted for personal therapy to not be significantly related to self-care was how personal therapy might be viewed in the field as a something to be engaged in due to impairment (Ziede & Norcross, 2020). In further support of why personal therapy might not be connected to self-care for this population, the most recent research reviewed did not find personal therapy as one of the effective self-care training methods for mental health professional trainees (Callan et al., 2021). As noted by Callan et al. (2021) in their systematic review of self-care for mental health professional trainees and implementation of it into the education and training of mental health professionals, "results from personal therapy studies did not demonstrate significant relationships between engagement in psychotherapy and self-care related gains" (p. 122).

The findings that personal therapy was important but likely did not constitute self-care were similar to conclusions stated by Grimmer and Tribe (2001) and Kumari (2011) in that attendance had many positive benefits but also increased stress levels and did not contain themes of self-care. Specifically, Grimmer and Tribe in their qualitative study found the themes in benefits included increases gained in personal and professional growth, professional identity development, enhancement of clinical effectiveness, experiencing the role of the client, having personal therapy as a professional socialization experience, and feeling support for the emerging professional. Self-care did not emerge as a theme in the benefits.

In some studies, the negative impact rate of attending therapy was reported as high as 27% and was noted to increase stress for mental health professional trainees (Grimmer & Tribe, 2001; Kumari, 2011). More empirical research examining the impact of personal therapy and perceptions from graduate students are needed to better understand how it might or might not relate to self-care, or which parts of personal therapy related to self-care. If attending therapy is perceived as adding stress to already busy mental health trainees' lives, then it might not be

perceived as self-care. Therapy can often be emotionally demanding and add to the stress the trainee is feeling. Time constraints due to busy schedules as graduate students might add to further stress, financial considerations, as well as the energy that goes into changing patterns that were unhealthy and developing new ones. It seems important in future research to explore in greater depth the perceptions of the trainees in relation to the quality of their therapeutic experience and their evaluation of it as self-care or not at the time of attending graduate school. A combination of quantitative and qualitative research methods might allow for greater depth in answering the question of how trainees perceived personal therapy as self-care or not. As mentioned previously, Ziede and Norcross (2020) recommended encouraging research, including dissertations, on psychologist self-care and development in professional psychology programs. It seems important to continue to conduct empirical research and ask graduate students themselves as to the pros and cons of personal therapy in relation to self-care.

As clinicians, supervisors, professors, and other mental health professionals, this finding of non-significance for attendance in personal therapy and anticipated stigma might point to concentrating on other areas when encouraging self-care within the trainee population. Although the most recent literature noted that the field lacked significant research to guide implementation practices of self-care into the education and training of mental health professional trainees (Callan et al., 2021; Collins & Cassill, 2021; Guler & Ceyhan, 2021; Wong & White, 2021), these authors indicated many areas that showed preliminary support for incorporation of self-care methods such as creating cultures of self-care that increase programmatic emphasis of self-care including self-care training interventions and courses, workbooks, and tools that contain action planning for engagement in self-care behaviors.

Other areas of note from the most recent literature that did not have as much evidence but were identified as even more tenuous potential areas of incorporating self-care were providing quality mentorship and supervision and using tools that increased mindfulness (Callan et al., 2021). Personal therapy was also a suggested method within the research but the authors concluded engagement in personal therapy was found to have no significant correlations to other wellness constructs and self-care efficacy for the mental health trainee population. The current study echoed this conclusion of findings from the most recent research regarding attendance in personal therapy not explaining a significant amount of the variation within self-care. Although stigma and its many variations have been a constant within the mental health professional field, the finding of non-significance within the current study of anticipated stigma explaining a significant amount of the variation within self-care appeared to be a positive one, meaning stigma would not interfere with self-care. Practice implications for the findings of non-significance with anticipated stigma and CSIs could tentatively be that stigma does not need to be a priority focus for trainees and might already be adequately addressed within the education and training of mental health professionals. This conclusion was made with caution because 28% of participants in this study thought it likely they would experience negative treatment if others knew of their CSI. Faculty, supervisors, and training directors of doctoral programs in counseling psychology programs need to be aware that trainees might not volunteer to share and incorporate into their training concealed stigmatized identities. For example, trainees might not share a disability including a mental illness diagnosis out of fear they would be stigmatized and possibly isolated. Given that POTT makes a case for incorporating the self of the therapist in the training of mental health professionals, concealing parts of one's identity might have a negative impact on their training. It is important for those in charge of doctoral programs in counseling

psychology to be thinking of the role of concealed stigmatized identities and how to make for a more open culture of inclusivity.

Current literature suggested programmatic emphasis on self-care and implementing self-care interventions in training had the most evidence supporting trainees' ability to improve self-care (Callan et al., 2021). Suggestions on practical implementation of self-care could be on three levels including professional leaders in counseling psychology, faculty and supervisors, and trainees themselves. Specifically, suggestions for professional leaders included weaving more self-care language into the standards of accreditation for programs in health service psychology (APA, 2017). This seemed to be an answer to Bamonti et al.'s (2014) call to action to create a culture of self-care. Program handbooks could easily incorporate more self-care language. According to Callan et al. (2021), Section II.B (Discipline-Specific Knowledge, Profession-Wide Competencies, and Learning/Curriculum Elements Required by the Profession) could be an area for self-care competency. Suggestions for faculty and supervisors included offering continuing education in self-care, which might encourage them to become more mindful of the self-care competency, and emphasize it in supervision and training (Rummell, 2015; Zahniser et al., 2017). Suggestions for trainees included incorporating self-care into ethics courses taken by doctoral students, providing trainees with content from self-care intervention studies, and making available an independent self-care workbook (Weinstein, 2013). Trainees could measure their own competency development using Santana and Fouad's (2017) measure, the Self-Care Behavior Inventory (SCBI). The SCBI was designed and validated for assessment of trainees' self-care practices for both practice and research in graduate training.

In summary, this section addressed practical implications on the findings of current studies. Material was provided on how self-care could be approached in practical terms for

graduate programs and trainees, and suggestions were made. It is important that trainees understand the importance of self-care and in addition how and when to implement it in practice. Faculty, supervisors, and training directors could all play a role in infusing self-care in training.

Research Implications

From a research perspective, the current study did not find any evidence that anticipated stigma and attendance in personal therapy explained a significant amount of the variation within self-care and its five factors. When the current research project started, even less research existed on self-care for those professionals and trainees within the mental health field, and the only two measurement tools for self-care were recently published (Dorociak, Rupert, Bryant, et al., 2017; Santana & Fouad, 2017). In this study, self-care was measured by the SCAP; it was the one known available, empirically based, psychometrically sound, and comprehensive measure of self-care for those within the field and was made synthesizing key themes for mental health professionals in general (Dorociak, Rupert, Bryant, et al., 2017). The SCAP was developed using licensed psychologists and was noted by the authors as a limitation to the scale's generalizability to other populations and samples despite the items being generated from and reflective of key themes in the literature on self-care (Dorociak, Rupert, Bryant, et al., 2017). In the dissertation, the sample was comprised of doctoral- (71%) and master- (29%) level mental health professional trainees who were on average three years into their program and had a mean age of 27 years (*SD* = 4.13). In the SCAP development, the samples consisted of 422 licensed psychologists with a mean age of 50.48 years (*SD* =14.50) and mean years since licensure was 16.71 (*SD* =12.39); Sample 2 consisted of 374 psychologists with a mean age of 51.55 years (*SD* =13.21) and mean years since licensure was 18.13 (*SD* =12.04 years).

Although the average year into programs in the sample of the current study was three and it was likely the mental health trainees were engaging in providing therapeutic services, trainee stressors, development, available support, coping abilities, and other variables differed from licensed and practicing professionals. Developmentally, mental health trainees had not yet completed the requisite training and practice mental health professionals have and were likely lacking in comparison developmentally to licensed psychologists practicing in the field. Although mental health professional trainees are noted to have high levels of burnout and distress while also experiencing low levels of vigor throughout the graduate school process, many of the experienced stressors stemmed from sources other than the provision of mental health services (Bamonti et al., 2014; Swords & Ellis, 2017). The system of educating and training for mental health professional trainees includes rigorous coursework, personal exploration and growth, and demands on the time of trainees might differ from those experienced by licensed professionals (Colman et al., 2016). The stressors and experiences likely differed qualitatively from what is currently experienced by mental health professionals in the field as trainees might be somewhat insulated from more serious stressors commonly experienced by professionals who provided mental health services for many years. This insulation for graduate students could be due to the educational model and system that includes screening of clients and other protective processes like supervision and guidance that could reduce client severity and feelings of incompetence and being overwhelmed on the part of the trainee practitioner (Sciberras & Pilkington, 2018). Mental health trainees also exist in an environment that provides professional support and development that might not be equivalent to the systems professionals exist within given that training environments tend to provide a professional support system and mandate participation in professional development activities. Connection to a university and

classes also promotes trainees to stay up to date on research and offer updated access to many different journals and other published material that professionals in the field do not have equal opportunity to use or have access to that contribute to professional development, one of the factors in the SCAP.

Differences in the samples might have negatively impacted the accuracy of measuring and conceptualizing self-care for the mental health trainee population. Specifically, the areas of professional development and professional support within the five factors of self-care might have reduced accuracy or importance in the conceptualization of self-care for mental health professional trainees (Dorociak, Rupert, Bryant, et al., 2017). Because these two areas targeted professional support and development areas that might be covered in part by being a mental health trainee within a graduate program, the accuracy and importance of these areas might have been negatively impacted by being used within the current study's sample. Trainees might also have not achieved as high a level of growth or possessed methods of self-care engagement within the areas of daily balance and cognitive strategies that mental health professionals might have otherwise gained from their work experience in the field and completing the educational and training process (Ziede & Norcross, 2020). Other measures specifically developed or tailored to this population might provide more accurate results in the future on self-care for mental health professional trainees. The current research used the SCAP and intended to begin the process of filling the gap within the research by contributing quantitative data to the existing literature; the current research was the first known study to use an empirical, comprehensive measure of self-care for mental health professional trainees in relation to anticipated stigma and personal therapy. However, because the measure was developed on a population of licensed psychologists and the

current study involved graduate students in mental health programs, it is important to consider this as a limitation that might have impacted measurement of self-care for the reasons described.

Having little research to draw from made the intention of this research challenging to meet on many levels. Model development to explain the variation within self-care was a challenging area that would benefit from testing an exhaustive list of theorized variables in either structural equation modeling or exploratory factor analysis with path analysis to see what variables explained most of the variation in self-care within mental health professional trainees. Such a design to test for a model was outside the scope for the current research. However, other variables for consideration in studying self-care suggested by the research were valuing of the person of the therapist, satisfaction of helping, freedom, independence, intellectual and emotional stimulation, interpersonal relationships, employment opportunities, recognition of hazards, physical and emotional isolation, patient behaviors, working conditions, burnout, physical variables of self-care (e.g., sleep, nutrition, etc.), having nurturing relationships, boundaries, cognitive restructuring, humor, learned and taught behaviors in programs, self-reflection and other mindful practices, education and training shifts, creating cultures of self-care including self-care training interventions and courses, workbooks and tools that contain action planning for engagement in self-care behaviors, providing quality mentorship, and using mindfulness tools (Bamonti et al., 2014; Barnett et al., 2007; Callan et al., 2021; Collins & Cassill, 2021; Guler & Ceyhan, 2021; Kissil & Niño, 2017; Norcross & VandenBos, 2018; Wise & Reuman, 2019; Wong & White, 2021; Ziede & Norcross, 2020).

Other options to measure self-care might have included the SCBI developed by Santana and Fouad (2017). This validated instrument on a sample of clinical and counseling psychology students measured factors in three areas of self-care: Cognitive-Emotional-Relational, Physical,

and Spiritual. The researchers discussed how one might be interested in understanding the role of self-care on how trainees coped with challenges specific to the training developmentally in the program. The author of the current study suggested possibilities such as including how a trainee coped and used self-care around comprehensive exams, proposal time, internship applications, etc. Furthermore, the SCBI could be implemented as a screening tool to evaluate promotion of self-care practices in graduate training. The SCBI could also be used to measure changes in self-care practices in training and implement pre post designs for research purposes. These focused efforts in self-care might lead to a decrease in potential burnout. The SCBI might be used to guide performance evaluations using longitudinal data. For example, trainees could be asked to use the SCBI intermittently during the semester to self-monitor and record changes, and throughout their graduate training. Such evaluations could give more longitudinal data for research purposes.

The Mindful Self-Care Scale is a general assessment that was not specific to those within the mental health field but included a variety of measurement areas. The SCPS was noted to distinguish between the two areas of professional and personal self-care, contained a .3 minimum for factor loadings, had an alpha based off test re-test, and was noted to be for specifically for social workers (Lee et al., 2020). Other reviewed studies on self-care did not include empirically based comprehensive measurements of self-care and instead measured it by either having the individual score their comprehensive self-care or by examining specific self-care behaviors. Measurement tools for most of the variables indicated by research do not exist at this time or are not currently tailored for measurement in relation to self-care within mental health professional trainees. Some of the variables would also call for a different research methodology to be used.

Another implication of the current research and as mentioned by authors of the most recent research (Callan et al., 2021; Guler & Ceyhan, 2021; Wong & White, 2021) would be the use of different research designs like longitudinal research, action research, and experimental research. These different research designs would contribute significantly to the literature but tended to be more resource intensive and required the ability to introduce interventions within the population of interest. Research implications of the current study are akin to the studies and recent literature reviewed in that the implications are that more research needs to be done around the self-care of mental health professional trainees. In the area of self-care for trainees, Callan et al. (2021) emphasized a "more rigorous methodology, such as peer-reviewed outcome study designs, is sorely needed before any definitive conclusions can be drawn" (p. 123); this statement is important to keep in mind with the current study's findings and the current research on self-care to date for any implications.

Limitations and Recommendations for Future Study

Although self-report data are a common way to gather research information within the field of psychology, self-reported data have several limitations (Adams & Lawrence, 2019). It is possible the participants did not accurately self-report their experience due to a variety of reasons including misunderstanding of assessment items, social desirability, the wording of items, and cognitive dissonance (Remler & Van Ryzin, 2015). It must also be noted that this was a self-selected sample that consisted of individuals who chose to participate in this study from the programs contacted. Possible limitations similar to and incorporating those mentioned above should be kept in mind when interpreting the results of any self-reported data as were used in the current study.

Limitations stemming from the generalizability of the current study's sample should be considered as well given the context in which this study was conducted and the participants. The impact of COVID-19 has been felt worldwide. The field of mental health was impacted in various ways that included sweeping changes to rules, regulations, and administration of mental health services all while increasing the strain on those within the field. Generalizability outside of this context and outside of the matching demographics of mental health professional trainees during this time might not be possible. At the time of data collection for this study and currently when writing this concluding chapter, the novel coronavirus known as SARS-CoV-2 (COVID-19) has impacted the world and field of mental health professionals in a myriad of ways. Globally, as of November 2021, there have been 250,154,972 confirmed cases of COVID-19, including 5,054,267 deaths, reported to the World Health Organization (2021). The total impact COVID-19 has had and will have on the world at large is not currently known; to date, the pandemic has significantly altered people's daily lives and created multiple societal and medical challenges. Effects within the mental health field are more evident with broad changes to practice requirements, regulations, policies, guidance, and more (Sümen & Adibelli, 2021; Weissman et al., 2020). The current pandemic has placed strain on the mental health and well-being of all, which consequently compounded on mental health professionals given the increased need for mental health services, increased severity of those seeking services, and novel psychological problems that came from these times (Bell et al., 2021; Clerici et al., 2020; Sümen & Adibelli, 2021). This additional strain was on top of the already large stressors present within the field that are well known to impact mental health professionals (Kleespies et al., 2011; Norcross & VandenBos, 2018; Sciberras & Pilkington, 2018; Wise & Reuman, 2019). It ought to be considered that data for the current study were collected during the summer of 2021 when

COVID-19 was impacting the world including the sample of mental health professionals. It would only be speculative how the COVID-19 related stressors might have impacted perceptions of self-care, personal therapy, and anticipated stigma.

Lastly, the limitations should take into consideration the current state of the research on self-care for those within the mental health field. Many authors (Callan et al., 2021; Dorociak, Rupert, Bryant, et al., 2017; Jiang et al., 2020; Norcross & VandenBos, 2018; Zahniser et al., 2017) noted the state of self-care research for those within the mental health field is scarce, fragmented and disjointed, in its infancy, lacks a well-established definition and conceptualization, and has limited options for assessment. The current study was limited by the above considerations and the fact that the assessment tools used, though the best available, might not have reflected the data accurately within this unique context and population.

Within the current study, a limitation to note is that of cross-loading. Cross-loading might have negatively impacted the power and significance through validity factors like internal validity (Laerd Statistics, 2015). Cross-loading occurs when a certain item is associated simultaneously with multiple concepts (Li et al., 2020). Cross-loadings are especially common in areas like the social sciences, which do not have pure items (Li et al., 2020). The normalcy of cross-loading occurring and not having pure or true simple structure was also reviewed in Worthington and Whittaker's (2006) work on how the social sciences use approximate simple structure rather than true simple structure. The impact of cross-loadings for some authors is a matter of debate despite its common occurrence. The conclusion from Worthington and Whittaker (2006) was that EFA contains debates and conflicting recommendations when it comes to cross-loadings. The following was stated by Tabachnick and Fidell (2001) regarding item retention and deletion:

> Most researchers use some guideline for a lower limit on item factor loadings and cross-loadings to determine whether to retain or delete items, but the criteria for determining the magnitude of loadings and cross-loadings have been described as a matter of researcher preference. (p. 823)

For the current study, items within the anticipated stigma scale and the SCAP could be identified as areas of concern because of cross-loading and possible impact on finding non-significant results. The cross-loadings pertained to some items for both the Anticipated Stigma Scale and the SCAP scale and led to the question whether it was appropriate to utilize these two scales for the mental health professional trainee population without any revisions of these two scales.

Specifically for the Anticipated Stigma scale, the item "People acting as if they think you are not as good as they are" had a loading of .460 on Factor 1 and had a loading of .344 on Factor 2. These two loadings were close, raising the question whether it should belong to Factor 1. Similarly, the items "People acting as if they think you are not smart" hae a loading of .412 on Factor 1 and .362 on Factor 2. The lack of distinctiveness of these two items in their ability to measure only one factor clearly could be seen as a limitation. Typically, for items like these that have cross-loading issues, it should be considered whether they need to be deleted rather than retained. In general, the items did load to the primary factor as indicated by the developers of the scale (Quinn & Chaudoir, 2009) and it could be considered a limitation since it was not entirely a fit to support the original construct. It could also be seen as a contribution to the literature that mental health trainees in this sample somehow interpreted the items in a way that did not clearly measure only one latent factor; therefore, these items might be general items for this sample.

Items might have had different meanings for the participants of the current study, which did not necessarily mean the results of the study were invalid.

Modifying current scales or constructing a new scale was beyond the scope of the current study and not a part of the permissions given by the authors or sought around scale usage (see Appendices I, J, and K). In addition, ethical issues could be raised when deleting items because participants spent time on answering the questions on the survey and their contribution should not be discarded. Future research with several samples would benefit from creating or adapting the scale specifically to the mental health professional trainee population.

The SCAP items of "I am mindful of triggers that increase professional stress" and "I try to be aware of my feelings and needs" might require further assessment because of cross-loading issues even though the items loaded where they were supposed to load in the primary factor as indicated by the authors of the scale (Dorociak, Rupert, Bryant, et al., 2017). Caution should be exercised when considering decisions around deleting or retaining items as Worthington and Whittaker (2006) reiterated, "Conceptual interpretability is the definitive factor-retention criterion." (p. 822). Conceptually, these items fit as cognitive strategies for mental health professional trainees in that mindfulness of triggers and awareness of feelings and needs seem important for mental health professional trainees. It should also be considered that deleting these two items would most likely eliminate Factor 5, cognitive strategies, which would be left with an insufficient amount of items to support a factor (Costello & Osborne, 2005). It could be seen as a contribution to the field that the above two items, on triggers and feelings, might have different meanings for mental health graduate students as compared to the sample of licensed psychologists on which the scale was originally developed (Dorociak, Rupert, Bryant, et al., 2017). It would be a beneficial area for future research and development to investigate

differences for mental health graduate students on being mindful of triggers in professional stress and awareness of feelings and needs.

More research needs to be done on self-care for mental health professional trainees. Different methodology using test-retest structure and experimental design that investigates each area of self-care using specific methods and method combinations of self-care strategies that includes other variables of note (e.g., supervision quality, creating a culture of self-care in programs that emphasize self-care, incorporating interventions designed to increase self-care, having trainees complete and use self-care workbooks and other training tools, timeframe, social support and interpersonal relationships, physical areas of self-care, work and client conditions, and personal attributes) would likely benefit future research into self-care for mental health professional trainees (Callan et al., 2021; Depner et al., 2021). Using a methodology that allows for control and implementation to be able to see self-care changes on an individual level would likely benefit research and increase self-care for this population before implementation and examination on a more system wide level. Other research methodologies such as building a structural equational model of self-care and related variables might also be a method to identify variables and areas of interest for future intervention. Further development and use of specific measurement tools for this population and the variables/strategies of note would also benefit the research.

Conclusion

As it currently stands, the research was clear that burnout, stress, and other detriments of well-being are currently impacting the mental health field and those who work in it like mental health professional trainees to the extent that many have made calls for changes to incorporate self-care into the education and training of mental health professionals (Bamonti et al., 2014;

Barnett et al., 2007; Norcross & VandenBos, 2018; Sciberras & Pilkington, 2018; Swords & Ellis, 2017; Wise & Reuman, 2019; Ziede & Norcross, 2020). What was less clear was what is being implemented about these calls and the rising need to combat burnout, stress, and other detriments of well-being for those professionals and trainees within the mental health field.

The results of the current study indicated the variation in the five factors of self-care was not significantly explained by anticipated stigma, attendance in personal therapy, nor the combination of the two. Furthermore, no significant difference was found in self-care between mental health professional trainees who had experienced personal therapy and those who had not.

Researchers noted that literature on self-care for those within mental health field on self-care training had occurred "exclusively in the last 10 years" (Callan et al., 2021, p. 122); this research also experienced an influx of research with 10 peer reviewed articles identified in 2021 alone. The findings of the current research were non-significant in that no evidence was found that attendance in personal therapy and anticipated stigma explained a significant amount of the variation within self-care and its five factors. It is hoped the current research results and recommendations for further research could be used to increase the knowledge of self-care and incorporation into the training for those within the mental health field and promote research efforts that garner results that help promote practitioners who are able to flourish in such dire times. Mental health trainees and professionals work in a culture of one-way caring (Guy, 2000) where they are required to demonstrate empathy, compassion, and patience. Maintaining such working relationships requires energy and efforts. To provide effective care to their clients, mental health trainees and professionals must first be well themselves (Norcross & Guy, 2007). Burnout and professional impairment are risks when self-care is not in place. It is critical to

integrate self-care in graduate training programs for counseling psychologists. Future directions in self-care include developing new research methodologies to examine self-care training in counseling psychology programs; further research on how psychologists are trained to competency in practicing self-care including specific training techniques and methods; outcome studies and exploration of which measures were used; and finally, which self-care training methods are shown to be effective. Graduate programs could increase the emphasis on self-care and implement self-care training interventions that have evidence in supporting trainee competency in this area. Living during these historical times and prioritizing self-care to cope with COVID-19 related distress seems to be especially important.

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APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL

UNIVERSITY OF
NORTHERN COLORADO

Institutional Review Board

Date:	05/12/2021
Principal Investigator:	Morgan Condie
Committee Action:	**IRB EXEMPT DETERMINATION – New Protocol**
Action Date:	05/12/2021
Protocol Number:	2009010282
Protocol Title:	The Importance of Personal Therapy and Anticipated Stigma in Developing Self-Care
Expiration Date:	

The University of Northern Colorado Institutional Review Board has reviewed your protocol and determined your project to be exempt under 45 CFR 46.104(d)(702) for research involving

Category 2 (2018): EDUCATIONAL TESTS, SURVEYS, INTERVIEWS, OR OBSERVATIONS OF PUBLIC BEHAVIOR. Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met: (i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects; (ii) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or (iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by 45 CFR 46.111(a)(7).

You may begin conducting your research as outlined in your protocol. Your study does not require further review from the IRB, unless changes need to be made to your approved protocol.

As the Principal Investigator (PI), you are still responsible for contacting the UNC IRB office if and when:

APPENDIX B

RECRUITMENT SCRIPT

Dear interested participant,

Thank you for your willingness to participate in my study. My name is Morgan Condie, and I am a Ph.D. student in Counseling Psychology. I am conducting research examining stigma, personal therapy, and self-care within mental health professional trainees for my dissertation. I am looking for mental health professional trainees who are enrolled in a graduate training program to take a 10-15-minute survey for the chance to win (1) of four (4) $50 amazon gift cards from a raffle. These gift cards will be distributed to the winners via the entered email once all data has been collected and all participants have had the opportunity to enter into the raffle.

Please know that I take your privacy very seriously; and security measures are taken to ensure your anonymity. Internet protocol address will not be collected and the email you enter for the drawing is not linked to your answers. If you are within the population of interest for this study (i.e., a mental health professional trainee who is enrolled in a graduate training program) and wish to participate, please use the following link (link to survey). Thank you for your time.

APPENDIX C

INFORMED CONSENT

UNIVERSITY OF
NORTHERN COLORADO

Informed Consent Form for Participation in Research

Title of Research Study: The Importance of Personal Therapy and Anticipated Stigma in Developing Self-Care

Researcher(s): Morgan Condie, University of Northern Colorado Counseling Psychology
Phone Number: email: cond5399@bears.unco.edu
Research Advisor: Dr. Basilia Softas-Nall
Phone Number: email: Basilia.SoftasNall@unco.edu

Purpose and Background: The purpose of this study is to better understand the effect of personal therapy and anticipated stigma on the self-care among mental health professional trainees. This study is focused on mental health professional trainees who are currently enrolled within a graduate program to become a practicing mental health professional. Thank you for your time and interest in this research.

Procedures: You will be asked to take complete an online survey that will take approximately 10-15 minutes to complete. After completing the survey, you will have the option of navigating to a separate form to enter into the raffle for one (1) of four (4) $50 amazon gift cards. These gift cards will be distributed to the winners via the entered email once all data has been collected and all participants have had the opportunity to enter into the raffle. The estimated completion date is by the end of February 2022. Your responses to the study survey are not connected in any way to the raffle entry. Your answers are kept confidential and not linked with identifying data like your IP address or the email you provide to be entered into the raffle.

Questions: If you have any questions about this research project, please feel free to contact Morgan Condie at cond5399@bears.unco.edu. If you have any concerns about your selection or treatment as a research participant, please contact Nicole Morse, Research Compliance Manager, University of Northern Colorado at nicole.morse@unco.edu or 970-351-1910.

Voluntary Participation: Your participation is voluntary. You may decide not to participate in this study and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled.

Online Survey Studies: Please note that the data you provide may be collected and used by Amazon as per its privacy agreement. Additionally, this research is for residents of the United

States over the age of 18; if you are not a resident of the United States and/or under the age of 18, please do not complete this survey.

Note: Amazon Mechanical Turk, Qualtrics, and Inquisit have specific privacy policies of their own. You should be aware that these web services may be able to link your responses to your ID in ways that are not bound by this consent form and the data confidentiality procedures used in this study. If you have concerns, you should consult these services directly.

Please take all the time you need to read through this document and decide whether you would like to participate in this research study.
If you decide to participate, your completion of the research procedures indicates your consent. Please keep this form for your records.

APPENDIX D

SCREENING QUESTIONNAIRE

Screening Questionnaire

Are you currently in a **graduate** training program to become a mental health professional who will provide mental health services?

- Yes, I am currently enrolled in a graduate training program to become a mental health professional.
    - Please indicate the degree being sought below.
- Masters
- Doctorate
- Other (please indicate)

    - Please indicate which type of graduate training program you are enrolled in below.
- Counseling
- Counseling Psychology
- Couples, Marriage, Family Therapy/Counseling
- Counselor Education and Supervision
- Other (please indicate)

    - Please indicate what year in the program you are in below.
- 1st
- 2nd
- 3rd
- 4th
- 5th
- 6th
- 7th
- Other (please indicate)

- Please indicate the accreditation of your program below.

- APA
- CACREP
- COAMFTE
- Other (please indicate)

- No, I am not currently enrolled in a graduate training program to become a mental health professional.
  - Thank you for your interest in our study. You have indicated that you are not included within the population of interest for purposes of this survey.

APPENDIX E

DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

What is your ethnicity?

- African American
- Asian
- Hispanic/Latina/o
- Pacific Islander
- White/Caucasian
- American Indian
- Alaska Native
- Multiple Ethnicities
- Prefer not to specify
- Prefer to self-describe

What is your age?

What is your relationship status?

- Single
- Married
- Divorced
- Separated
- Partnership
- Prefer not to specify
- Prefer to self-describe

What is your gender?

- Male
- Female
- Transgender
- Non-binary/third gender
- Prefer not to specify
- Prefer to self-describe

What is your sexual orientation?

- Heterosexual
- Gay/Lesbian
- Bisexual
- Asexual
- Pansexual
- Prefer not to specify
- Prefer to self-describe

What social economic class do you most identify with?

- Upper Class
- Upper Middle Class
- Lower Middle Class
- Working Class
- Poor
- Prefer not to specify

APPENDIX F

ATTENDANCE IN PERSONAL THERAPY

Attendance in Personal Therapy

Personal therapy/counseling is a collaboration with a mental health professional to work through mental health concerns to accomplish mental health and goals to live a happier, healthier life.

Please answer the questions below:

Have you attended any personal therapy/counseling that comprised of at least one session?

- Yes
  - I currently am attending personal therapy/counseling.
  - I attended personal therapy/counseling in the past (please indicate how long ago).
- No

Please indicate the licensure of the person from whom you are seeking or sought services.

- Licensed Professional Counselor
- Licensed Psychologist
- Licensed Clinical Social Worker
- Psychiatrist
- Do not know
- Other (please indicate)

How many personal therapy/counseling sessions have you attended in your lifetime?

Please indicate the reason for entering into your most recent therapy/counseling experience that comprised of at least one session.

- Personal reasons
  - Please indicate presenting concern (e.g., depression, anxiety, personal growth, academics)
- It was required
  - Please indicate why this was required (e.g., course/program/licensure requirements, remediation, court mandated, recommendation from other)

Taken as a whole, how would you rate your most recent therapy/counseling experience that comprised of at least one session?

Very harmful, Somewhat harmful, Neutral, Somewhat helpful, Very helpful

APPENDIX G

ANTICIPATED STIGMA SCALE

Anticipated Stigma Scale (Quinn & Chaudoir, 2009; Quinn et al., 2014)

Every person has different identities and attributes that both construct and impact their identity. Concealable stigmatized identities (CSI's) are any identities that can be hidden from others and may contain social devaluations or negative stereotypes that could negatively impact a person's life. This covers a large and diverse range of identities and attributes such as previous mental illness (e.g., depression or anxiety), substance use, minority status (e.g., sexual orientation, ethnicity, disability, etc.), sexual or other forms of abuse, domestic violence, previously seeking personal therapy, feelings of being overly stressed or inadequate, and more. CSI's are thought to have particular relevance within the training of mental health professionals due to the population characteristics like the higher levels of stress, burnout, and other negative correlates that are shown to affect this population. Please think of any attributes or CSI's you hold. If you believe that none of these attributes or identities apply to you, please mark that no CSI's apply below.

- I do not have any concealable stigmatized identities (CSI's)
- I have a concealable stigmatized identity (CSI).

Please think about the identified CSI(s) as you answer the following questions. If others knew your {*insert concealable identity here*}, how likely do you think the following would be to occur?

1. People acting as if they think you are not as good as they are

1	2	3	4	5	6	7
Very Unlikely						Very Likely

2. People acting as if they think you are not smart

1	2	3	4	5	6	7
Very Unlikely						Very Likely

3. Treated with less respect than other people

1	2	3	4	5	6	7
Very Unlikely						Very Likely

4. Treated with less courtesy than other people

1	2	3	4	5	6	7
Very Unlikely						Very Likely

5. People acting as if they are afraid of you

1	2	3	4	5	6	7
Very Unlikely						Very Likely

6. Getting poorer service than others do at restaurants or stores

1	2	3	4	5	6	7
Very Unlikely						Very Likely

7. People acting as if they think you are not to be trusted

1	2	3	4	5	6	7
Very Unlikely						Very Likely

8. People calling you names or insulting you

1	2	3	4	5	6	7
Very Unlikely						Very Likely

9. People threatening or harassing you

1	2	3	4	5	6	7
Very Unlikely						Very Likely

10. Current friends stop hanging out with you

1	2	3	4	5	6	7
Very Unlikely						Very Likely

11. Friends avoiding or ignoring you

1	2	3	4	5	6	7
Very Unlikely						Very Likely

12. Roommates wanting to move out of apartment or house

1	2	3	4	5	6	7
Very Unlikely						Very Likely

13. People not wanting to get to know you better

1	2	3	4	5	6	7
Very Unlikely						Very Likely

14. People not wanting to date you.

1	2	3	4	5	6	7
Very Unlikely						Very Likely

15. People not wanting to get involved in a relationship with you.

1	2	3	4	5	6	7
Very Unlikely						Very Likely

APPENDIX H

SELF-CARE ASSESSMENT FOR PSYCHOLOGISTS

Self-Care Assessment for Psychologists (Dorociak, Rupert, Bryant, et al., 2017)

Self-care is defined as a multidimensional, multifaceted process of purposeful engagement in strategies that promote healthy functioning and enhance well-being. Please report the extent to which you engage in the following behaviors on a seven-point scale ranging from 1 (never) to 7 (almost always).

Items:

Professional Support

1. I cultivate professional relationships with my colleagues.

1	2	3	4	5	6	7
Never						Almost Always

2. I avoid workplace isolation.

1	2	3	4	5	6	7
Never						Almost Always

3. I share work-related stressors with trusted colleagues.

1	2	3	4	5	6	7
Never						Almost Always

4. I share positive work experiences with colleagues.

1	2	3	4	5	6	7
Never						Almost Always

5. I maintain a professional support system.

1	2	3	4	5	6	7
Never						Almost Always

Professional Development

6. I participate in activities that promote my professional development.

1	2	3	4	5	6	7
Never						Almost Always

7. I connect with organizations in my professional community that are important to me.

1 2 3 4 5 6 7
Never Almost Always

8. I take part in work-related social and community events.

1 2 3 4 5 6 7
Never Almost Always

9. I find ways to stay current in professional knowledge.

1 2 3 4 5 6 7
Never Almost Always

10. I maximize time in professional activities I enjoy.

1 2 3 4 5 6 7
Never Almost Always

Life Balance

11. I spend time with people whose company I enjoy.

1 2 3 4 5 6 7
Never Almost Always

12. I spend time with family or friends.

1 2 3 4 5 6 7
Never Almost Always

13. I seek out activities or people that are comforting to me.

1 2 3 4 5 6 7
Never Almost Always

14. I find ways to foster a sense of social connection and belonging in my life.

1 2 3 4 5 6 7
Never Almost Always

Cognitive Strategies

15. I try to be aware of my feelings and needs.

1 2 3 4 5 6 7
Never Almost Always

16. I monitor my feelings and reactions to clients.

1	2	3	4	5	6	7
Never						Almost Always

17. I am mindful of triggers that increase professional stress.

1	2	3	4	5	6	7
Never						Almost Always

18. I make a proactive effort to manage the challenges of my professional work.

1	2	3	4	5	6	7
Never						Almost Always

Daily Balance

19. I take breaks throughout the workday.

1	2	3	4	5	6	7
Never						Almost Always

20. I take some time for relaxation each day.

1	2	3	4	5	6	7
Never						Almost Always

21. I avoid overcommitment to work responsibilities.

1	2	3	4	5	6	7
Never						Almost Always

APPENDIX I

PERMISSION TO USE THE ANTICIPATED STIGMA MEASURE

The Anticipated Stigma Scale has the permissions of "May use for Research/Teaching"; however, further permissions were sought for clarification and other purposes.

From: **Quinn, Diane** diane.quinn@uconn.edu
Subject: Re: Anticipated Stigma Measure
Date: October 30, 2018 at 1:45 PM
To: Condie, Morgan Morgan.Condie@unco.edu

Dear Morgan,
It's on my website: https://na01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fquinnlab.weebly.com%2Fscales.html&data=02%7C01%7CMorgan.Condie%40unco.edu%7C27df010de23b4551d0b808d63ea041d4%7Cb4dce27cd088445499652b59a23ea171%7C0%7C0%7C636765255372081784&sdata=BKvHg3W35UojlerNfcoCz2gt6UmOG0r2m4DZVEzktUU%3D&reserved=0 Diane

Diane M. Quinn, Ph.D.
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Department of Psychological Sciences
University of Connecticut
406 Babbidge Rd, U-1020
Storrs, CT 06269-1020
diane.quinn@uconn.edu
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Lab Website: https://na01.safelinks.protection.outlook.com/?url=http%3A%2F%2Fquinnlab.weebly.com%2F&data=02%7C01%7CMorgan.Condie%40unco.edu%7C27df010de23b4551d0b808d63ea041d4%7Cb4dce27cd088445499652b59a23ea171%7C0%7C0%7C636765255372081784&sdata=3rbgOwQsWVEZ8IWWyXlwZOGFYf%2FYK8HQSRETkm0EB7s%3D&reserved=0

UConn Social Psychology: https://na01.safelinks.protection.outlook.com/?url=http%3A%2F%2Fsocialpsych.uconn.edu%2F&data=02%7C01%7CMorgan.Condie%40unco.edu%7C27df010de23b4551d0b808d63ea041d4%7Cb4dce27cd088445499652b59a23ea171%7C0%7C0%7C636765255372081784&sdata=aLOdyqLF6n54fUNq4ekAEMaJQedV9NFmC86AGa7cpg0%3D&reserved=0

On 10/30/18, 2:44 PM, "Condie, Morgan" <Morgan.Condie@unco.edu> wrote:

> Hello Dr. Quinn,
> I was interested in the anticipated stigma measure you used in multiple articles. I was hoping it may pertain to work I want to do on my dissertation, but I could not find the full scale anywhere to see if it would fit. Would it be possible for you the send me the full scale to use in my dissertation research?
> Thank you,
> Morgan Condie

APPENDIX J

THERAPY MEASURE PERMISSION FORMS

The therapy assessments used have the permissions of "May use for Research/Teaching"; however, further permissions were sought for clarification and other purposes.

From: **John C. Norcross PhD, ABPP** john.norcross@scranton.edu
Subject: [External]RE: Psychotherapists Who Abstain From Personal Therapy: Do They Practice What They Preach
Date: November 9, 2020 at 5:47 AM
To: Condie, Morgan Morgan.Condie@unco.edu

Here are those questionnaires, Morgan. Feel free to sue them in whole or in part.
Cheers,
John Norcross

John C. Norcross, Ph.D., ABPP
Distinguished Professor & Chair of Psychology
Board-certified Clinical Psychologist
University of Scranton, Scranton, PA 18510-4596
570.941.7638 I https://nam02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.scranton.edu%2Ffaculty%2Fnorcross%2F&data=04%7C01%7CMorgan.Condie%40unco.edu%7C3ff3641433354ea87ab108d884ad518f%7Cb4dce27cd088445499652b59a23ea171%7C0%7C1%7C637405228194951335%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C2000&sdata=PpptXfdySEvz0Uh0dZQLSw3%2FPJ7Pl22qZ8LBQA4EfKw%3D&reserved=0
New editions of Psychotherapy Relationships that Work,
and Systems of Psychotherapy: Transtheoretical Analysis

-----Original Message-----
From: Condie, Morgan <Morgan.Condie@unco.edu>
Sent: Wednesday, November 4, 2020 4:27 PM
To: John C. Norcross PhD, ABPP <john.norcross@scranton.edu>
Subject: Psychotherapists Who Abstain From Personal Therapy: Do They Practice What They Preach

Hi Dr. Norcross,
My name is Morgan Condie and I am a doctoral student in an APA accredited U.S. program in Colorado. I have been reviewing literature for my dissertation and have come across the measure you and others made in the 1987 study and adopted in the 2008 study above to measure multiple things surrounding use of personal therapy. This was later used by Byrne and Shufelt (2014) to explore the use of counseling among counselor trainees. I was hoping to use it or part of it to measure the extent to which personal therapy impacts self-care within trainees. Could you let me know if there was any way I could use the questionnaire or parts of it within my research or even to just see the specific items to inform my research? I exhausted all the ways I could think of to find it and it is noted as needing to contact the author for permission.

Thank you,
Morgan Condie
Pronouns: He, Him, His


questionnaire.coun.doc


questionnaire.psych.doc


questionnaire.socwork.doc

From: **Byrne, Steve** byrne@alfred.edu
Subject: RE: [EXTERNAL] Factors for Personal Counseling Among Counseling Trainees
Date: November 11, 2020 at 1:57 PM
To: Condie, Morgan Morgan.Condie@unco.edu

Sure, that's fine. Good luck!

SB

-----Original Message-----
From: Condie, Morgan <Morgan.Condie@unco.edu>
Sent: Wednesday, November 11, 2020 3:42 PM
To: Byrne, Steve <byrne@alfred.edu>
Subject: Re: [EXTERNAL] Factors for Personal Counseling Among Counseling Trainees

Hi Dr. Byrne,
I also wanted to let you know that I received permission from Norcross to use his assessment, would it be okay if were to use yours in part or full as well since you have already made most of the adaptations I would need?
Thank you,
Morgan Condie
UNC Counseling Center
Pronouns: He, Him, His

CONFIDENTIALITY NOTICE: This email, including any attachments to it, is for the sole use of the intended recipient(s) and may contain confidential and/or privileged information. Any unauthorized review, use, disclosure, or distribution is prohibited. If you have received this email and are not the intended recipient, please inform the sender by an email reply, delete this email and destroy any copies (in whatever format) of the email and any attachments to it.

> On Nov 5, 2020, at 1:09 PM, Condie, Morgan <Morgan.Condie@unco.edu> wrote:
>
> Hi Dr. Byrne,
> Thank you so much for these. I am certain it will be very helpful.
>
> Thank you,
> Morgan Condie
> UNC Counseling Center
> Pronouns: He, Him, His
>
> CONFIDENTIALITY NOTICE: This email, including any attachments to it, is for the sole use of the intended recipient(s) and may contain confidential and/or privileged information. Any unauthorized review, use, disclosure, or distribution is prohibited. If you have received this email and are not the intended recipient, please inform the sender by an email reply, delete this email and destroy any copies (in whatever format) of the email and any attachments to it.
>
> > On Nov 4, 2020, at 8:06 PM, Byrne, Steve <byrne@alfred.edu> wrote:
> >
> > Hi Morgan,
> >
> > Glad to help out. The questionnaires, in a single document, are attached. Best of luck with the dissertation.
> >
> > SB
> >
> > Steve Byrne, Psy.D.
> > Associate Professor of Counseling
> > Program Director, Counseling and College Student Development
> > Practicum and Internship Coordinator
> >
> > P 607-871-2857
> > E byrne@alfred.edu
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> > 1 Saxon Drive, Alfred, NY 14802
> > https://nam02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.
> > alfred.edu%2F&data=04%7C01%7CMorgan.Condie%40unco.edu%7C0647864db
> > 28445a36e1708d88137c491%7Cb4dce27cd088445499652b59a23ea171%7C0%7C0%7C
> > 637401423937950652%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIj
> > oiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=rX9pzTTfi90
> > di4xrJmwIEFsIn9qU%2BheJKSxTn08M%2FQE%3D&reserved=0

APPENDIX K

PERMISSION TO USE THE SELF-CARE ASSESSMENT FOR PSYCHOLOGISTS

The Self-Care Assessment for Psychologists has the permissions of "May use for Research/Teaching"; however, further permissions were sought for clarification and other purposes.

Thank you for sharing this! Very exciting.

On Mon, Jan 18, 2021 at 2:50 PM Condie, Morgan <Morgan.Condie@unco.edu> wrote:
Hi Dr. Dorociak,
Thank you so much for this. I wish you the best with coming off maternity leave and wanted to congratulate your recognition of the SCAP or PSCS as found by

Jiang, X., Topps, A. K., & Suzuki, R. (2020). A systematic review of self-care measures for professionals and trainees. *Training and Education in Professional Psychology*. https://doi.org/10/ghrq42

Best wishes,
Morgan Condie
UNC Counseling Center
Pronouns: He, Him, His

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On Dec 14, 2020, at 4:38 PM, Katie Dorociak <katiedorociak@gmail.com> wrote:

Hi Morgan,

Attached is my Master's Thesis. On pages 39-41 you can find the original self-care items sent to the group of experts. Also, to clarify, the SCAP was previously named the PSCS.

Let me know if you have any other questions,

Katie

On Sat, Dec 12, 2020 at 3:24 PM Condie, Morgan <Morgan.Condie@unco.edu> wrote:
That would be amazing if you could.

On Dec 12, 2020, at 7:51 AM, Katie Dorociak <katiedorociak@gmail.com> wrote:

Hi Morgan,

I apologize for the delay as I was on maternity leave. Do you still need the above information?

Best,

Katie

On Thu, Nov 5, 2020 at 3:37 PM Condie, Morgan <Morgan.Condie@unco.edu> wrote:
Hi Dr. Dorociak,
My name is Morgan Condie, and I am a doctoral student at an APA accredited program in Colorado. I have been reviewing the Self-Care Assessment for Psychologists and other self-care measures for my dissertation and the SCAP has by far been the best available measure. I am interested in measuring the effects of personal therapy on self-care for trainees.