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Cultural Differences Among Psychologists in Pursuit of Self-Care

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Abstract

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Lisa Paliotta

MA, Adelphi University, 2000

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Dissertation Submitted in Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

Psychologists experience a myriad of professional stressors and barriers to self-care that can affect their well-being and ability to offer effective care to patients. The purpose of this study was to examine the relationships between demographic variables, professional stressors, barriers to treatment and help-seeking behaviors among psychologists. Using a revised Bearse survey and the professional quality of life measurement, data were collected and analyzed using analysis of variance and hierarchical multiple regression. The 235 respondents comprised 74% women, 62.3% European American, and 56.2% reported having a PhD in psychology. Findings indicated significant differences between non-European American and European American ethnic groups in relation to seeking out psychotherapy. European American and Asian/Pacific Islander ethnic groups sought out psychotherapy nearly twice as often. Private practice and psychodynamic orientation increased the likelihood of seeking help, whereas government/industry settings and cognitive behavioral orientation decreased this. The professional stressors of burnout and countertransference were predictive for the number of psychotherapy courses of help-seeking participants but explained a small amount of the variance. Lack of time, difficulty finding a therapist, and the number of psychotherapy sessions performed per month were significant predictors for not seeking help. The results of this study could contribute to positive social change by encouraging psychotherapy when a perceived need is present. More research is needed to understand better why some ethnic groups seek out therapy more often when it is perceived to benefit them.

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Dedication

I dedicate this research to my family and friends who greatly supported me in this endeavor. I would like to thank my mother, Catherine Paliotta, and my daughter, Sarah Rose Paliotta. I also share this appreciation with Kenneth S. Gordon and his family for their encouragement and friendship.

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Chapter 1: Introduction to the Study

Psychologists experience a myriad of professional stressors and barriers to self-care. Such stressors can include burnout, depression, countertransference compassion fatigue, and personal trauma histories. Research has shown that these stressors can impact a therapist's professional performance, leading to less effective management of client caseloads (Burwell-Pender & Hainski, 2008; Figely, 2002; Gilroy et al., 2007; Pearlman & Saakvitne, 1995; Rupert & Morgan, 2005). Barriers include lack of time, financial resources, professional stigma, difficulty admitting distress, and difficulty selecting an acceptable therapist. Studies have demonstrated that obstacles to self-care delay or negate the use of psychotherapy when the professional may perceive a need and that it could be helpful to them (Bearse et al., 2013; Dearing et al., 2005; McCarthy et al., 2008; Norcross et al., 2009; Siebert, 2005). Both stressors and barriers have been shown to influence the practice of self-care.

Management of these stressors and barriers has long been encouraged as an ethical practice of the American Psychological Association's (APA, 2010a) code. Although the practice of self-care is recommended within the profession, little research has been done to investigate the use of personal psychotherapy among psychologists during the span of their professional careers as a way of addressing this need. In this study, I examined the personal use of psychotherapy among licensed practicing psychologists from different cultural backgrounds. There has been no research conducted to compare how these stressors may affect the personal use of psychotherapy among psychologists from diverse ethnicities.

Chapter 1 includes a description of the background, problem, and purpose of this study. I also include the research questions, theoretical foundation, and nature of the study. Then, I describe the definitions, assumptions, scope and delimitations, and limitations. The chapter ends with the significance of the study.

Background

Professional psychologists have higher rates of suicide and depression than the general population and other professional disciplines that suggest a greater need for personal therapy across the profession (Gilroy et al., 2007; Norcross et al., 2009; Norcross & Guy, 2005; Pope & Tabachnick, 1994; Ukens, 1995). Therapists provide care and guidance for others as a part of their profession. This work involves significant stressors, including difficult patients and high workloads (Barnett et al., 2007; Wagaman et al., 2015). During a psychologist's career, self-care is necessary for both personal and professional functioning.

Other stressors, like burnout, compassion fatigue, countertransference, and personal traumatic experiences, have been studied as stressors that affect mental health providers (Burwell-Pender & Hainski, 2008; Figely, 2002; Gilroy et al., 2007; Pearlman & Saakvitne, 1995; Rupert & Morgan, 2005). Some of these stressors, such as the severity of depression, may increase help seeking (Siebert & Siebert, 2007). Within these studies, however, psychologists have been a subset, and there has been only one other study in that researchers focused on these stressors among only psychologists (Bearse et al., 2013). Another obstacle to therapy is the lack of services because possible therapists who could provide personal therapy have similar work schedules as those psychologists

who need to seek treatment (Bearse et al., 2013). This can lead to less available space within a personal schedule to invest in self-care needs at a moment when useful psychotherapy requires an ongoing time commitment (Bearse et al., 2013). The results of this study build on the findings from previous studies and address questions other researchers have not investigated. I examined cultural differences in self-care practices among psychologists and the use of psychotherapy during their professional tenure.

Research has shown that obstacles to personal psychotherapy play a part in accessing self-care when the professional may perceive it as helpful (Bearse et al., 2013). One barrier for psychologists is a monetary concern (APA, 2007, 2015; Barnett et al., 2007; Bearse et al., 2013; Siebert, 2005). After completing a doctoral program, most who enter the field of psychology begin their careers with heavy financial debt (APA, 2007). Psychologists beginning a career often have heavier caseloads both as a condition of initial employment and as a way to earn enough money to manage their responsibilities (APA, 2015; Barnett et al., 2007). Confidentiality and difficulty in finding an appropriate therapist may also deter psychologists from seeking treatment (Bearse et al., 2013; Dearing et al., 2005).

Researchers have found that professional stigma and difficulty in admitting distress can discourage the use of psychotherapy as a means of self-care (Barnett et al., 2007; Bearse et al., 2013; Vogel et al., 2007; Vogel & Wester, 2003). Psychologists often are invested in following specific psychological theories and practicing specific modalities. These preferences may contribute to difficulty finding a suitable therapist for their treatment and scheduling conflicts (Bearse et al., 2013). Until this study, no research

studied these barriers' influence on treatment across different cultural ethnicities among practicing psychologists.

In recent years, ethnic diversity among psychologists has steadily increased (APA, 1997, 2007, 2010a); they have grown sufficiently to allow for comparison in this study. Researchers have demonstrated that psychologists seek treatment providers who have similar demographic backgrounds (Norcross et al., 2009), which may compound the effects of this stigma. However, research involving the influence of ethnicity on these behaviors among psychologists is not available. This may be because limited diversity within the profession did not allow for this evaluation two decades ago (APA, 1997).

Further research is needed to uncover how personal therapy is accessed for practicing psychologists from various cultures and to determine whether stressors and barriers are involved in this process. Although previous researchers have asked therapists if they had ever accessed personal therapy and investigated factors influencing their choice of a therapist (Norcross et al., 2009), the use of therapy was not narrowed to the tenure of professional life (Bearse et al., 2013). With this study, I sought to fill this gap.

Problem Statement

Psychologists experience high rates of suicide and depression (Gilroy et al., 2007; Norcross & Guy, 2005; Norcross et al., 2009; Pope & Tabachnick, 1994; Ukens, 1995) even though some researchers have argued that self-care is an ethical imperative for psychologists (Barnett et al., 2007). Professional stigma and difficulty in admitting distress can discourage the use of psychotherapy as a means of self-care within this population (Barnett et al., 2007; Bearse et al., 2013; Vogel et al., 2007; Vogel & Wester,

2003). Little is known about psychologists' care-seeking behaviors related to demographic variables, professional stressors, and barriers to treatment. Without a clear understanding of the variables contributing to care-seeking behaviors, reducing stigma and increasing the likelihood that a psychologist will receive care is difficult.

Purpose of the Study

The purpose of this study was to examine the relationships between demographic variables, professional stressors, and barriers to treatment and help-seeking behaviors among psychologists. Independent variables consisted of demographic information, professional stressors, and barriers to accessing treatment. Stressors included burnout, depression, countertransference, compassion fatigue, and personal trauma histories. Barriers to treatment included professional stigma, difficulty admitting distress, difficulty finding a suitable therapist, lack of time, and financial resources. Dependent variables were the number of times psychologists have used psychotherapy and the number of instances that psychologists did not seek out therapy even though they perceived it useful.

In this study, I examined the differences between different cultural/ethnic groups among psychologists on help-seeking measures and the number of therapy courses. Additionally, I examined demographic variables, professional stressors, and barriers to treatment in predicting decisions to seek out therapy when there is a perceived need. The data collected reflect the number of courses of treatment and the number of times treatment was not sought when there was a perceived need.

Research Questions and Hypotheses

RQ1: What are the differences between different cultural/ethnic groups among psychologists on measures of help seeking and number of courses of therapy?

$H_0$1: There are no differences between ethnic groups in help seeking.

H_A1: For participants who sought treatment, there are no differences between ethnic groups in number of courses of therapy.

RQ2: For each of the different cultural/ethnic groups among psychologists, do the demographic variables, professional stressors, and barriers to treatment predict the decision to seek help and number of courses in therapy?

$H_0$2: Demographic variables, professional stressors, and barriers to treatment do not predict the decision to seek help.

H_A2: For participants who sought help, demographic variables, professional stressors, and barriers to treatment do not predict number of courses in therapy.

RQ3: For each of the different cultural/ethnic groups among psychologists, do the demographic variables, professional stressors, and barriers to treatment predict the decision not to seek help when a respondent may have benefitted from therapy and predict the number of periods of not seeking help when it could have benefitted the respondent?

$H_0$3: Demographic variables, professional stressors, and barriers to treatment do not predict the decision to seek help was there a time that a respondent may have benefitted from therapy.

H_A3: Demographic variables, professional stressors, and barriers to treatment do not predict the number of periods of not seeking help when it could have benefitted the respondent.

Theoretical Foundation

Constructivist self-development theory (CSDT; McCann & Pearlman, 1990) was used to frame the independent variables associated with self-care among psychologists and any ethnic differences in seeking therapy. Theorists of CSDT proposed that a person builds a view of the world from the accumulation of interpreted circumstances that shape schemas (McCann & Pearlman, 1990). These schemas provide a scaffold for individuals to understand their personal experiences throughout their lives. The concepts of work-life balance and schema preservation from CSDT may be relevant for understanding psychologists' experiences and their help-seeking behaviors.

According to CSDT, a worldview is needed for a stable work-life balance. Work-life balance is satisfaction in fulfilling the needs and responsibilities relating to work and personal care (APA, 2015). An individual achieves this balance by prioritizing qualities of life that support a particular individual. If family life and unity are culturally important to an individual, sacrificing family time for work or individual pursuits will produce conflict and dissatisfaction. For psychologists, balancing family, individual, and client needs can produce stress (APA, 2015). This expression of stress is adaptive rather than symptomatic (Pearlman & Saakvitne, 1995).

In addition, therapists interpret trauma through the lens of their trauma histories (Pearlman & Saakvitne, 1995). Personal psychology, culture, family, relational

connectedness, and societal experience are factors that encompass and give meaning to past trauma histories for therapists (Pearlman & Saakvitne, 1995). This dynamic adapts to new trauma and stress while striving to preserve functioning. However, when traumatic experiences lie beyond previous exposure, they force them into preexisting schema to shatter the worldview and maintain stability (Pearlman & Saakvitne, 1995). An example might be a time of monetary restriction, excessive workload, and difficult clientele, as experienced by new psychologists. This stress can lead to the formulation of illogical beliefs to preserve existing schema and worldviews.

This theory further states that these illogical beliefs can eventually impair functioning over time if not addressed (Pearlman & Saakvitne, 1995). For example, these illogical beliefs can impair the interpretation of client experiences for a practicing psychologist and potentially create less efficacious treatments for clients. These beliefs may also create a barrier to seeking treatment because of the exacerbation of professional stigma associated with help-seeking behaviors (Bearse et al., 2013). One of the ways to address this problem and reduce illogical beliefs is through psychotherapy (Pearlman & Saakvitne, 1995).

Nature of the Study

In this study, I used a quantitative, nonexperimental, correlational design with an online survey approach. Quantitative, correlational studies are appropriate for examining the strength of relationships between numerically measurable constructs (Howell, 2013). A nonexperimental design was selected because there was no random assignment of participants to control or treatment groups (Bordens & Abbott, 2008). An online survey

approach provides efficiency and cost effectiveness than alternative surveying methods (Tuten, 2010). Online surveys are frequently used in academic research and offer comparable rates of completed surveys and those that were individually mailed (Creswell, 2014).

I used a revised Bearse survey (RBS, 2016) and professional quality of life measure (ProQOL, 2005) as instruments in an online application. The original Bearse questionnaire (2013) did not capture ethnic differences among psychologists and did not gather information on psychotherapy during professional tenure. The Bearse questionnaire (2013) was modified to capture ethnic differences and therapy use during a psychologist's career. The RBS asked participants to report demographics, stressors, and barriers. The RBS also asked the number of times therapy was used or not used during professional tenure. The ProQOL was be used to provide a more reliable measure of burnout and compassion fatigue.

G*Power 3.1.7 (Faul et al., 2014) software was used to estimate the minimum sample size for the study. Online surveys were collected anonymously and confidentially. Only completed surveys were included in the analysis. All completed surveys were preliminarily checked to ensure they met the qualifications for inclusion and that all data met assumptions. A comparison between the original Bearse questionnaire (2013) and the RBS (2016) was made with descriptive statistics. The first research question was analyzed with a multivariate analysis of variance (MANOVA). The second and third research questions were analyzed with hierarchical multiple linear regressions.

The independent variables consisted of demographics, professional stressors, and barriers to accessing treatment. Demographics that are standard for survey research for professional fields, such as gender, age, ethnicity, and type of license, were used (Fowler, 2013). To incorporate ethnic diversity among participants, I posted invitations to participate in this study in listservs with 10 different psychological associations. Some of these associations' memberships are comprised primarily of a particular cultural or ethnic group: the National Latinx Psychological Association (NLPA), Asian American Psychological Association (AAPA), and the Association of Black Psychologists (ABP). The professional stressors included burnout, depression, countertransference, compassion fatigue, and personal trauma histories. The barriers to treatment included lack of time, lack of financial resources, professional stigma, difficulty in admitting distress, and difficulty finding a suitable therapist.

Definitions

Burnout: Experiencing negative feelings toward work, demanding employee interactions, and emotional fatigue (Maslach, 1993). These feelings slowly worsen over time the longer the situation lasts in the work environment (Rupert & Morgan, 2005).

Compassion fatigue: The slow loss of empathy toward clients and a decreased reaction to clients' distress (Figely, 2002).

Countertransference: Distress therapists encounter when their trauma histories are not adequately dealt with when processing their clients' experiences (Burwell-Pender & Hainski, 2008).

Depression: A prolonged period of sadness marked by isolation, social withdrawal, poor motivation, and low energy (Gilroy et al., 2007).

Difficulty in admitting distress: A barrier to accessing treatment that occurs when a professional feels their respect as a psychologist will be diminished due to experiencing an issue they cannot handle on their own (Vogel & Wester, 2003; Vogel et al., 2007).

Difficulty in finding a suitable therapist: The personal needs of the professional psychologist in finding a therapist who matches their preferences. Preferences can include location, a fellow professional with similar academic achievement, a similar level of licensure, similar choice of psychological theory, similar choice in practice modality, similar ethnicity, and similar gender (Bearse et al., 2013; Clement et al., 2015; Norcross et al., 2009).

Personal trauma histories: Traumatic events and loss experienced (Pearlman & Saakvitne, 1995).

Professional psychologists: For this study, those who have doctorates in psychology (PhD and PsyD) and are licensed to practice and treat clients.

Professional stigma: The concern that a professional cares about how their use of therapy may interfere with their professional reputation, including the possibility that self-care might negatively impact their livelihood if therapy is disclosed (Vogel & Wester, 2003).

Related mental health fields: These fields include counselors, social workers, and psychiatrists.

Assumptions

For this study, I made several assumptions. First, I assumed that psychologists encounter stressful situations through their profession that may require psychological treatment. This assumption was consistent with the limited extant research about psychologists' increased needs for psychological care (Gilroy et al., 2007; Norcross et al., 2009; Norcross & Guy, 2005; Pope & Tabachnick, 1994; Ukens, 1995). As a result, I assumed that a design was required that allowed psychologists to be open and honest, which is a requirement for this study. I chose the survey research design that allowed for such anonymous participation and complete confidentiality for the largest possible number of respondents, as reported by Fowler (2014).

I also assumed that Bearse et al.'s (2013) RBS and the ProQOL were valid for collecting the data for the study. To measure construct validity, some of the constructs were assessed with more than one approach (e.g., Bearse's original item and a separate measure). The ProQOL offered more reliability in measuring key concepts of compassion satisfaction, burnout, and compassion fatigue/secondary trauma. This instrument has established rates of internal validity and reliability (Stamm, 2005).

Scope and Delimitations

For this study, only registered, licensed professional psychologists and active members of 10 different psychological associations were recruited: (a) APA Division 45, (b) ABP, (c) NLPA, (d) AAPA, (e) New York State Psychological Association (NYSPA), (f) Maryland Psychological Association (MPA), (g) Pennsylvania Psychological Association (PPA), (h) California Psychological Association (CPA), (i)

Illinois Psychological Association (IPA), and (j) Texas Psychological Association (TPA). The participants completed an online survey. The participants were delimited to individuals who are active members of the scholarly community who follow the listservs for the various professional organizations. These delimitations may have affected the generalizability of the study to other ethnic groups or to psychologists who are not members of these organizations.

The study is delimited to the use of therapy or lack thereof during participants' careers. The rationale for limiting the scope of the RBS to the use of therapy or lack thereof to the career span of the practicing professional was because this question was not answered in the Bearse et al. (2013) study. Research has demonstrated that practicing psychologists are at risk for experiencing professional stressors along with barriers to treatment and that personal psychotherapy is an effective way to manage these stressors (Bearse et al., 2013; Bike et al., 2009). The limited focus in this area was also necessary to increase internal validity with the RBS.

Limitations

The sample for this study provided some limitations to the data. A potential limitation of the sample was that the choice to recruit participants from professional listservs eliminates the opportunity to sample individuals who have left the psychology field, perhaps leaving out key participants who experienced barriers to seeking treatment and thus ultimately left the profession. Additionally, psychologists could have felt threatened professionally in reporting their help-seeking behaviors (Barnett et al., 2007; Bearse et al., 2013; Vogel & Wester, 2003; Vogel et al., 2007). As a result, participants

may have felt uncomfortable responding honestly regarding their personal treatment histories. To reduce the effects of this limitation, I chose a survey research design. Fowler (2014) noted that the survey design allows for anonymous participation and complete confidentiality for the largest possible number of respondents.

Some limitations may nevertheless arise from the use of a survey design. The results are limited to the validity of the instruments chosen to collect data. The Bearse et al. (2013) original questionnaire was a research instrument created for their study, as I used this survey instrument in a slightly modified form (RBS). However, since this was the first replication of the Bearse et al. (2013) study, the instrument was compared to the original questionnaire to improve instrument validity. In addition, the ProQOL, an instrument with established rates of internal validity and reliability (Stamm, 2005), provided results for the variables of compassion satisfaction, burnout, and compassion fatigue/secondary trauma. Survey design research is also vulnerable to internal and external validity threats due to the inability to regulate sample selection and data collection conditions integral to estimate sampling error and minimum confounding variables (Creswell, 2009).

Significance

Significance for the Discipline

This study has the potential to identify the self-care experiences of culturally diverse licensed psychologists. Those in the psychological profession have been identified as needing professional treatment because of the requirements of their jobs (Gilroy et al., 2007; Norcross et al., 2009; Norcross & Guy, 2005; Pope & Tabachnick,

1994; Ukens, 1995). By examining the professional stressors and barriers to treatment that psychologists encounter within their cultural experience, the field of psychology may be better positioned to address psychologists' need for self-care through psychotherapy. Without knowing the particular stressors and barriers that best predict self-care behavior among these groups, the profession will continue to lose valuable trained practitioners because of burnout or potentially because of long-term, untreated mental health issues. In addition, the professional integrity of psychologists will be maintained by the increased ability to identify the barriers and stressors that may impede a psychologist's ability to provide quality services.

Such knowledge can be incorporated in continuing education to maintain licensure to promote self-care for established professionals. Those students still in training for their doctorate could be offered electives in self-care methods to prepare them for a better professional tenure. Continued research in this area is needed to tailor these strategies to meet the most current needs of professional psychologists as the field grows and changes. This study is significant as a first step in promoting self-care within this population.

Significance for Practice and Policy

Once the barriers and stressors for psychologists are more clearly defined, strategies to address them can develop in a more effective and targeted fashion. Norcross et al. (2009) found that use of therapy prior to becoming a therapist was the best predictor as to whether a therapist was likely to use therapy. Not all graduate schools require that doctoral students participate in therapy as an adjunct to developing their therapeutic

knowledge. Perhaps with more definitive data on how often professional psychologists choose to use therapy and the times they choose not to do so when such a need is present, this policy will no longer remain a voluntary one for the student or optional for the training program curriculum.

Similarly, more specific guidelines for self-care may develop with ethical guidelines in future iterations of the APA code. This future code may give specific situations where therapy is more strongly recommended. These could incorporate barriers and stressors identified as significant in the present study. This future code could also recommend and outline the role of supervisors in stressful situations to promote an open and supportive atmosphere to decrease any professional stigma (Fogel et al., 2006). Such recommendations could also reduce the fear of professional stigma among practitioners.

Significance for Social Change

The ultimate ethical aim is for all psychologists to maintain psychological stability during personally stressful periods to protect their well-being and retain steady levels of effectiveness in the treatment of their clients (APA, 2010a). Maintaining a psychologist's well-being is essential to protecting both the professional and the client (Dearing et al., 2005). The availability of information about stressors and barriers influencing psychologists' help-seeking behaviors may impede professional organizations' and supervisors' abilities to intervene and ensure that psychologists receive necessary psychological interventions. Therefore, this topic must be examined to establish the rates of self-care among the culturally diverse field of psychologists. If

appropriate self-care is not occurring, then both the professional and the clients they treat are at risk.

The profession should minimize this risk as much as possible; therefore, the results can influence a significant social change by ensuring that psychologists and clients receive appropriate, high-quality psychological treatment. Through clients, psychologists reach far outside the profession and into all their clients' everyday lives. This study could contribute to positive social change by ensuring the constancy of effective treatment by psychologists. Thereby, the study results can enhance not only the lives of the psychologists but also the real-world relationships of all the clients those psychologists treat.

Summary

Psychologists experience significant stressors and trauma throughout their careers (Barnett et al., 2007; Bearse et al., 2013). As a result, they may need to seek care, but factors may be barriers to their care-seeking behaviors (Barnett et al., 2007). The purpose of this study was to examine the relationships between demographic variables, professional stressors, and barriers to treatment and help-seeking behaviors among psychologists. Chapter 2 will include a literature review that addresses current knowledge in the discipline and the gap in the literature. Subsequently, in Chapter 3, the research design and rationale will be discussed in more detail. The chapter will cover methodology, including population, sampling, sampling procedures, recruitment, participation, data collection, instrumentation, operationalization of constructs, and a data

analysis plan. Threats to validity and ethical procedures also will be examined in Chapter 3.

Chapter 2: Literature Review

As demands of the psychological profession change, researchers and governing bodies are concerned with how providers obtain self-care and the influence of stressors and barriers to seeking help (Barnett et al., 2007; Daw & Joseph, 2007; Norcross et al., 2009). Despite self-care being an ethical imperative for these care providers, little is currently known about the factors that contribute to or impede self-care among psychologists (Barnett et al., 2007). The purpose of this study was to examine the relationships between demographic variables, professional stressors, and barriers to treatment and help-seeking behaviors among psychologists.

Current literature regarding this topic is limited. Researchers have noted that psychologists experience significant stressors as part of their occupation, contributing to their need for self-care. These stressors may increase the likelihood of burnout (Bearse et al., 2013; Norcross & Guy, 2007; Ruper & Morgan, 2005; Schaefeli & Peters, 2000), compassion fatigue (Bearse et al., 2013; Nikcevic et al., 2007), countertransference (Bearse et al., 2013; Burwell-Pender & Hainski, 2008), personal trauma (Bearse et al., 2013), and increased rates of depression and suicide (Bearse et al., 2013; Pope & Tabachnick, 1994; Gilroy et al., 2007). There are conflicting findings related to the rate at that psychologists seek personal therapy, ranging from 44% (McCarthy et al., 2009) to 86% (Goodyear et al., 2008). Norcross and Guy (2007) determined that only about 60% of their sample of psychologists sought psychotherapy during their career, and Bearse et al. (2013) found that 59% of psychologists did not seek help at a time when it would have been beneficial to them. This lack of self-care may be due to the following barriers:

confidentiality concerns (Bearse et al., 2013; Dearing et al., 2005), cost (Bearse et al., 2013; Dearing et al., 2005; McCarthy, 2008; Siebert, 2005), finding a suitable therapist (Bearse et al., 2013), lack of time (Bearse et al., 2013), and professional stigma (Bearse et al., 2013; Fogel et al., 2006; Siebert, 2005).

This chapter begins with a description of the literature research strategy and the theoretical framework that informed the study. In this section, I describe how psychologists are affected by stressors that may shape their perception of obstacles to personal treatment. In addition, I provide information about how a psychologist's ability to develop coping strategies is impacted by personal psychology, culture, family, relational connectedness, and societal experience (Pearlman & Saavkvtine, 1995). The chapter concludes with a description of key concepts detailed in seminal literature addressing current professional psychologists' stressors and obstacles.

Literature Search Strategy

I used the following databases for my literature search: Academic Search Complete, ProQuest Central, PsycINFO, PsycARTICLES, SAGE Premier, SOCindex with full text, and CINAHL & MEDLINE Simultaneous Search. I also used the Google Scholar search engine. Key search terms included *self-help*, *self-care*, *therapy*, *psychotherapy*, *mental health worker*, *social worker*, *mental health counselor*, *psychotherapist*, *psychologist*, *psychiatrist*, *constructivist self-development theory*, *stressors*, *depression*, *trauma histories*, *burnout*, *compassion fatigue*, *countertransference*, *barriers to treatment*, *professional stigma*, *finding a therapist*, *risk of disclosure*, and *obstacles to treatment*. Seminal and recent peer-reviewed literature

spanned the years 1993 through 2021. Because the research was sparse for the study topic, I searched for literature that addressed particular stressors and obstacles to treatment in studies focusing on psychologists. This further supports the Bearse study (2013), that researchers used only professional psychologist participants as uniquely impacted by these particular stressors and obstacles.

Theoretical Foundation

I used constructivist self-development theory (CSDT) as the theoretical framework to describe the factors related to help seeking among psychologists and possible cultural differences in accessing mental health support (McCann & Pearlman, 1990). Developed by McCann and Pearlman (1990), CSDT is based on the view that people create their perception of the world through their interpretation of their experiences and existing schemas based on these interpretations (McCann & Pearlman, 1990). Therapists manage the traumatic histories of their clients in accordance with their present situations and their prior trauma histories (Pearlman & Saakvitne, 1995). Therapists' trauma history and present life situation are framed by their psychology, culture, family, relational connectedness, and societal experience (Pearlman & Saakvitne, 1995). Therefore, coping with traumatic material is more adaptive than symptomatic (McCann & Pearlman, 1990).

However, one may cope with this novel experience by creating an illogical belief to adapt it to a preexisting schema when traumatic material is outside of any of these types of experiences (Pearlman & Saakvitne, 1995). This process protects the person's coping process from being threatened and stabilizes the person's worldview overall. For

example, if a therapist works with prisoners, they might believe that most people are untrustworthy. This therapist would then act in ways to avoid people who are perceived as untruthful. Likewise, a therapist treating patients with sex abuse histories might begin to distrust potential relationships and perceive possible sex partners as conceivable sex abusers. These thoughts and behaviors are used to cope with trauma and vicarious trauma that become widespread and build over time. Eventually, this coping branches out into all areas of a person's life.

Pearlman and Saakvitne (1995) used this theory to examine countertransference and vicarious traumatization within the psychotherapeutic process among therapists who treat victims of incest. When a therapist and client explore long past events, those events must be framed through the eyes of the developmental stage of the client when the events occurred (Pearlman & Saakvitne, 1995). CDST is applied to understanding how the client developed through time to their current world view. CDST provides a scaffold that psychological, interpersonal, and transpersonal development can be followed after trauma is experienced and to trace how vicarious trauma is experienced by the therapist (Pearlman & Saakvitne, 1995). When CDST is applied for these purposes, it encompasses both psychodynamic and cognitive modalities and object relations theory, interpersonal psychology, and self-psychology (Pearlman & Saakvitne, 1995).

CDST closely mirrors the qualities of social learning theory and cognitive developmental theory. CDST is an event centric paradigm in which therapy can be mapped by stages individualized by the person's experience in treatment because of its contextual flexibility (Pearlman & Saakvitne, 1995). These contexts can be

developmental, social, cultural, and time sensitive. Contexts are even sensitive to the time of day or level of life experience when trauma or neglect was experienced (Pearlman & Saakvitne, 1995). The client's story and history are clearly understood when seen through this lens. Theorists of CDST fundamentally believe that individuals create and understand their truth about how their world works (Pearlman & Saakvitne, 1995). Therefore, the significance and sense of trauma exist within a client's experience of it (Pearlman & Saakvitne, 1995). In this way, every traumatized client can be seen as a view into a unique world separate from any other account in a therapist's experience. The creation of meaning re-forms when new experiences are added to the client's story. These experiences continue to reshape beliefs and redefine a system of understanding of the therapist's worldview.

The CDST framework for vicarious trauma explains that this experience for the therapist is marked by deep disturbances within a therapist's orientation between themselves and how they see themselves in connection to the world as they understand it to operate (Pearlman & Saakvitne, 1995). Shifts in their orientation can manifest in reduced resiliency, lowering of tolerance, and increases in psychological needs with possible changes in beliefs about who they are and how they see others be (Pearlman & Saakvitne, 1995). These shifts can also alter the therapist's relationships with others, how they experience their own body, and how they behave when interacting with circumstances and other people (Pearlman & Saakvitne, 1995). Vicarious trauma is a unique response to specific therapy work constructed as a coping and protective adaptation to assist therapists in dealing with many different trauma stories (Pearlman &

Saakvitne, 1995). As clients tell their stories, the therapist may experience reenactments of trauma themes that may occur many times throughout treatment for each client. However, the long-term effects of vicarious trauma need not be forever when these adaptations are addressed in ways that transform them into more useful adaptations.

The research questions may develop CDST further by providing insight into how stressors, combined with barriers, may contribute to psychologists' worldviews regarding the necessity of personal therapy and seeking help. Dearing et al. (2005) provided information on the predictors of help seeking among clinical and counseling graduate students that could be useful in conceptualizing predictors of help-seeking behavior among professional psychologists. This theory was used to view the professional stressors that impact practicing psychologists and barriers that inhibit help seeking among mental health providers to view how they develop for the psychologist. Stressors include burnout, depression, countertransference, vicarious trauma/compassion fatigue, and personal traumatic histories, as listed in the Bearse survey (2013). Barriers include personal stigma, professional stigma, difficulty admitting distress, difficulty selecting an acceptable therapist, lack of time, and lack of financial resources, as listed in the Bearse survey (2013). These factors were defined and described in relation to the experience of the working psychologist through the lens of CSDT.

Literature Review Related to Key Variables and Concepts

Overview of the Psychological Profession

Roysircar et al. (2004) spoke about the need for cultural diversity competency in therapists. In accomplishing this task, U.S. census (2001) figures were cited that

demonstrate the Caucasian population has decreased and the Euro-centric psychological perspective is no longer a workable source of knowledge for training programs for mental health professionals whose clients will represent a more diverse population. To support the now accepted imperative of cultural competency for psychologists, an APA workforce study (1997) was cited that reported that all students of color who attained a doctorate in psychology combined represented only 6% of those similarly awarded. This 6% comprised African Americans, Asian Americans, Hispanic Americans, and Indian Americans combined.

The APA (2007) workforce study reported that 74% earned doctorate degrees in psychology, PhDs, and 26% earned PsyDs. Of those who earned a PhD in psychology (n = 2413), 84% were granted to Caucasian students. Seventy-six percent of these new doctorates were awarded to women, representing a 24% increase between 1997 and 2007 (Wicherski et al., 2009). The remaining 14% are ethnic or racial minorities; 5% are African American and Hispanic students, 6% are Asian students, 2% are students with multiracial/ multiethnic backgrounds, and the remaining did not identify any racial or ethnic background. Only two participants responded that they identified as Native American.

The APA (2010b) workforce study found that of the 2,837 U.S. citizens and permanent residents who received PhDs in psychology, 76% of the PhDs were granted to White students that went down 10% since the 2007 APA workforce study. The remaining 24% are ethnic or racial minorities: 9.7% Hispanic students, 5.8 % Black students, 5.2% Asians, 2.5% those who indicated more than one race, and less than 1% to

Indian/Alaskan Natives. The combined percentages of African Americans and Hispanics at 15.5% more than tripled the 5% combined percentage reported in the 2007 APA workforce study. While Asians and multiracial participants granted PhDs in psychology experienced a slight decrease of .8 % and .5%, respectively, since 2007, Native Americans/Indians/Alaskan Natives increased from two respondents to 1% in the 3-year period. Michalski et al. (2011), who conducted the APA 2010b study, sent out 10,000 questionnaires to APA members with 15% response rate, n = 6407. The ethnic identification of participants was 1.7% Asian, 2.7% African American, 2.2% Hispanic, 87.5% Caucasian, Multiracial/Hispanic 1.2%, multiracial 3.4%, other race 1.1%, and American Indian or Alaskan Native .2%. Approximately 80% of the participants held a PhD in psychology, 18% held PsyDs, and 3% held doctoral EdDs in education (APA, 2010c). Forty percent of participants reported working in many settings, and 60% reported working in a single placement. APA (2010c) reported that almost half of all psychologists worked in private practice at 51%. Individuals in this profession may experience significant stressors (Barnett et al., 2007; Bearse et al., 2013).

Recent workforce studies reported that the population of American psychologists has continued to become more closely aligned with levels of diversity found in the U.S. populace (Lin et al., 2018). Lin et al. (2018) stated that as of 2015, people in the United States from different ethnicities represented 38% of the populace. However, among American psychologists, only 16% reported being from ethnicities other than European American that year (Lin et al., 2018). Lin et al. (2018) found that by 2016, the representation of ethnically diverse psychologists nearly doubled to 34%. Of those who

completed doctoral degrees in psychology in 2016, 32% were granted to ethnicities other than European Americans (Lin et al., 2018).

Stressors in the Psychological Profession

Job stress is a significant issue for psychologists (Bearse et al., 2013). Schaufeli and Peeters (2000) described job stress as an interaction between job stressors and job strain. Job stressors refer to the environmental aspects of the workplace. Job strain refers to the use of work resources mentally, physically, and behaviorally. Examples of job strain would be high blood pressure for physical strain, absenteeism for behavioral strain, and anxiety for mental strain. Job stressors specific to psychologists include burnout, compassion fatigue, countertransference, a lack of work-life balance, and increased rates of depression and suicidality (APA, 2015; Bearse et al., 2013; Burwell-Pender & Hainski, 2008; Gilroy et al., 2007; Norcross & Guy, 2007; Rupert & Morgan, 2005).

Burnout

Burnout is defined as a combination of stressful work relationships, adverse feelings concerning an employment position, and emotional exhaustion (Maslach, 1993). Other work-related factors related to burnout are increases in travel to work, confusion over work responsibilities, struggles with position boundaries among coworkers, and difficult client conduct (Landsman, 2001). Among psychologists, problematic client behaviors, absence of client progress, management of detailed documentation, and other organizations related responsibilities play a role in developing burnout (Norcross & Guy, 2007).

Maslach and Florian (1988) described three components of burnout. Emotional exhaustion is an absence of emotional resources marked by the sensation that a worker has nothing to offer psychologically. The sense of depersonalization is represented by negative perceptions toward coworkers that contribute to stressful work relationships. Adverse feelings towards a worker's employment stem from a personal perception of poor overall performance, low accomplishment, and dissatisfaction with achievement.

Bakker et al. (2003) described burnout as a model of imbalance between job demands and job resources. Job demands are the parts of a job that require continued effort that taxes a worker both mentally and physically, contributing to exhaustion. Job resources are described as parts of a job that assist a worker in assignment completion. Job resources can decrease mental or physical reserves or nurture individual progress and improvement (Demerouti et al., 2001).

Jenaro et al. (2007) describe coping strategies as among job resources that can reduce the experience of burnout. This concept of burnout manifests in decreased emotional resources, decreases in completed work production, and increases in the sensation of lost personal identity (Jenaro et al., 2007; Schaufeli & Peeters, 2000). Among coping strategies suggested in this study are communication, conflict resolution, team development, and changes in work hours (Jenaro et al., 2007).

The work-related atmosphere where burnout gradually develops over time includes lower pay rates, changes in work schedules, and heavy workloads (Rupert & Morgan, 2005). Rupert and Morgan (2005) studied burnout among professional psychologists n = 571 with 261 male and 310 female participants. Of those who

participated, 96% were Caucasian, 1% African American, 1% Hispanic, and 2% Asian. All participants had a doctorate, with 84% of them holding PhDs in psychology. The study found that rates of burnout among psychologists are a serious issue but that rates of burnout were similar to Ackerley et al.'s (1988) study. Additionally, the study found that psychologists were at the highest risk for emotional exhaustion instead of the two other components for burnout. Mental health workers, including psychologists, can be adversely affected by the process of burnout over time, as evidenced by increased work distress, job attrition, and less efficacious outcomes for clients who are treated with a compromised therapeutic ability (Rupert & Morgan, 2005).

Compassion Fatigue

Closely related to burnout is compassion fatigue. Compassion fatigue lessens a therapist's capacity to empathize with clients' suffering, lowers the impetus to react to client distress, and diminishes the ability to feel a client's painful emotional responses (Figley, 2002). Nikcevic et al. (2007) found that psychologists have an increased occurrence of childhood trauma and family dysfunction compared to the overall population. This previous exposure to unresolved trauma could predispose psychologists to burnout and compassion fatigue when absorbing the pain and suffering of clients that are challenging to treat (Nikcevic et al., 2007).

Craig and Sprang (2010) found that using evidence-based modalities in psychotherapy treatment lowered the incidence of compassion fatigue and burnout while raising perceptions of compassion satisfaction. These modalities include "exposure therapy, cognitive behavioral interventions, and eye movement desensitization and

reprocessing" (Craig & Sprang, 2010). Craig and Sprang studied social workers and psychologists n = 532 in their use of evidenced-based practices for their clients and if such evidenced-based practices concurrently reduced incidences of compassion fatigue among the participating therapists. Of the participating therapists, 52% reported doctoral education in clinical psychology, and 98% of all the therapists in this study were treating clients with PTSD (Craig & Sprang, 2010). Their research study found that compassion fatigue and burnout are affected by trauma histories, work-life satisfaction, professional level of employment, and higher levels of work experience (Craig & Sprang, 2010). Moreover, Craig and Sprang (2010) found through hierarchical regression that a therapist's youth, lack of experience with trauma treatment, higher caseloads with trauma cases, and using none of the evidence-based practices for trauma significantly predicted incidences of compassion fatigue. These findings support the possibility that age and work tenure may be mitigating factors in experiencing compassion fatigue, job stress, and burnout.

Compassion satisfaction is related to both burnout and compassion fatigue. Compassion satisfaction refers to the level of enjoyment derived from engaging in a particular profession (Stamm, 2005). Research done by Stamm (2005) demonstrates that as levels of burnout and compassion fatigue increase, the levels of compassion satisfaction decrease. When applied to psychologists, this would mean that as psychologists experience more burnout and compassion fatigue, they would feel that performing in their profession was less pleasurable. Stamm developed the ProQOL to

capture this interaction between burnout, compassion fatigue, and compassion satisfaction.

Countertransference

Countertransference can cause particular distress when the psychologist has personal trauma that has not been adequately addressed (Burwell-Pender & Hainski, 2008). Burwell-Pender and Hainski (2008) found that countertransference can also be stressful for the psychologist unaware of its potential benefit to client treatment and avoid these feelings when they arise. In such cases, a therapist would find it difficult to differentiate between countertransference-related feelings and behaviors from their perceptions and responses within themselves and in their outward behaviors (Burwell-Pender & Hainski, 2008). When such distress remains unaddressed in the presence of countertransference, these emotions can disrupt behavior, with the most concerning being expressions of hostility and sexuality (Burwell-Pender & Hainski, 2008). Burwell suggests that ongoing supervision and personal therapy can offer safe places for a therapist to explore their feelings and honest reactions to client content that can encourage self-knowledge and the best use of countertransference material (Burwell-Pender & Hainski, 2008). Personal therapy for the therapist is recommended to improve the quality and efficacy of treatment of clients as professional development (Phillips, 2011). Taken together, these studies suggest that psychologists are at risk for burnout, secondary trauma, vicarious trauma, compassion fatigue, countertransference, and post-traumatic stress disorders (Phillips, 2011; Rupert & Morgan, 2005).

Personal Trauma Histories

Research has found that psychologists demonstrate higher rates of having personal trauma histories (Nikcevic et al., 2007). Pearlman and Saakvitne (1995) theorize that these exposures to trauma can affect how therapists process and interpret their clients' experiences. Burwell-Pender & Hainski (2008) suggest that such traumas can be reframed through personal therapy, and the therapist can then use their experience to understand their clients better.

Additionally, research has found that there was also an increased incidence of the caretaker role in the family and/or instances where the child took on aspects of the parent's role in the family (Nikcevic et al., 2007). When this occurs, children experience a responsibility toward ensuring the welfare of those who are part of the family. This is usually the result when parents fulfill feelings and household needs through their child, who subsequently holds confidences and mediates relationships within the family (Nikcevic et al., 2007). Such childhood experiences can give rise to a perception that the needs of family members and others take precedence over the self needs. Over time children take on self-worth through the caretaking of others. Nikcevic et al. (2007) reviewed research that connects these assumptions of roles with a family, such as a child that takes on the responsibilities as confidante or mediator, with later career choices for future psychologists.

Depression and Suicidality

Perhaps due to the stressors of their jobs, psychologists have higher rates of depression and suicidality than in other professions (APA, 2015; Bearse et al., 2013;

Gilroy et al., 2007; Norcross & Guy, 2005). In a sample of 476 psychologists, Pope and Tabachnick (1994) found that 4% of the usable completed surveys disclosed that these psychologists had attempted suicide at least once, with 29% reporting having had thoughts of suicide (Pope & Tabachnick, 1994). Approximately 60 percent of psychologists surveyed reported that they had experienced an episode of clinical depression, with rates of suicidal ideation were as high as 62% (Pope & Tabachnick, 1994; Gilroy et al., 2007).

Gilroy et al. (2007) surveyed 425 members of counseling psychology within APA 17 and reported that 62%, n = 264, disclosed that they felt depressed, withdrawn, and isolated, while 38% reported no depressive symptoms. The study comprised 55% female and 45% male participants, with all participants identifying as Caucasian. Almost all respondents had obtained doctoral degrees in psychology. The rates of depression were not significantly affected by the number of years in practice, employment setting, income, or the number of children. Seventy-eight percent of those with prescriptions for psychotropic medications had their medications prescribed by psychiatrists. Only 2% reported that they were hospitalized for depression. This study also found that 42% of participants indicated that they experienced suicidal ideation or attempts.

Gilroy et al. (2007) reported that psychologists that experience symptoms of being depressed identified with poor motivation, decreased concentration, low energy, unhappiness, and the absence of satisfaction. Their review noted that psychologists had reported that depressive symptoms had resulted in a lower quality of client care when these symptoms went unaddressed (Gilroy et al., 2007). One study reported that 5% of

psychologists disclose inadequate care of clients due to symptoms of depression (Guy, Poelstra & Stark, 1987). These high rates of depression suggest the need for psychologists to seek out personal therapy, though many do not reach out for this treatment (Bearse et al., 2013).

Self-Care Among Psychologists

Psychologists are unlike other mental health workers in education, professional identity, and work-life. Psychologists' experience of work-life balance reflects the stressors experienced both personally and professionally. Many practicing psychologists lack work-life balance (APA, 2015). Work-life balance is that ideal state where one's work life and one's personal/ home life exist harmoniously and that all needs in both areas of one's life are fulfilled satisfactorily. APA (2015) studied 902 adult psychologists employed full or part-time. The study found that men were more likely than women to use work benefits to address personal concerns as frequently as every week or more (APA, 2015). These benefits include child care, accrued personal time, flexible hours, paid leave, and unpaid leave (APA, 2015). However, men were more likely to have positions encompassing these perks instead of their female counterparts (APA, 2015). While on the job, men were more likely to address personal needs and take important personal phone calls than women (APA, 2015).

Conversely, men were less likely to do all their work at work and reported bringing work home and doing work during vacations. Although these men reported a perception of a better work-life balance (APA, 2015). Women were more likely to perceive work and home life as separate and still report that they feel an investment in

their family life (APA, 2015). Similarly, women reported that they had accomplished the most meaningful objectives in their lives (APA, 2015). Typically women report greater job fulfillment, increased performance motivation, better collaborative experiences with superiors, and were the least likely to plan to move to another job elsewhere with a 12 month period (APA, 2015).

In an APA study, Martin (2010) surveyed psychologists n = 800 about work-life balance. Seventy-two percent reported that struggling with this balance was stressful (Martin, 2010). Other stressors that interfered with this balance were dealing with burnout/ compassion fatigue 59%, insurance/managed care 68%, concerns about client welfare 63%, and personal family concerns 61% (Martin, 2010). Coping strategies reported by psychologists are support from colleagues 94%, personal friends/ peers 95%, use of hobbies 91%, more physical exercise 89%, and participation in psychotherapy or counseling 64% (Martin, 2010).

Research on psychologists' help seeking is sparse, and the few studies that have been conducted focused on mental health practitioners in training or social workers as the populations of interest. For example, one study found that 44% of mental health counseling trainees (n = 108) had used therapy at any period during their lifetime (McCarthy et al., 2009). These findings were much less than the 70% rates of psychotherapy treatment within other clinical training programs found by Dearing et al. (2005), 75% in the clinical programs researched by Holzman et al. (1996), and 86% in Goodyear et al.'s (2008) sample.

Researchers have found that psychologists seek mental health treatment at three times the rate of the general population (Norcross & Guy, 2005; Norcross et al., 2009). However, following formal training, only 60 % of all therapists, including psychologists, re-enter psychotherapy during their career (Norcross & Guy, 2005). Conversely, the National Institute of Occupational Safety and Health epidemiologists studied 230 professions and found that men psychologists have the highest incidence of attempted suicide at a rate over 3 times that of any other type of employment (Ukens, 1995). These rates suggested that additional self-care during a psychological career was necessary to mitigate significant mental health issues.

Pope and Tabachnick (1994) studied psychologists' (n = 476) experiences as clients in psychotherapeutic treatment. Of the total number of participants, 400 reported that they had been treated with psychotherapy at some time in their past. The median number of therapists that participant psychologists had used was 3, with a median treatment length of 4 years. Of the total number of participants, 100 psychologists reported that they were engaged in psychotherapy at the study. The status of accessing psychotherapy appeared to be lower with age in contrast to younger participants (< 40 years) who disclosed past use of therapy at 92.9%. This could point to better work-life balance and/or overall emotional management that may be a function of age, work experience with aggregate closer approximations toward a better work-life fit in choice of work setting, or cumulative benefits from previous rounds of personal therapy.

Daw and Joseph (2007) studied British psychotherapists n = 48, and their experience with psychotherapy where 71% identified with being clinical psychologists.

In this study, 98% of participants were Caucasian, and 2% were Asian, Indian from India. Of the total number of participants, 67 % reported using personal therapy at some time in their life. The remainder reported that they had never participated in therapy. All but 2.1 percent of this group stated that they would consider using therapy in the future. Most of the therapists that participated highly rated personal growth and improved practice as benefits of personal psychotherapy. The most significant reasons for participating in treatment for the therapist were reported as personal distress and development. The study found that therapists are aware that personal therapy has value both professionally and personally.

Regarding a therapist's profession, the therapist indicated that they perceived psychotherapy as a type of experiential education that could enhance their professional performance. This research did not explore differences in gender, therapeutic orientation, or type of licensed mental health profession. This study did not qualify if any of the therapy experienced by the participants occurred during their career as therapists, and it did not examine any possible barriers to accessing personal therapy.

Goodyear et al. (2008) reported that 86% of counseling psychologists have engaged in psychotherapy treatment. Goodyear et al. studied counseling psychologists n = 1319 from memberships in the APA, Society for Counseling Psychology, and non-membership counseling psychologists for roles, functions, and career satisfaction changes. This study was a repeated study, and data sets were presented from 1985, n = 716, and a 2000 study, n = 716, using the same questionnaire. This study reported an increase in minority respondents from 5% to 10.6% over the 15-year period. Similarly

awarded PhDs increase from 69.4% to 85.7 % over the same time period. Of those studied in 2000, 55.4% reported that after experiencing a career in counseling psychology, they would choose to enter this profession if upon entry they had the benefit of this foreknowledge about their profession. Norcross et al. (2005) reported that 62% of clinical psychologists would make a similar choice, demonstrating somewhat increased ratings of professional fulfillment. Norcross et al. (2005) studied clinical psychologists n = 694 where 90.7% were granted PhDs, and .9 % had PsyDs. Norcross and Rogan (2013) reported a further increase in career satisfaction to 88% for n = 401, consisting of members and fellows of Division 29 of the APA.

Dorociak et al. (2017) examined psychologists' self-care during their careers in 2 samples. The first sample (n = 438) and second sample (n = 277) in this study completed The Professional Self –Care and Well Being Survey. However, the measures in this study did not offer psychotherapy as a self-care option. Dorociak et al. (2017) compared psychologists at different stages in their careers, including early career, mid-career, and late career. Comparing these stages throughout professional life for psychologists' was used by Dettle (2014) for dissertation research. The results of this study were slightly different for the 2 samples. Overall, the study found that most early career psychologists did not work in a private practice setting, which was more likely for mid to late stage psychologists (Dorociak et al., 2017). Dorociak et al. (2017) reported that most participants were European American, but more ethnic diversity was found among early stage psychologists, especially in the second sample. Early stage psychologists reported more emotional fatigue and less personal achievement than late stage psychologists

(Dorociak et al., 2017). Dorociak et al. (2017) reported that late stage psychologists were more likely to report a pronounced sense of well-being, less stress, more days with good psychological health, and greater fulfillment in their work. While late stage psychologists in sample one practiced more self-care, which was consistent with what Dettle (2014) found, the early stage psychologist in sample two practiced the most self-care (Dorociak et al., 2017).

However, Bearse et al. (2013) surveyed 221 psychologists and found that many (59%) psychologists indicated that they did not seek out psychotherapy as a means of self-care at a time that they thought they could have benefitted from such treatment. This was higher than previous studies that either focused on psychologists or included psychologists as a sub group (Bike et al., 2009; Pope & Tabachnick, 1994). The study did not report the percent of psychologists that attended psychotherapy in the past before their tenure as a psychologist but revealed that most of the sample had at one time sought out personal psychotherapy and found the experience beneficial (Bearse et al., 2013).

Tay et al. (2018) examined mental health issues among clinical psychologists focusing on stigma, disclosure, and help-seeking in the United Kingdom. The study included 678 psychologists, of whom 91.6% were European British between the ages of 30 and 50 (84.2%), and reports that this distribution is similar to the diversity found in the UK population (Tay et al., 2018). More than half the participants (54.1%) had 11 years or more of career experience, and approximately 66% reported experience with psychological issues (Tay et al., 2018). While cognizant of the stigma associated with psychological problems, most participants in this study did not judge themselves in this

manner. The study found that 10.8% of respondents never disclosed at all. These psychologists experienced high levels of stigma, fear of discovery, and levels of shame that were barriers to disclosing and seeking help (Tay et al., 2018). Tay et al. (2018) found that of those who reported having had psychological problems, 89.2% disclosed their issues, with 44.5% sharing this within their employment environment and 84% who reached out for psychological treatment. The differences between psychologists who sought help in this UK study and the percentage of psychologists in the Bearse et al. (2013) study are concerned.

The Bearse et al. (2013) findings are troubling because Barnet et al. (2007) described self-care as an ethical imperative for psychologists in an overview of peer reviewed literature. This review lists the unique factors that place psychologists at risk, such as "distress, burnout, vicarious traumatization" and possible impairment of "professional competence" (Barnett et al., 2007). Barnet et al. (2007) define distress as a response to continuing stress due to disputes, obligations, responsibilities, and challenges. Burnout is defined as distress that is unresolved over an extended period of time (Barnett et al., 2007). Barnet et al. (2007) describe vicarious traumatization as the experience of treating clients with histories of violence and trauma where the therapist experiences second hand distress as defined in previous research (Figley, 1995: Pearlman & Saakvitne, 1995). This review highlighted the fact that research supports the finding that many psychologists do not access therapy when they perceive a need for it even though they are aware that containing distress in such a fashion can increase their distress and

lower efficacy in working with clients (Barnett et al., 2007). However, this review did not discuss the possible barriers to treatment that psychologist encounter.

Stressors and Barriers to Self-Care Among Mental Health Workers

Dearing et al. (2005) studied counseling psychology graduate students (n = 262) and their help seeking behaviors. Of those who participated, the majority were women at slightly over 75%, with about 70% having had experienced psychotherapy at some time before the study (Dearing et al., 2005). This study found that cost, time, and confidentiality were the most significant barriers to treatment for their psychology graduate student participants (Dearing et al., 2005). Interestingly cost and confidentiality had the most significant findings for those participants who disclosed that they at one time needed therapy but did not seek it out (cost, r = .39, p <.01; confidentiality, r =.31, p <.05) (Dearing et al., 2005). Similarly, McCarthy et al. (2009) determined that the most common barriers to psychotherapy were scheduling, finances, and medical coverage. These outcomes point to barriers to accessing treatment that proceeds to enter graduate school and may persist for these participants well into their careers as clinicians.

Dearing et al. (2005) also found that participant students had favorable attitudes toward therapy when they perceived that their faculty had a favorable view of therapy while training to be a clinician. Thus, Dearing et al. (2005) suggested that training to be a clinician could be a good time to instill psychotherapy as an effective coping tool to deal with emotional issues and promote good self-care during their eventual career as a clinician. Additionally, they suggested that faculty express positive attitudes about treatment and encouragement for graduate clinical students who could benefit from

treatment while in training (Dearing et al., 2005). Currently, therapy is not mandated for all graduate students in all clinical training programs. Dearing et al. (2005) suggested that confidentiality and boundary concerns must be addressed between students and faculty in a training program. Perhaps if these concerns were dealt with at this stage, they would be perceived as less of a concern during the graduate student's future career. The connection between self-care and professional career benefits as a motivator towards treatment was indicated by Dearing et al. (2005) as an area for future study.

Siebert (2005) found that social workers listed private reasons for not seeking help (n = 751), including not believing they needed help, that they could handle it on their own, that treatment was too expensive, that they knew treatment providers professionally, and that there would be negative professional consequences such as loss of licensure in cases of illegal substance abuse or other violation of professional, ethical behavior. Of the social worker participants who identified at high risk for drug or alcohol issues, 71% indicated that they had never accessed assistance for these concerns instead of 22% who did use treatment for these concerns in the past (Siebert, 2005). In this study (n = 52), participants indicated that were in recovery or long term recovery (recovered) (Siebert, 2005). However, 38% of these participants (n = 52) indicated that they never used treatment, implying that these social workers handled these issues themselves (Siebert, 2005). Of those seeking treatment in this study (n = 60), the study found these participants to rate treatment as most helpful (Siebert, 2005). This points to clinicians not accessing treatment when it could be beneficial.

Siebert and Siebert (2007) found that burnout, emotional impairment, and years of professional experience did not improve the likelihood that social workers (n = 751) would seek help. Of the participants, 84% were female, and 88% were Caucasian (Siebert & Siebert, 2007). Increases in role identity as a caregiver decreased the likelihood of accessing treatment (Siebert & Siebert, 2007). However, the severity of depression rates and licensure increased the likelihood of participants accessing treatment (Siebert & Siebert, 2007). Siebert and Siebert's (2007) study focused on North Carolina members of NASW and suggested that a more diverse and cross-sectional study would provide more information for future studies.

Fogel et al. (2006) found that 76% of psychiatric residents (n = 228) sought therapy for the first time during their training and 60% stated it was related to personal concerns, and 22% for its educational value. Among the participant, 57% were in psychotherapeutic treatment at the time of the study, with 18 % also prescribed psychotropic medication (Fogel et al., 2006). Twenty-seven percent of these participants had at one time during their life taken psychotropic medication (Fogel et al., 2006). Fogel et al.'s (2006) study found that participants who perceived that faculty supported psychotherapeutic treatment were more likely to disclose this type of treatment with others in the program, including faculty. However, these resident participants did not feel the same way about disclosing their prescription treatment with medication, and 66% of participants indicated concerns that being medicated for psychiatric issues still represented significant stigma as opposed the psychotherapeutic treatment alone, where 83% of participants indicated that psychotherapy represented minimal to zero stigmas (x^2

= 7.151, $df = 1$, $p \leq .007$) (Fogel et al., 2006). Ninety-five percent of all resident participants indicated that present or previous psychotherapeutic treatment enhanced their educational experience, and 67% of participant residents indicated that they would recommend psychotherapeutic treatment to their current and future patients (Fogel et al., 2006).

Fogel et al. (2006) concluded that there exists significant stigma toward psychotropic medication for residents that need to be addressed by educators and future research. Fogel et al. (2006) pointed out that the experience of having been on psychotropic medication did little to reduce the stigma of the necessity of being prescribed such medication. This study demonstrates that these resident participants were sensitive to the supportive environment toward psychotherapy in their education process and could have been equally sensitive to perception expressed in this environment toward medication. This research points to the residual professional stigma that may be present in the future clinical careers of these residents.

Psychologists' Obstacles to Self-Care

Bearse et al. (2013) is the only study to date that has solely focused on the population of professional psychologists regarding their use of psychotherapy for self-care. However, other studies have included psychologists as a part of their sample. Bearse et al. (2013) examined the possible obstacles to accessing treatment and the likely stressors that impact psychologists. Obstacles included finding a suitable therapist, difficulty admitting distress, professional stigma, risk of professional censure, available time, finances, and disclosure of personal information.

Psychologists appear to rate finding a suitable therapist as the most difficult barrier to seeking therapy (Bearse et al., 2013). Psychologists listed concerns with a therapist's work experience, ineffectiveness, remote location, preference for similar cultural background, the duality of relationships, and poor outcomes in previous treatment (Bearse et al., 2013). Barnett et al. (2007) found that psychologists can have concerns that their competence to treat others may be negatively perceived by other mental health professionals, supervisors, and those who provide therapeutic services. This points to the possibility of experiencing professional stigma. Barnett et al. (2007) suggested that this may be overcome if the profession of psychology would develop continuity of self-care as the norm, emphasizing it as integral to the practicing of psychology. This can be created through education, training, and supervision to develop an atmosphere of encouragement for open communication and professional development without fear of sharing self-perceived weakness (Barnett et al., 2007).

Psychologists have concerns that personal therapy may be viewed as a circumstance that could potentially require correction under their state regulatory licensing panels, perhaps due to possible ethical violations that may have taken place due to the psychologists growing distressed (Bike et al., 2009). APA Code of Conduct (2010a) stipulates that a psychologist should take appropriate steps when personal issues can negatively impact work competency (2.06 a; 2.06 b). This can increase the difficulty for psychologists to completely disclose their distress level (Vogel & Wester, 2003). Vogel et al. (2007) found that those highly invested in concealing their material rated potentially accessing personal therapy less positively. Vogel et al. (2007) found that

potential utility and risks of engaging in therapy are significant predictors of perceptions with regard to accessing therapy.

Other obstacles to accessing personal therapy for psychologists can include issues with available time, income, and discussion of personal information. Heavy caseload, the need to provide treatment around client accessibility, travel time to different work venues, and attendance at conferences to remain up to date with recent research concerning evidence-based treatments all combine to increase barriers to treatment (Bearse et al., 2013). Financial resources may be strained for a psychologist that carries heavy education debts. The 2007 APA Workforce Study cited an average debt of $100,000 for psychologists who have completed clinical psychology graduate programs (Wicherski et al., 2009). Self-disclosure of difficulties could potentially cause issues with insurance coverage where the psychologist may incur higher premiums due to assumed elevated practice risk (Bearse et al., 2013).

Bike et al. (2009) found that among psychologists, the only predictor for the increased use of personal therapy was a history of having had a course of psychotherapy before embarking on a career as a psychologist. Psychologists that have entered therapy before their professional career start are satisfied with the treatment that they received (Bike et al., 2009). Daws and Joseph (2007) found that the process of therapy for the psychologist as a client offers the opportunity to increase their sensitivity to clients' needs and enhance their appreciation of the impact of their profession. The experience of the deepening of therapeutic rapport has been reported to lessen the client's perception of isolation (Coster & Schwebel, 1997).

The sample of psychologists studied by Bearse et al. (2013) was primarily Caucasian (87 %), with an average of 23.7 years of professional practice (Bearse et al., 2013). To date, there is a lack of research on help-seeking by minority psychologists. There has been an increase in this professional group's cultural and ethnic diversity (Daniel et al., 2004' Michalski et al., 2011; Wicherski et al., 2009). Thus, investigating demographics' influence on self-care among psychologists is an essential undertaking.

Gender and Ethnicity and Self-Care Among Psychologists

Norcross et al. (2009) surveyed psychotherapists n = 727, of which n = 261, and psychologists PhD and PsyD represent 36 % and 6%, respectively. Norcross et al. examined the characteristics that therapists prefer in their therapist. The respondents were 93% Caucasian and 63 % women, and their mean age was 52.8 years. Female participants highly rated warm and caring as necessary characteristics in a preferred therapist.

In contrast, ethnic minorities highly rated ethnic background, flexibility, and cost as factors that strongly influence their choice of therapist. The psychologists who participated in the study demonstrated fewer issues with warmth, openness, active style, and finances than their other mental health practitioners. This group highly rated a preference in therapists with an established positive history of treating other therapists. Women therapists demonstrated a preference for a woman therapist, while most all therapists in 1987 preferred a male therapist. While this research demonstrates that a therapist's choice in a personal therapist is based on a combination of interpersonal factors, professional efficacy, there is present an overarching repetitiveness of choosing a

therapist similar to themselves in "age, gender, theoretical orientation and profession" (Norcross et al., 2009, p. 39). The least likely to be chosen by a therapist is a close friend or professional peer. While this study addresses psychologists as a subgroup, it did not address what barriers this group experiences when attempting to access therapy.

In Gilroy et al.'s (2007) study, of those who reported as depressed, 60 % were female, and 40% were male, indicating a significant difference between genders ($x^2(1, N = 425) = 6.07, p \leq .01$). Female depressed participants reported a higher caseload at 56% than non-depressed female participants at 43%. Similarly, male depressed participants reported higher caseloads at 65% than non-depressed male participants at 46%. Of the male participants that reported depressive symptoms, only 61.7 % accessed help, and of the female participants that reported depression, only 71.3% accessed help. Among those who sought out help, there was no significant difference between genders. Of those who identified as depressed, 31% reported that they had been prescribed antidepressants.

Conversely, some researchers have determined that demographics do not influence help-seeking behaviors. McCarthy et al. (2009) found no significant difference between the men and women who participated in this study with F = .1446; $df = 43$; $p = .400$). Women participants demonstrated a significantly higher positive attitude toward accessing personal psychotherapy as opposed to their male counterparts (F = 2.813; $df = 106$; $p < .01$) (McCarthy et al., 2009). When differences such as gender, income, and race were compared, Siebert (2005) found no statistical difference between those who sought help and those participants who did not.

Summary and Conclusions

Psychologists are at risk of suffering from depression, suicidality, burnout, compassion fatigue, and adverse effects from personal traumatic histories. They may also struggle with issues that occur due to countertransference. This professional group can encounter barriers to treatment such as (a) finding a suitable therapist, (b) difficulty in admitting distress, (c) professional stigma, (d) risk of professional censure, (e) available time, (f) finances and (g) disclosure of personal information. Psychologists and psychotherapists who use therapy have found it beneficial, yet many do not seek out treatment when it would be beneficial to them. The need for accessing self-care mental health services appears to be a necessary component of professional efficacy and personal wellness. Both of these factors seem essential for maintaining longevity in the field of psychology. More research is necessary to understand why self-care is not used more widely and thoroughly by this professional group during their career (Bearse et al., 2013; Bike et al., 2009; Pope & Tabachnick, 1994). The latest research in the Bearse Study (2013) gave no information on the possible cultural differences among different ethnic groups represented in professional psychologists. Such ethnic and cultural differences among psychologists are not represented in related peer reviewed literature as well. This information is needed to frame better the effects of stressors within this profession and better judge what barriers may prevent the necessary use of self-care.

This study was conducted using an online survey design including the Revised Bearse et al. (2013) survey instrument and the Stamm (2005) ProQOL measure. I attempted to refocus the Bearse et al. (2013) study on the self-care practices of licensed

psychologists, using the questionnaire developed for that study in a modified form from a written form for mailing to an online version. The Stamm (2005) ProQOL measure also provided psychometric support for the findings of the Revised Bearse et al. (2013) survey instrument. In addition to revising and providing psychometric support for this questionnaire, I compared these results to the prior study of a primarily Caucasian sample framed in the Bearse et al. (2013) study. The ProQOL measure also expanded and compared the experience of burnout and compassion fatigue among respondent participants. In Chapter 3, research design and rationale will be discussed in more detail. The following chapter will cover methodology, including population, sampling, sampling procedures, recruitment, participation, data collection, instrumentation, operationalization of constructs, and a data analysis plan. Threats to validity and ethical procedures also are examined in Chapter 3.

Chapter 3: Research Method

The purpose of this study was to examine the relationships between demographic variables, professional stressors, and barriers to treatment and help-seeking behaviors among psychologists. In this section, I present the research design, rationale, instrumentation, study population and sampling, data collection, and analysis plan. The dependent variables were personal therapy during tenure as a psychologist and length of therapy treatment during tenure as a psychologist. The independent variables were demographics, stressors experienced as a psychologist, and barriers to treatment.

Research Design and Rationale

A quantitative, nonexperimental, correlational design including online survey research methods was selected for this study. A quantitative correlational design is appropriate when analyzing the strength of relationships between numerically measurable constructs (Howell, 2013). Because the study did not involve manipulating participants into control or experimental conditions, a true experimental design was not appropriate. An online survey was chosen because it represents a convenient, effective, and efficient means of collecting detailed quantitative data anonymously from many participants (Braithwaite et al., 2003; Fowler, 2014). Online surveys are frequently used in academic research and offer improved reliability over paper-based survey instruments (Creswell, 2014). Such a survey focuses exclusively on participants who have computer access and have provided an email address. Mail surveys given to different professional groups have proven to offer a consistent return response rate, and recent research in web-based surveys has shown similar rates (Dillman, 2011).

Survey research has collected self-report data on attitudes, opinions, behaviors, and past events since the 1930s (Babbie, 1990; Fowler, 2014). However, these designs were subject to internal and external validity threats, primarily because a researcher lacks control over sample selection and data collection conditions necessary to estimate sampling error and minimum confounding variables (Creswell, 2009). These threats are discussed in detail in the limitations section, and the results of this study have been interpreted with caution.

For this study, the independent variables were grouped into three predictors: (a) demographics, (b) professional stressors, and (c) barriers to help seeking. Their selection was influenced by variables used in Bearse et al.'s (2013) study. The demographics consisted of gender, ethnicity, age, professional tenure (in years), and type of professional practice. Professional stressors included burnout, compassion fatigue, countertransference, depression, and a history of personal trauma. Barriers to help seeking included finding a suitable therapist, professional stigma, available time, and financial resources. Help seeking during tenure as a professional psychologist was the outcome and is defined using two variables: (a) the number of times the participant sought help (courses of therapy) and (b) the number of times that the participant did not seek help when they could have benefitted from it.

Research Questions

The research addressed the following questions:

RQ1: What are the differences between different cultural/ethnic groups among psychologists on measures of help seeking and number of courses of therapy?

$H_0$1: There are no differences between ethnic groups in help seeking.

H_A1: For participants who sought treatment, there are no differences between ethnic groups in number of courses of therapy.

RQ2: For each of the different cultural/ethnic groups among psychologists, do the demographic variables, professional stressors, and barriers to treatment predict the decision to seek help and number of courses in therapy?

$H_0$2: Demographic variables, professional stressors, and barriers to treatment do not predict the decision to seek help.

H_A2: For participants who sought help, demographic variables, professional stressors, and barriers to treatment do not predict number of courses in therapy.

RQ3: For each of the different cultural/ethnic groups among psychologists, do the demographic variables, professional stressors, and barriers to treatment predict the decision not to seek help when a respondent may have benefitted from therapy and predict the number of periods of not seeking help when it could have benefitted the respondent?

$H_0$3: Demographic variables, professional stressors, and barriers to treatment do not predict the decision to seek help was there a time that a respondent may have benefitted from therapy.

H_A3: Demographic variables, professional stressors, and barriers to treatment do not predict the number of periods of not seeking help when it could have benefitted the respondent.

Methodology

Population

The target population was licensed professional psychologists practicing in the United States. The accessible population consisted of registered, licensed professional psychologists and active members from different psychological associations, including (a) APA Division 45, (b) ABP, (c) NLPA, (d) AAPA, (e) NYSPA, (f) MPA, (g) PPA, (h) CPA, (i) IPA, and (j) TPA.

The AAPA had 280 professional members, eight retiree/emeritus members, and 375 student members, for 663 members, as of year's end in 2015. Professional members include those with both masters and doctoral degrees in psychology. APA Division 45 had 903 members, and 146 were fellows with doctoral degrees in psychology as of 2015. The ABP has a total membership of 932 members. Of the members of ABP who wished to be in their public directory, 104 were practicing psychologists in the United States. The NLPA has reported 485 members, and of this number, 43% identify as students. However, the NLPA has not yet responded about the size of the membership with doctoral status. The PPA has 2,800 members, and its listserv has 672 active members. However, the PPA does not report that these 672 members are professional psychologists. The TPA offers listservs for diversity (65 members), women (61 members), and schools (67 members), all of whom are professional members. The MPA reports over 600 members on their listserv but does not identify how many are professional psychologists. The CPA reports that it has 2,854 members but does give information on how many of these members also participate in their listserv. The IPA has over 1,400 members,

according to their website and reports that 750 members subscribe to their listserv. The NSPA states that it has 1,698 members and that 676 subscribe to their listserv.

Sampling and Sampling Procedures

The participants were invited to participate in the study through a listserv offered by an association affiliated with their position in psychology. The listserv manager for each association posted the invitation as submitted by email. Email confirmation of permission to post invitations was provided with the addresses and contact information for each association.

A nonprobability sampling method was used through a convenience sample. The sample consisted of persons receiving the email invitation who chose to respond. Using the different lists was to maximize the number of participants in each ethnic group, so there was sufficient data for the analyses. This type of sampling is at risk for self-selection bias, which is discussed in the section on limitations.

The sample size was estimated using two methods. Using G*Power (Faul et al., 2014), with a medium effect size (.15), $\beta = .80$, $\alpha = .05$, and 1 of the 14 predictors entered, the sample size was estimated at n = 135. Tabachnick and Fidell's (2013) guidelines for estimating sample size: "The simplest rules of thumb are $N \geq 50 + 8m$ (where m is the number of IVs) for testing the multiple correlations and $N \geq 104 + m$ for testing individual predictors" (p. 123), with a recommendation to use the higher number, in this case, $N \geq 50 + 8 (14) = 162$.

Procedures for Recruitment, Participation, and Data Collection

Recruitment

Psychologists on the association listservs were invited to participate in the study via listserv email. The listserv manager for each list posted the invitation as submitted. Recruitment of participants was voluntary, and no entitlements or compensation were provided.

I also posted the invitation as a member of NLPA under the rules and guidelines specified by NLPA for such submissions. Listserv emails were sent out once a week to invitees over 9 weeks among those listservs whose protocols allow for reminder emails and do not restrict the number of reminders. Some psychological associations do not allow reminder invitations for participation: the MPA and the ABP. The MPA and ABP received only one initial invitation. The PPA restricts reminders to participate in research to one time over 12 months. The PPA received an invitation to participate and one reminder email. Invitation emails informed the participant of the purpose of the survey, how the information was collected, how the responses would be used, how to contact me, and a link to the survey. This email also provided links to the anonymity, privacy, and security policies provided by Survey Monkey.

Participation

Potential respondents were directed to a website link hosted by Survey Monkey. The first webpage of the survey contained the letter of informed consent that informed them of their role, benefits and risks of participation, my contact information, and contact information for the Walden University Institutional Review Board (IRB). If a participant

clicked on the link to the survey, this indicated they understood and agreed to the informed consent. Participants were taken to the Survey Monkey site, where the participant could begin responding to the survey.

Data Collection

Each of the invitations only allowed single access so that once a participant logged out of the survey, they were able to return to complete or change their answers later. Once a single page of the survey was completed, participants moved to the next page. The cutoff date for collecting responses was 9 weeks from the initial email invitation. There was no response limit set. Because invitations were sent through a listserv, there was no way to know the total invitations sent. Demographic information had the added protection of being SSL encrypted as further protection of anonymity.

Exit

Upon completing the survey, a participant was connected to a webpage customized to thank them for participating. This page included how to contact me with any questions or concerns and so that they may have access to the completed study upon request. I did not follow up with participants after they exited the survey.

Instrumentation

In this section, I present the constructs and variables of interest, grouped according to operational definitions and plans for inclusion in the data analyses. The two survey instruments used for this study correspond to the Bearse et al. (2013) instrument and the ProQOL. Permission was granted to use both instruments for this research. Many of the measures are duplicated or modified from the original Bearse et al. (2013)

instrument. To assess construct validity, some constructs were measured using more than one approach (e.g., Bearse's original item and a separate measure). The similarities and differences between the original and revised questionnaires were outlined. The original study did not carry out any psychometric assessments on the data. I compared measures between this and the earlier study to enhance measurement validity.

Independent Variables

Demographics

A total of 29 demographic indicators were examined. Demographic information, such as gender, age, ethnicity, type of license, highest degree, year degree awarded, number of years in practice, theoretical orientation, practice environment, type of employment, number of therapy sessions per week (as a practitioner), and number of assessments per week (as a practitioner), are considered standard for this type of survey research and have been used in government and research applications since the 1950s (Fowler, 2013). For the most part, these were identical to Bearse et al. (2013). These were presented as descriptive statistics and compared to Bearse's sample. Ethnicity was the independent variable to examine differences in help seeking and the number of therapy courses (RQ1). Gender, ethnicity, professional tenure (in years), type of professional practice, and other demographic variables were used as predictor variables to examine their relationship to help seeking and the number of courses in therapy for each of the ethnic groups (RQ2). For each of the different cultural/ethnic groups among psychologists, demographic variables, professional stressors, and personal barriers were independent variables to examine the differences in not accessing therapy when

respondents thought that it could be useful to them and the number of times this occurred during their tenure as psychologists (RQ3).

Professional Stressors

Bearse et al.'s (2013) open-ended question about "other professional stressors" was eliminated. Professional stressors were originally measured as single item 5-point Likert scales (Appendix D). No psychometrics were reported. I included these items and descriptively compared the summary statistics of the Bearse study with the current effort.

Barriers to Treatment

Bearse et al.'s (2013) open-ended question about "other professional barriers" was eliminated. Professional barriers were originally measured as single 5-point Likert scales. No psychometrics were reported. I included these items and descriptively compared the summary statistics of the Bearse study with the current effort. Note that personal stigma and reliance on spiritual means of coping were omitted in the current version due to lack of scale reliability with ideological differences and lack of personal stigma reported in the original study (Bearse et al., 2013) (Appendix D).

In addition, **t**he ProQOL was included to more reliably measure the key consequences of helping others (Stamm, 2012). The ProQOL contains 30 items that measure compassion satisfaction, burnout, and compassion fatigue/secondary trauma and has demonstrated stable internal validity and reliability (Stamm, 2005). ProQOL alpha reliability are reported for compassion satisfaction at alpha = .87, burnout at alpha = .72 and compassion fatigue at alpha = .80. Stamm (2005) also reported that this version of the measure,

> Has considerable improvement over the original scale on the item-to-scale statistics due to increased specificity and reduced collinearity. The standard errors of the measure are quite small, so that the test typically has less error interference improving the potential measurable effect size. This latter point is particularly important with the sample sizes common among small clinical studies. Early returns on test-retest data suggest good reliability across time with a small standard error of the estimate. (p. 4)

Construct validity for the PRoQOL is well established in peer reviewed articles (Stamm, 2006). The ProQOL used the multi-trait multi- method mode for convergent and discriminant validity (Campbell & Fiske, 1959, cited in Stamm, 2006). The reported interscale correlations were small, with compassion satisfaction having 5% shared variance with burnout and 2% shared variance with compassion fatigue, and shared variance between burnout and compassion fatigue is 21%. Despite this higher correlation, the measures for compassion fatigue and burnout are distinctly different and represent separate scales. Continued research by several universities at the doctoral level investigates the concurrent and discriminant validity within the ProQOL.

> To score the ProQOL, reverse items 1, 4, 15, 17, and 29 then score the Three scales (Compassion Satisfaction Scale, Burnout Scale, and Trauma/Compassion Fatigue Scale) of the ProQOL. It is important to note that 0 remains 0 when scores are reversed as it always denotes the absence of the construct. RECODE pq1 pq4 prq15 pq17 pq29 (1=5) (2=4) (3=3) (4=2) (5=1) INTO pq1R pq4R pq15R pq17R pq29r. COMPUTE CS =

> SUM(pq3,pq6,pq12,pq16,pq18,p20,pq22,pq24,pq27,pq30). COMPUTE BO = SUM(pq1r,pq4r,pq8,pq10,pq15r,pq17r, pq19, pq21, pq26, pq29r). COMPUTE Trauma = SUM(pq2,pq5,pq7,pq9,pq11,pq13,pq14,pq23, pq25,pq28). (Stamm, 2005, pp. 11–12).

Missing data were handled using a summed score across each of the three scales in the instrument instead of an average score.

Dependent Variables

For each of the different cultural/ethnic groups among psychologists, two single item measures were used as dependent variables for this study: the number of courses of psychotherapy during tenure as a psychologist and number of periods of time (2 or more weeks) during tenure as a psychologist when the participant chose not to seek out therapy when the respondent thought they could have benefitted from therapy.

The Bearse (2013) dependent variables consisted of whether professional psychologists had sought out psychotherapy during any time of their lives (YES/NO?) and, if so, for how long were they in treatment (# of sessions attended?). In this study, the survey was not clear if the treatment experience was before or during the career of the psychologist. These had been revised as per the study's recommendations (Bearse et al., 2013).

Data Analysis Plan

The data were compiled into SPSS version 24.0 for Windows (IBM, 2015). Data were first examined for completion and accuracy. The data were validated to ensure the scores fall within the theoretical range of potential values. Frequencies and percentages

were examined for the nominal variables of interest. Means and standard deviations were calculated for continuously measured variables. First, preliminary analyses were conducted to verify that the data met the analyses; and examine the ProQOL measures for internal consistency (Fowler, 2014; Stamm, 2005). Then, a comparative examination of the Bearse and the current study was conducted, using descriptive statistics.

RQ1: What are the differences between different cultural/ethnic groups among psychologists on measures of help seeking and number of courses of therapy?

$H_0$1: There are no differences between ethnic groups in help seeking.

H_A1: For participants who sought treatment, there are no differences between ethnic groups in number of courses of therapy.

For the first research question, a multivariate analysis of variance (MANOVA) was conducted to examine differences in practice variables, help-seeking, compassion fatigue, burnout, and length of time in therapy between ethnic groups. A MANOVA was an appropriate analysis when examining differences on multiple continuous dependent variables between groups (Tabachnick & Fidell, 2013). Before analysis, the assumptions of normality, homogeneity of variance, and homogeneity of covariance were assessed. The normality assumption was used to check that the continuous dependent variables follow a normal (bell-shaped) distribution. The homogeneity of variance and covariance assumptions were assessed by Levene's test and Box's M test, respectively (Howell, 2013).

The *F* test made the overall comparison on whether significant differences exist on each dependent variable between the ethnic groups. Post-hoc tests were conducted by

Tukey comparisons to identify where the significant differences lie. Significance was evaluated at the conventional alpha level, $\alpha = .05$.

RQ2: For each of the different cultural/ethnic groups among psychologists, do the demographic variables, professional stressors, and barriers to treatment predict the decision to seek help and number of courses in therapy?

$H_0$2: Demographic variables, professional stressors, and barriers to treatment do not predict the decision to seek help.

H_A2: For participants who sought help, demographic variables, professional stressors, and barriers to treatment do not predict number of courses in therapy.

RQ3: For each of the different cultural/ethnic groups among psychologists, do the demographic variables, professional stressors, and barriers to treatment predict the decision not to seek help when a respondent may have benefitted from therapy and predict the number of periods of not seeking help when it could have benefitted the respondent?

$H_0$3: Demographic variables, professional stressors, and barriers to treatment do not predict the decision to seek help was there a time that a respondent may have benefitted from therapy.

H_A3: Demographic variables, professional stressors, and barriers to treatment do not predict the number of periods of not seeking help when it could have benefitted the respondent.

For the second and third research questions, hierarchical multiple regressions were conducted to explain the variance in the outcome variables (i.e., length of therapy and help-seeking) based on the influence of multiple predictor variables within the demographic, stressors, and barriers categories for each ethnic group. Hierarchical linear regressions were appropriate when examining the predictive effect of a group of independent variables while controlling for the effect of additional variables (Tabachnick & Fidell, 2013). Before analysis, the assumptions of normality and homoscedasticity were assessed by examination of scatterplots. The absence of multicollinearity assumption was tested by examining Variance Inflation Factors (VIFs) (Stevens, 2009). The *F* test was used to determine the significance of the overall regression model. The change in R^2 between the steps identified how the predictors can explain much additional variance over the covariates. Individual *t*-tests were conducted to examine the strength of each predictor variable and covariate. Significance was evaluated at the conventional alpha level, $\alpha = .05$.

Threats to Validity

Construct Validity

Assessing the construct validity of self-report data occurs over time through repeated studies, assessments of convergent and discriminative validity as well as internal consistency. While the current study has strived to use measures with demonstrated use, it is also recognized that some of these efforts are not sufficient to strongly demonstrate good construct validity (Trochim, 2006). Therefore, these results were interpreted with caution.

The reliability of the demographic variables, barriers to treatment, and dependent variables was based on the assumption that participants would reliably and accurately self-report. The Pro-QOL measures of response to professional stressors were examined using Cronbach's coefficient alpha, compared to prior studies. Correlations between the Pro-QOL measures and Bearse et al. (2013) single items were calculated to explore convergent validity.

Internal Validity

This non-experimental correlational design used in this online survey research method offered no ability to manipulate the independent variable or control the participant's experience. This means that there was a higher probability that confounding variables could impact the findings. However, an online survey ensured that the study instruments were presented in identical format to all participants (Creswell, 2009; Fowler, 2014; Litwin, 1995).

The participants most likely accessed the survey site at their convenience. This meant that participants would be responding to the study questions over many different testing environments. This point could have possibly confounded results. To minimize this as part of the study's online introduction, participants were asked to make sure that they answered the study questions in a quiet and private area where they could remain undisturbed for a least 30 minutes. There was no way to observe or measure the participants' compliance with these recommendations.

It is possible that something could have happened during data collection that could confound results. For example, the internet site's web-link could go down or not

function properly due to technical problems on Survey Monkey. Braithwaite et al. (2003) experienced such a problem when surveying health professionals in the UK. Due to a technical error, 95 responses were lost, and 38 surveys were received blank (Braithwaite et al., 2003). However, Survey Monkey (2015) reported that technical issues with their site are few. Technical issues were monitored during the operation of the online survey throughout data collection. Any extraneous and confounding variables that could have occurred during the running of data collection would be represented in the results, and findings would be discussed with appropriate caution if this occurred.

External Validity

External validity measures how well research findings are generalizable to the population the survey sample was designed to represent (Creswell, 2009; Litwin, 1995). Threats to external validity weaken the strength of confidence in the findings as relevant to practicing psychologists in the United States in this study (Fowler, 2014). The study design used the self-selection of invitees from multiple data sources to ensure enough responses from each ethnic group for statistical comparison. However, this may cause an interaction effect due to selection bias that would not have occurred if random sampling could have been used. While it is best to have randomly selected invitees to participate in a survey, this was not feasible for the current effort.

External validity can be affected by response bias (Fowler, 2014). Response bias is defined as the "effect of non-responses on survey estimates" **(**Creswell, 2009). This type of bias is found in research that relies on self-reporting, as is the case in this study (Fowler, 2014). Sending reminders has been noted as a possible way to decrease response

bias. Braithwaite et al. (2003) found that the response rate increased twofold when five reminders to participate were used. Meta-analysis of health care professionals by Cho et al. (2013) found that there are fewer expected differences between clinician responders and non-responders as well those that responded to the first invitation versus later reminders (Field et al., 2002; Kellerman & Harold, 2001; McFarlane et al., 2007). Therefore weekly email invitations reminders were included here for the duration of the study.

Statistical Conclusion

Statistical conclusion validity measures the reasonableness of deductions based upon the correlational relatedness of variables within the survey (Fowler, 2014; Litwin, 1995). Appropriate sampling protocols, reliable instrument measures, and statistical procedures were used to increase the statistical validity of conclusions (Fowler, 2014).

Ethical Procedures

Researchers who involve human subjects have an ethical responsibility to inform and protect the participants (Bloomberg & Volpe, 2012). While conducting this research, I closely followed the ethical guidelines suggested by the Institutional Review Board (IRB) and federal regulations. I first sought permission to conduct this research from the IRB at Walden University. Once permission was granted, participant invitations were sent to each psychological association listserv. Individuals who chose to participate could opt in by clicking on the link to go to the Informed Consent page. Consent was indicated by clicking on the link to proceed to the survey. Participation was anonymous and voluntary, and respondents could withdraw at any time without penalty. Participants

could decline to participate in this study at any time. Should the participant enter the survey and then decide not to continue, there was no penalty for withdrawal. Responses from incomplete surveys were not used in the study.

All study data use SSL encryption. SSL (Secure Sockets Layer) is a protocol developed for transmitting private documents or information via the Internet. SSL creates a secure connection between a client and a server, encrypting sensitive information transmitted through the web page (Survey Monkey, 2016). Data were downloaded from Survey Monkey into a CSV file that was password protected on my personal computer. Backup copies were stored on a flash drive in a locked filing cabinet. The stored data have no identifying information, so participant anonymity was protected. Data will be destroyed 5 years after the dissertation has been completed. Further, results were not presented in aggregates of five or fewer participants, so anonymity was protected in the published results.

Summary

This study was a nonexperimental correlational design using online survey research methods. Participants were recruited following IRB approval. Email invitations were posted on list serves for (a) ABP, (b) AAPA, (c) NLPA, (d) APA Division 45, (e) MPA, (f) TPA, (g) IPA, (h) CPA, (i) PPA, and (j) NYSPA. Volunteer respondents accessed the revised Bearse Study (2016) and the ProQOL through Survey Monkey. Upon completion of all collected surveys, an analysis of the data was conducted. Reports of findings were made available to participants following the analysis, and the report of

findings by email requests was sent to me. In Chapter 4, data collection, statistical analysis, and results will be explored.

Chapter 4: Results

The purpose of this study was to examine the relationships between demographic variables, professional stressors, and barriers to treatment and help-seeking behaviors among psychologists. To examine these issues, the following research questions and hypotheses were developed:

RQ1: What are the differences between different cultural/ethnic groups among psychologists on measures of help seeking and number of courses of therapy?

$H_0$1: There are no differences between ethnic groups in help seeking.

H_A1: For participants who sought treatment, there are no differences between ethnic groups in number of courses of therapy.

RQ2: For each of the different cultural/ethnic groups among psychologists, do the demographic variables, professional stressors, and barriers to treatment predict the decision to seek help and number of courses in therapy?

$H_0$2: Demographic variables, professional stressors, and barriers to treatment do not predict the decision to seek help.

H_A2: For participants who sought help, demographic variables, professional stressors, and barriers to treatment do not predict number of courses in therapy.

RQ3: For each of the different cultural/ethnic groups among psychologists, do the demographic variables, professional stressors, and barriers to treatment predict the decision not to seek help when a respondent may have benefitted from therapy and

predict the number of periods of not seeking help when it could have benefitted the respondent?

$H_0$3: Demographic variables, professional stressors, and barriers to treatment do not predict the decision to seek help was there a time that a respondent may have benefitted from therapy.

H_A3: Demographic variables, professional stressors, and barriers to treatment do not predict the number of periods of not seeking help when it could have benefitted the respondent.

Characteristics of the Sample

Nominal Variables

The summary statistics for the 235 cases are presented in Table 1 and Table 2. Table 1 presents the descriptive statistics for the nominal variables. There were more women (n = 174, 74%) than men, (n = 52, 22%) and nine participants identified as neither, 3.8 %. The majority identified as European American (n = 128, 63.2%), followed by the next largest identifying ethnic group Hispanic/Latinx (n = 37, 15.8%). Some participants identified as a combination of ethnicities, including European American/Hispanic/Latinx (n = 2, .9%), Asian/Pacific Islander/Hispanic/Latinx (n = 2, .9%), African American/Hispanic/Latinx (n = 1, .4%), and Hispanic/Latinx/Native American (n = 1, .4%). The other identified ethnicities were Asian/Pacific Islander (n = 28, 12%) and African American (n = 5, 2.1%). Some respondents did not identify with any of these choices: n = 10, 4.3%.

Most respondents reported having a PhD in psychology (n = 132, 56.2%) rather than a PsyD (n = 84, 35.7%) and those licensed to practice with another degree (n = 19, 8.1%). The largest group chose cognitive behavioral as their theoretical orientation (n = 86, 36.6%), followed by psychodynamic (n = 65, 27.7%), humanistic (n = 22, 9.4%), systemic (n = 14, 6%), and those who chose none of these choices (n = 48, 20.4%). Those respondents who worked in an urban location (n = 114, 48.9%) outnumbered those from a suburban location (n = 99, 42.5%) or rural location (n = 19, 8.2%). Among those who reported their work setting, the greatest concentration was found in private practice (n = 233, 56.7%); others were community mental health (n = 27, 11.6%), medical setting (n = 26, 11.2%), government (n = 17, 7.3%), or other (n = 15, 6.4%).

Table 1

Nominal Variables Descriptive Statistics (n = 235)

Variable	Freq.	Percent
Gender		
Male	52	22.1
Female	174	74.0
Other	9	3.8
Ethnicity		
African American	5	2.1
Asian/Pacific Islander	28	12
European American	148	63.2
Hispanic/Latinx	37	15.8
Other	10	4.3
European American/Hispanic/Latinx	2	.9
African American/Hispanic/Latinx	1	.4
Asian/Pacific Islander/Hispanic/Latinx	2	.9
Hispanic/Latinx/Native American	1	.4
Degree		
PsyD	84	35.7
PhD	132	56.2
Other	19	8.1
Theoretical orientation		
Cognitive behavioral	86	36.6
Humanistic	22	9.4
Psychodynamic	65	27.7
Systemic	14	6.0
Other	48	20.4
Primary work location		
Rural	19	8.2
Suburban	99	42.5
Urban	114	48.9
Primary work setting		
Academic	16	6.9
Community mental health	27	11.6
Government/industry	17	7.3
Medical	26	11.2
Other	15	6.4
Private practice	133	56.7

Continuous Variables

As shown in Table 2, only 231 respondents reported having had courses of personal psychotherapy (M = 15.88, *SD* = 95.70) during their professional tenure. The large standard deviation resulted from some participants reporting rather large numbers of psychotherapy courses (Max. = 1000) during their work life, resulting in an extremely skewed distribution, skewness = 8.45, SE =.16. There were far fewer respondents who reported periods that they could have benefitted from psychotherapy but did not seek it out (M = 3.23, *SD* = 11.441) during their career. This distribution was also highly skewed, skewness = 8.914, SE = .16. Therefore, the statistics for the research questions were examined nonparametrically as well as parametrically.

Of those respondents who reported their age (n = 234), the range spanned from age 23 to 80 years, M = 50.64, *SD* = 14.278. Respondents (n = 233) earned their degrees between the years 1971 and 2019, M = 2000.67, *SD* = 12.817. Of those who reported their number of years in practice (n = 233), the longest career spanned 53 years, M= 17. 91, *SD* = 13.216. For those who reported the number of therapy sessions they provided to clients in a month (n = 230), the maximum sessions provided was 280, M = 67.24, *SD* = 49.019. For those participants who provided assessments during a month interval (n = 231), the maximum assessments provided was 122, M = 5.23, *SD* = 12.299. Email confirmation of permission to post invitations, addresses, and contact information for each of these associations was acquired before sending invitations to the membership of each psychological association.

Table 2

Descriptive Statistics for Continuous Variables

	N	Min.	Max.	Mean	SD	Skewness	Std. Error	Kurtosis	Std. Error
# Courses personal therapy	231	0	1000	15.88	95.695	8.485	.160	74.808	.319
Could have benefited but did not seek therapy	231	0	120	3.23	11.441	8.194	.160	72. 974	.319
Age	234	23	80	50.64	14.278	–.067	.159	–1.274	.317
Year degree was awarded	233	1971	2019	2000.67	12.817	–.404	.159	–1.101	.318
Years in practice	232	0	53	17.91	13.216	.408	.160	–1.108	.318
Approx. # therapy appointments/month	230	0	280	67.24	49.019	.904	.160	1.285	.320
Approx. # assessments/month	231	0	122	5.23	12.299	5.620	.160	42.444	.319

ProQOL Descriptive Statistics

Scores were computed for each of the three ProQOL scales. Participants reported a mean of 18.32, *SD* = 5.39 on the compassion fatigue scale. The average ProQOL score reported in the manual (Stamm, 2005) for compassion fatigue is 13, *SD* = 6, suggesting that, on average, respondents were experiencing elevated levels of compassion fatigue. For compassion satisfaction, the 228 participants reported an average score of 42.41, *SD* = 5.31. In comparison, the ProQOL manual (Stamm, 2005) mean for compassion satisfaction is 37, *SD* = 7, suggesting that respondents experienced higher than average levels of compassion satisfaction. The respondents reported a mean burnout score of 17.14, *SD* = 4.60, for the ProQOL. In comparison, the mean burnout score in the manual for the ProQOL (Stamm, 2005) is 22, *SD* = 6, indicating a lower than average sense of burnout.

Table 3

ProQOL Descriptive Statistics

	Compassion fatigue	Compassion satisfaction	Burnout
n	229	227	229
Mean	18.32	42.41	17.14
Median	17	43	17
Mode	14	47	16
SD	5.39	5.30	4.60
Skewness	1.41	–1.68	.918
Kurtosis	3.76	5.66	2.23
Min.	14	9	10
Max.	50	39	45

Comparison of current study and Bears (2013) on Likert scale items

The current study also used the scales used in the Bearse et al. 2013 study. These are compared in Table 4 and discussed below.

Four of the comparisons were statistically significant including burnout, $t = 2.293$, $p \leq .01$, countertransference, $t = 3.889$, $p \leq .01$, lack of time, $t = 5.300$, $p \leq .01$, and lack of financial resources, $t = 5.604$, $p \leq .01$. Bearse calculated means for burnout, 2.18, *SD* = .89, countertransference, 1.93, *SD* = .68, lack of time, 2.36, *SD* = 1.34 and lack of financial resources, 2.36, *SD* = 1.34. The current study reported means for burnout, 2.4, *SD* = 1.51, countertransference, 2.15, *SD* = .877, lack of time, 2.36, *SD* = 1.34, and lack of financial resources, 2.01, *SD* = 1.19.

The Bearse et al. (2013) calculated means for Compassion fatigue, 1.92, *SD*= .86, Depression,1.86, *SD* = .87 and Personal Trauma,1.71, *SD*= .74. None of these variable values for stressors that impact therapeutic efficacy were significantly different from the current study. The mean scores in the current study for personal trauma, 1.76, *SD* = .877

were slightly higher whereas the mean scores for depression, 1.82, *SD* = .931 and compassion fatigue, 1.89, *SD* = .998, were slightly lower.

The mean scores for difficulty selecting a therapist, 2.61, *SD* = 1.37, difficulty admitting distress, 1.72, *SD* = .88 and professional stigma, 1.66, *SD* = 1.09 in the Bearse et al. (2013) study were also very close to the finding for the same questions in the current study. None of these variable values that are barriers to seeking psychotherapy were significantly different from those of the current study. In the current study, the mean scores of difficulty admitting distress, 1.84, *SD* = 1.05, were slightly higher while the mean score for professional stigma, 1.57, *SD* = .999 and finding acceptable therapist, 2.53, *SD* = 1.42, was slightly lower.

Table 4

Descriptive Statistics Compared From Current Study to Bearse (2013) Study

	Current study		Bearse (2013) study		
	Mean	SD	Mean	SD	t value
Burnout	2.40	1.51	2.18	0.89	2.293*
Depression	1.82	.931	1.86	0.87	–0.599
Countertransference	2.15	.877	1.93	0.68	3.889*
Compassion fatigue	1.89	.998	1.92	0.86	–0.403
Personal trauma	1.76	.877	1.71	0.74	0.926
Professional stigma	1.57	.999	1.66	1.09	–1.316
Difficulty admitting distress	1.84	1.05	1.72	0.88	1.811
Difficulty electing Acceptable therapist	2.53	1.42	2.61	1.37	–0.787
Lack of time	2.86	1.46	2.36	1.34	5.300*
Lack of financial resources	2.53	1.44	2.01	1.19	5.604*

* $p \leq .01$

Representativeness of the Target Population

The current study cannot claim to generalize to the population of practicing psychologists because this was a convenience sample. However, demographic comparisons are presented of the current data with the Bearse sample (2013) and the APA workforce studies (2007, 2010c, 2017, 2018).

The Bearse et al. (2013) study reported a more even distribution between males 48%, n =122 and females 52%, n = 134 as compared to the current study that reported males 22.1%, n =52, and females 74%, n =174 as well as offering the choice of other 3.8%, n =9. The APA (2007) reported that 76% of new doctorates were awarded to women. The most recent APA (2018) study found that 78.6% of psychologists are female. The current study appears to have represented this trend toward greater numbers of women practicing in the field.

Bearse et al. (2013) reported that 87% of their participants were European American, while the current study had more diversity, with European Americans making up 63.2% of the total respondents. The APA (2010c) work force study, n = 2837, found that 76% of Ph.D.'s in psychology were awarded to White students while the remaining 24% represented other ethnic groups. APA (2018) workforce study found that in 2016, 84% of active psychologists were White, and the other 16 % were from other ethnic backgrounds. The current study does demonstrate a higher representation of respondents from those not in the European American ethnic group when compared to the Bearse Study (2013) and APA (2018). Comparisons between the APA (2007) and APA (2010b) demonstrate a growing number of doctorates in psychology being earned by other ethnic

groups in contrast to the APA (2018). The trend for increases in the representation of other ethnic groups among psychologists appears to have been similar to findings in the current study.

The age range 23 to 80 years in the current study was slightly younger with a mean age of 50.64 compared to the average of 58 years old within the span of those aged 30 to 95 in the Bearse et al. (2013) study. This is in keeping with the APA (2018) study that placed the average age of psychologists nationally at 50.8 years in 2014. The Bearse et al. study reported that among their participants, 76% had Ph.D. and 22.3% had Psy.D. in psychology, whereas the current study found that the respondents reported that 56% had a Ph.D and 35.7% had a PsyD in psychology with 8.1% reporting having another type of degree that allowed them to work as a psychologist that was not otherwise specified. APA (2010c) reported that of the psychologists surveyed, n =6536 that there were more with a PhD., 78.6 than those with a Psy.D., 17.9. This APA (2010c) also reported that those with another doctorate work as psychologists at 3.4%. The current study has a lower percentage of psychologists with a PhD when compared to the Bearse (2013) or the APA (2010c) study. Both the Bearse et al. (2013) study, 70%, and the current study, 56.7%, reported that most respondents worked in a private practice setting. APA (2010c) study reported that 51 % of psychologists worked in private practice. This current study seems higher when compared with this finding.

Respondents in the current study reported a lower average of years in practice, 17.91, compared to the Bearse et al. (2013) study that had a mean of 23.7 years. The APA (2010c) reports that among practicing psychologists, the mean number of years that they

have had their doctorate is 17.8 years. The participants in the Bearse et al. (2013) study reported a slightly higher average number of sessions provided by the practitioner within a month, 74, compared with the response to the current study with an average of 67.24 sessions provided in a month. APA (2010c) study uses the category of direct client services that include therapy sessions, assessments, evaluations, etc., with no division among different direct client services. This study (2010c) cannot be compared to the single direct client service of a provided therapy session in either the Bearse (2013) study or the current study.

Table 5

Comparison for Representativeness With Other Published Studies

	Current study	Bearse (2013) study	APA (2010c*/2018)
Gender			
Female	74%	52%	65%
Male	22.1%	48%	35%
Other	3.8%	N/A	N/A
Ethnicity			
European American	63.2%	87%	84%
Other	36.8	13%	16%
Age range	23 to 80	30 to 95	26 to 75
Average age (mean)	50.64	58	50.8
Type of degree			
PhD	56%	76%	*78.6%
PsyD	35.7%	22.3%	*17.9%
Other	8.1%	N/A	*3.4%
Average years in practice (mean)	17.91	23.7	*17.18
Percent in private practice	56.7%	70%	*51%
Average # sessions (mean)	67.24	74	N/A

*APA (2010c)

Results

The ethnic categories were merged into four groups for analysis since there were not enough sample participants for each ethnic group identified in the study. These groups were Asian Pacific Islander, European American, Hispanic Latinx, and others. This grouping strategy was used in the analysis for research question 1. Since the 4 categories were extremely uneven, these 4 groups were analytically compared into two groups, European American and non- European American. This grouping strategy was used to evaluate research questions 1 and 2.

Research Question 1: Differences Between Groups on Help Seeking

A nominal variable was created for the Decision to Seek Help where those psychologists who did not seek help were compared to those who did seek help through psychotherapy treatment. The null hypothesis was tested using a contingency table analysis where rows represent the 4 categories of ethnic groups. The null hypothesis was rejected for this first research question, Pearson Chi-Square = 9.748 (3), p = .021; Cramers V = .204, p = .021; Contingency Coefficient = .20, p = .021. There were statistical differences between those who sought help and those who did not between the 4 ethnic groups. The cell sizes reveal that Asian/Pacific Islanders and European Americans sought help most frequently, and Hispanic/Latinx and Other sought help less often. Further, when the 2 groups of European American and non- European American were compared, they were also found to be significantly different, and the null hypothesis was rejected, such that European Americans sought help more frequently, Pearson Chi-

Square = 9.748 (3), p = .021; Cramers V= .140, p = .032; Contingency Coefficient = .138, p = .032.

Table 6

Four Category Ethnicity

	Frequency	Percent	Cumulative percent
Other	22	9.4	9.4
Asian/Pacific Islander	28	11.9	21.3
European American	148	63.0	84.3
Hispanic/Latinx	37	15.7	100
Total	235	100.0	

Table 7

Four Category Ethnicity by Help-Seeking Cross-Tabulation

		Help seeking		Total
		Did not seek help	Sought help at least once	
Other	Count	8	14	22
	% within four category ethnicity	36.4%	63.6%	100.0%
	% within help seeking	16.0%	7.6%	9.4%
	% of total	3.4%	6.0%	9.4%
Asian/ Pacific Islander	Count	4	24	28
	% within four category ethnicity	14.3%	85.7%	100.0%
	% within help seeking	8.0%	13.0%	11.9%
	% of total	1.7%	10.2%	11.9%
European American	Count	25	123	148
	% within four category ethnicity	16.9%	83.1%	100.0%
	% within help seeking	50.0%	66.5%	63.0%
	% of total	10.6%	52.3%	63.0%
Hispanic/ Latinx	Count	13	24	37
	% within four category ethnicity	35.1%	64.9%	100.0%
	% within help seeking	26.0%	13.0%	15.7%
	% of total	5.5%	10.2%	15.7%
Total	Count	50	185	235
	% within four category ethnicity	21.3%	78.7%	100.0%
	% within help seeking	100.0%	100.0%	100.0%
	% of total	21.3%	78.7%	100.0%

Note. Pearson Chi-square = 9.748 (3), p = .021; Cramers V = .204, p = .021; contingency coefficient = .20, p = .021

Table 8

Two Group Ethnicity Variable by Help Seeking Crosstabulation

	Did not seek help Freq. (%)	Sought help at least once Freq. (%)	Total
non-European American	25 (28.74)	62 (71.26)	87
European American	25 (20.33)	123 (79.67)	148
Total	50	185	235

Note. Pearson Chi-square = 4.589 (1), p = .032; Cramers V= .140, p = .032; contingency coefficient = .138, p = .032

The statistics for this research question were calculated both parametrically and non-parametrically due to the dependent variable being highly skewed. In both analyses, the null hypothesis was accepted. Parametric analysis found Levene's Statistic, F (3, 227) = .854, p = .466 and ANOVA F (3, 277) = .263, p = .852. T test for equality of means was performed and found t (229) = -.136, p = .892. The non-parametric analysis found no significance as well, the independent samples Median Test = .552. Therefore, the results suggest that for the people who seek therapy, there are no differences in the number of courses of therapy.

Table 9

Descriptive Statistics: Courses of Therapy

					95% Confidence interval for mean			
	N	Mean	SD	SE	Lower bound	Upper bound	Min.	Max.
Other	22	11.68	42.195	8.996	–7.03	30.39	0	200
Asian/Pacific Islander	27	7.89	13.882	2.672	2.40	13.38	0	50
European American	146	8.03	32.510	2.691	2.72	13.35	0	200
Hispanic/Latinx	36	4.61	14.547	2.425	–.31	9.53	0	88
Total	231	7.83	29.764	1.958	3.97	11.69	0	200

Table 10

ANOVA for Four Ethnic Groups and Number of Courses of Therapy

	Sum of squares	df	Mean square	F	Sig.
Between groups	705.592	3	235.197	.263	.852
Within groups	203052.824	227	894.506		
Total	203758.416	230			

Note. Levene's statistic for the mean = .854 (3, 227), p = .466; Levene's statistic for the median = .259(3, 227), p = .855

Table 11

T-Test

Group statistics					
	Two group ethnicity variable	N	Mean	SD	SE mean
# of courses of therapy	Non-European American	85	7.48	24.518	2.659
	European American	146	8.03	32.510	2.691

Note. Levene's test F = .142 (229), p = .707; t = -.136 (229), p = .892

Table 12

Hypothesis Test Summary

Null hypothesis	Test	Sig	Decision
# of courses of therapy	Independent median samples test	.552	Retain the null hypothesis

Research Question 2: Demographics, Professional Stressors, and Barriers to Treatment Predicting Help-Seeking and Courses of Therapy

Demographics

Exploratory bivariate and univariate analyses were conducted to examine potential predictive relationships to the two criterion variables on the continuous predictor variables. As shown in Table (14), the results indicate that the age-related variables were strongly associated with help-seeking (as well as with each other). To avoid multicollinearity in hypothesis testing, years in practice were selected as the most conceptually meaningful variable for the final model of help-seeking, $r = .322$, $p < .001$.

Table 13

Correlations

		1	2	3	4	5	6	7
Age	Pearson correlation	1	.853**	.863**	.122	–.070	.247**	.006
	Sig. (2-tailed)		.000	.000	.065	.290	.000	.925
	N	234	232	231	229	230	234	230
Years ago degree awarded	Pearson correlation		1	.933**	.147*	–.025	.290**	–.069
	Sig. (2-tailed)			.000	.026	.704	.000	.302
	N			230	229	230	233	229
Years in practice	Pearson correlation			1	.086	–.015	.322**	.010
	Sig. (2-tailed)				.195	.819	.000	.878
	N				228	229	232	229
# Psychotherapy appts./month	Pearson correlation			.	1	–.251**	.016	.092
	Sig. (2-tailed)					.000	.814	.166
	N					230	230	227
# Psych assessments/month	Pearson correlation					1	–.097	–.052
	Sig. (2-tailed)						.143	.434
	N						231	228
Help seeking	Pearson correlation						1	.139*
	Sig. (2-tailed)							.035
	N							231
# Courses of therapy since becoming a psychologist	Pearson correlation							1
	Sig. (2-tailed)							
	N							231

** Correlation is significant at the 0.01 level (2 tailed); * Correlation is significant at the 0.05 level (2-tailed).

To examine help-seeking, an independent samples t-test was conducted on the three demographic variables. The descriptive statistics and results of the analysis are shown in Tables 14 and 15. The results indicate that help-seeking is significantly different by years in practice, t = -5.663, df = 89.8, $p < .001$. Therapists with many years of practice are much more likely to seek help, M = 20.14, SD =12. 93.

Table 14

Group Statistics

	Help seeking	N	Mean	SD	SE mean
Years in practice	Did not seek help	50	9.80	10.988	1.554
	Sought help at least once	182	20.14	12.926	.958
Approximate # of psychotherapy appointments/month	Did not seek help	49	65.78	56.309	8.044
	Sought help at least once	181	67.64	47.018	3.495
Approximate # of psychological assessments/month	Did not seek help	49	7.51	10.268	1.467
	Sought help at least once	182	4.61	12.746	.945

Table 15

Independent Samples Test

		Levene's test for equality of variances		t-test for equality of means						
		F	Sig.	t	df	Sig. 2-tailed	Mean diff.	SE diff.	95% Confidence interval of the difference	
									Lower	Upper
Years in practice	Equal variances assumed	13.968	.000	–5.164	230	.000	–10.337	2.002	–14.282	–6.393
	Equal variances not assumed			–5.663	89.823	.000	–10.337	1.826	–13.964	–6.710
# of psychotherapy appts./month	Equal variances assumed	.175	.676	–.236	228	.814	–1.865	7.910	–17.452	13.721
	Equal variances not assumed			–.213	67.192	.832	–1.865	8.771	–19.371	15.640
# of psychological assessments/ month	Equal variances assumed	1.430	.233	1.469	229	.143	2.900	1.974	–.990	6.791
	Equal variances not assumed			1.662	91.895	.100	2.900	1.745	–.565	6.366

Because the correlations between the selected demographics and the dependent variable number of courses of therapy were non-significant and extremely small, a regression analysis was not run.

Categorical Variables

A cross-tabulation was done to compare primary work setting with help seeking as seen in Table (16). Help seeking was divided by those who did not seek help and those who sought help more than once. The differences between groups on help-seeking was significant, Chi-Squared (5) = 11.096, $p = .050$, Contingency coefficient = .213, $p = .050$. Private practice respondents sought help at least once, the most frequently, 85.6%. Government/industry and medical work setting respondents were least likely to seek help at least once, 58.8%, 65.4%, respectively. Because 2 cells had less than 5 cases per cell, the significance test results should be interpreted with caution.

Table 16

*Primary Work Setting * Help-Seeking Cross-Tabulation*

			Help-Seeking		
			Did not seek help	Sought help at least once	Total
Primary work setting	Academic	Count	4	12	16
		% within Primary Work Setting	25.0%	75.0%	100.0%
	CMH	Count	7	20	27
		% within primary work setting	25.9%	74.1%	100.0%
	Government/Industry	Count	7	10	17
		% within primary work setting	41.2%	58.8%	100.0%
	Medical	Count	9	17	26
		% within primary work Setting	34.6%	65.4%	100.0%
	Private practice	Count	19	113	132
		% within primary work setting	14.4%	85.6%	100.0%
	Other	Count	3	12	15
		% within primary work setting	20.0%	80.0%	100.0%
Total		Count	49	184	233
		% within primary work setting	21.0%	79.0%	100.0%

Note. (Chi Squared (5) = 11.096, p = .050, Contingency coefficient = .213, p = .050).

A cross-tabulation was done to compare primary work location with help seeking as seen in Table (17). Help seeking was divided by those who did not seek help and those who sought help more than once. The differences between groups on help-seeking was significant, Chi-Square (3) = 13.752, p = .003, Contingency Coefficient = .236, p = .003. The suburban location had the most respondents that sought help at least once, 84.8%. The rural location category had the fewest respondents who were least likely to seek help at least once, 47.4%.

Table 17

*Primary Work Location * Help-Seeking Cross-Tabulation*

			Help-Seeking		
			Did not seek help	Sought help at least once	Total
Primary work location	Rural	Count	10	9	19
		% within primary work location	52.6%	47.4%	100.0%
	Suburban	Count	15	84	99
		% within primary work location	15.2%	84.8%	100.0%
	Urban	Count	24	90	114
		% within primary work location	21.1%	78.9%	100.0%
Total		Count	49	183	232
		% within primary work location	21.0%	79.0%	100.0%

Note. Chi Square (3) = 13.752, p = .003, Contingency Coefficient = .236, p = .003

A cross-tabulation was done to compare theoretical orientation with help seeking as seen in Table (18). Help seeking was divided by those who did not seek help and those who sought help more than once. The differences between groups on help-seeking was significant, Chi-Squared (4) = 16.496, p = .002, Contingency Coefficient = .256, p = .002. Psychodynamic orientation had the most respondents that sought help at least once, 90.8. The cognitive behavioral orientation respondents were the least likely to seek help at least once had the least that sought out help at least once, 65.1%. Because 2 cells had less than 5 cases per cell *Theoretical orientation * Help-Seeking Crosstabulation*, the significance test results should be interpreted with caution.

Table 18

*Theoretical Orientation * Help-Seeking Cross-Tabulation*

			Help-Seeking		
			Did not Seek Help	Sought Help at Least Once	Total
Theoretical orientation	Cognitive behavioral	Count	30	56	86
		% within theoretical orientation	34.9%	65.1%	100.0%
	Humanistic	Count	3	19	22
		% within theoretical orientation	13.6%	86.4%	100.0%
	Psychodynamic	Count	6	59	65
		% within theoretical orientation	9.2%	90.8%	100.0%
	Systemic	Count	2	12	14
		% within theoretical orientation	14.3%	85.7%	100.0%
	Other	Count	9	39	48
		% within theoretical orientation	18.8%	81.3%	100.0%
Total		Count	50	185	235
		% within theoretical orientation	21.3%	78.7%	100.0%

Note. Chi Squared (4) = 16.496, p = .002, Contingency Coefficient = .256, p = .002

Stepwise multiple regression was computed to examine the influence of the professional stressors and personal barriers on the number of courses of therapy as seen in the following Tables (19, 20, 21). Burnout and countertransference appeared as the only significant predictors. While R squared was significant, this coefficient only explained 4.1% of the variance. The directions of the standardized coefficients suggest

that countertransference positively predicts number of courses of therapy, and burnout negatively predicts the number of courses of therapy.

Table 19

Correlations for Predicting No. Courses of Therapy

n = 227

	1	2	3	4	5	6	7	8	9	10	11
1. # Courses of therapy	1.00	-.094	-.073	.139	-.029	-.047	-.043	-.110*	-.074	-.115*	-.129*
2. Burnout		1.00	.407**	.316**	.500**	.266**	.262**	.271**	.345**	.393**	.295**
3. Depression			1.00	.150*	.314**	.439**	.185*	.218**	.294**	.103	.324**
4. Counter-transference				1.00	.357**	.220**	.102	.188*	.102	.048	.024
5. Compassion Fatigue					1.00	.273**	.230**	.271**	.231**	.243**	.124*
6. Personal history/Trauma						1.00	.157*	.080	.115*	-.057	.221**
7. Professional stigma							1.00	.315**	.239**	.206**	.132*
8. Difficulty in admitting distress								1.00	.173**	.245*	.046
9. Difficulty selecting an acceptable therapist									1.00	.270**	.220**
10. Lack of time										1.00	.493**
11. Lack of financial resources											1.00

** Correlation is significant at the 0.001 level (2-tailed); * Correlation is significant at the 0.05 level (2-tailed).

Table 20

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics R Square Change	F Change	df1	df2	Sig. F Change
1	.139a	.019	.015	29.792	.019	4.435	1	225.036	
2	.201b	.041	.032	29.533	.021	4.951	1	224.027	

a. Predictors: (Constant), Countertransference; b. Predictors: (Constant), Countertransference, Burnout

Table 21

Coefficients [a]

Model	Unstandardized Coefficients B	Unstandardized Coefficients Std. Error	Standardized Coefficients Beta	t	Sig.	Collinearity Statistics Tolerance	Collinearity Statistics VIF
1(Constant)	-2.273	5.231		-.435	.664		
Countertransference	4.763	2.262	.139	2.106	.036	1.000	1.000
2(Constant)	3.743	5.848		.640	.523		
Countertransference	6.428	2.364	.188	2.719	.007	.900	1.111
Burnout	-4.049	1.820	-.154	-2.225	.027	.900	1.111

Research Question 3: Demographics, Professional Stressors, and Barriers to Treatment Predicting the Decision to not Seek Help

To examine this RQ, the dependent variable (Thought of Benefit but Didn't Seek Help) was transformed to remove potential effects of the extremely non-normal distribution of values, M= 1.1794, *SD*= 1.0108. A correlational analysis was computed to examine relationships to the dependent variable. The number of psychotherapy sessions reported per month was the only variable significantly correlated with those who did not seek help, $p = .005$. The number of psychotherapy sessions reported was also highly correlated with the number of psychological assessments reported in the same time

period, $p < .0001$. The number of psychotherapy sessions per month approached significance when correlated with age, $p =. 051$. The year that their doctorate was conferred was significantly negatively correlated to the number of therapy sessions performed monthly, $p = .021$.

Table 22

Correlation

n = 226	1	2	3	4	5	6
1. Thought of benefit but didn't seek help	1.000	-.013	.018	.004	-.171 *	-.005
2. Age		1.000	-.849 **	.860 **	.109	-.094
3. Year degree was awarded			1.000	-.932 **	-.135 *	.054
4. Years in Practice				1.000	.085	-.044
5. Approx. # of therapy appt. per mo.					1.000	-.251 **
6. Approx. # of psychological asmt. per mo.						1.000

** Correlation is significant at the 0.001 level (2-tailed); * Correlation is significant at the 0.05 level (2-tailed).

A step-wise regression analysis was computed to examine the influence of continuous variables on the number of times that personal therapy was not sought when it was thought to be beneficial. The number of psychotherapy sessions per month was found to be the only significant predictor. While R squared was significant, this coefficient only explained 2.9% of the variance. The directions of the standardized coefficient suggest that the number of psychotherapy sessions per month negatively predicts the number of times personal psychotherapy was not sought out.

Table 23

Model Summary

					Change Statistics			
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	F Change	df1	df2	Sig. F Change
1	.171[a]	.029	.025	1.00280	.029	6.744	1	224	.010

a. Predictors: (Constant), Approximate number of psychotherapy appointments per month

Table 24

ANOVA [a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	6.781	1	6.781	6.744	.010[b]
	Residual	225.258	224	1.006		
	Total	232.040	225			

a. Dependent Variable: Thought of Benefit but Didn't Seek Help; b. Predictors:

(Constant), Approximate number of psychotherapy appointments per month.

Table 25

Coefficients [a]

		Unstandardized Coefficients		Standardized Coefficients			Collinearity Statistics	
Model		B	Std. Error	Beta	t	Sig.	Tolerance	VIF
1	(Constant)	1.439	.114		12.640	.000		
	Approximate number of psychotherapy appointments per month	-.004	.001	-.171	-2.597	.010	1.000	1.000

a. Dependent Variable: Thought of benefit but didn't seek help

Categorical Variables

The variable categorizing the 4 ethnic groups was examined for its relationship the dependent variable thought of benefit but did not seek help, as this was one of the key questions of the current study. Both parametric (One-Way ANOVA) and non-parametric

statistics (cross-tabulation) were computed; in both cases the results were non-significant, F (3) = .717, *p* = .543, Chi-Square (9) = 5.008, *p* = .834, respectively.

The means for a work setting, work location, and theoretical orientation were examined to see differences between the groups on the perceived benefit of therapy. One way ANOVA's were computed and none of the independent variables were significantly different for this dependent variable.

Table 26

One-Way ANOVA for thought of benefit but didn't seek help

Independent Variable	F Test	DF	Sig.
Work setting	1.598	5, 228	.156
Work location	.432	3, 231	.730
Theoretical orientation	1.231	4, 230	.298

A correlational analysis was computed to examine relationships between the dependent variable and the Bearse (2013) professional stressors and personal barriers. Professional stressors, burnout, depression, compassion fatigue were significantly correlated to the dependent variable, $p \leq .05$. Among the personal barriers, professional stigma, difficulty admitting distress, and lack of financial resources were significantly correlated with the dependent variable, $p \leq .05$. The remaining personal barriers listed as difficulty finding a therapist and lack of time were highly correlated with the dependent variable for those who choose not to seek help when it was thought to be beneficial $p \leq .0001$. Burnout was highly correlated with all other stressors and barriers, $p \leq .0001$. Difficulty finding a therapist was highly correlated with lack of time and financial resources, $p \leq .0001$.

Table 27

Correlations

n = 229	1	2	3	4	5	6	7	8	9	10	11
1. Thought benefit but didn't seek help	1.00	.213*	.187*	.007	.115*	.099	.139*	.148*	.351**	.351**	.216*
2. Burnout		1.00	.411**	.314**	.499**	.259**	.257**	.271**	.353**	.395**	.303**
3. Depression			1.00	.154*	.312**	.435**	.180*	.218**	.299**	.111*	.329**
4. Counter-transference				1.00	.345**	.239**	.093	.188*	.097	.067	.021
5. Compassion Fatigue					1.00	.259**	.232**	.270**	.233**	.235**	.128*
6. Personal Hx/Trauma						1.00	.147*	.081	.102	-.038	.207*
7. Professional stigma							1.00	.314**	.235**	.196*	.129
8. Difficulty in admitting distress								1.00	.172*	.245**	.046
9. Difficulty selecting an acceptable therapist									1.00	.269**	.234**
10. Lack of time										1.00	.488**
11. Lack of financial resources											1.00

** Correlation is significant at the 0.01 level (2-tailed); * Correlation is significant at the 0.05 level (2-tailed).

A stepwise regression analysis was computed to examine the influence of professional stressors, personal barriers, and the number of psychotherapy sessions per month on the number of times that personal therapy was not sought when it was thought to be beneficial. Lack of time, difficulty finding an acceptable therapist, and the number

of psychotherapy sessions per month were significant predictors. R-squared was significant, and this coefficient explained 19.9% of the variance. The directions of the coefficient suggest that lack of time and difficulty finding a therapist positively predicts the number of times personal psychotherapy was not sought out. However, the number of psychotherapy sessions per month negatively predicts the number of times personal psychotherapy was not sought out.

Table 28

Model Summary

					Change Statistics			
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	F Change	df1	df2	Sig. F Change
1	.342a	.117	.113	.95290	.117	29.330	1	222.000	
2	.426b	.182	.174	.91934	.065	17.504	1	221.000	
3	.446c	.199	.188	.91168	.017	4.728	1	220.031	

a. Predictors: (Constant), Lack of time; b. Predictors: (Constant), Lack of time, Difficulty selecting an acceptable therapist; c. Predictors: (Constant), Lack of time, Difficulty selecting an acceptable therapist, Approximate number of psychotherapy appointments per month.

Table 29

ANOVA [a]

Model	Sum of squares	df	Mean square	F	Sig.
1 Regression	26.632	1	26.632	29.330	.000b
residual	201.578	222	.908		
total	228.210	223			
2 Regression	41.426	2	20.713	24.507	.000c
residual	186.784	221	.845		
total	228.210	223			
3 Regression	45.355	3	15.118	18.190	.000d
residual	182.854	220	.831		
total	228.210	223			

a. Dependent Variable: Though Benefit but Didn't Seek Help; b. Predictors: (Constant), Lack of time; c. Predictors: (Constant), Lack of time, Difficulty selecting an acceptable therapist; d. Predictors: (Constant), Lack of time, Difficulty selecting an acceptable therapist, Approximate number of psychotherapy appointments per month.

Table 30

Coefficients [a]

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
1(Constant)	.513	.138		3.727	.000
Lack of time	.235	.043	.342	5.416	.000
2(Constant)	.169	.156		1.082	.280
Lack of time	.187	.043	.272	4.308	.000
Difficulty selecting an acceptable therapist	.189	.045	.264	4.184	.000
3(Constant)	.379	.183		2.078	.039
Lack of time	.181	.043	.264	4.204	.000
Difficulty selecting an acceptable therapist	.185	.045	.258	4.124	.000
Approximate number of psychotherapy appointments per month	-.003	.001	-.132	-2.174	.031

a. Dependent variable: Thought of benefit but didn't seek help.

Summary

Despite efforts to recruit a diverse representation among respondents, this survey had more than three times as many women as men and 54% identified with the European American ethnic group. Hispanic/ Latinx was the second largest group represented in this current study. Very few respondents identified with the ethnic group of African Americans, and these respondents were included in the other ethnic group. Ten respondents did not identify an ethnic group.

More than half reported having a Ph.D. in psychology. The next second highest degree choice represented was Psy.D. Cognitive behavioral accounted for the majority of the respondent's choices for theoretical orientation followed by psychodynamic. Most respondents reported working in an urban location, with the second largest groups reporting working in a suburban area. The largest group of respondents reported working in private practice.

The average age of the respondent was 50, with an average of almost 18 careers post-doctoral work in the field of psychology. For those respondents who work delivering psychological treatment, they provided an average of 67 therapy sessions and 5 assessments a month. A wide range of survey responses for both numbers of courses of therapy participated in during career tenure and the number of those who did not seek help resulted in skewed results. Both of these dependent variables ranged to remove potential effects of the extremely non-normative distribution of values.

The ProQOL results indicated that respondents were experiencing increased levels of compassion fatigue. Survey participants revealed that they experienced higher

than average levels of compassion satisfaction and lower than average feelings of burnout. The current study was compared with Bearse (2013). The variables of burnout, countertransference, lack of time, and lack of financial resources were found to be statistically significant when compared to Bearse (2013). Compassion fatigue, depression, and personal trauma were not significantly different from the Bearse (2013) study. Difficulty admitting distress and professional stigma findings in the current study were very close to values in the Bearse (2013) study.

The current study was compared with available workforce studies completed by the APA (2007, 2010c, 2017, 2018). Overall similar trends were present in the current study. Most notably, the increased numbers of women graduating with doctorates in psychology and practicing in the field. APA(2007, 2010c, 2017, 2018) continues to report that most of their survey responders identify with European American ethnic group, and similar findings were reported in the current study. The average number of years working as a psychologist (APA, 2010c) was also very close to the average reported in this current study.

The first research question examined differences between participants who sought help at least once and those who did not seek help**.** The ethnic group variable demonstrated significant differences in their use of help seeking. European American and Asian American ethnic groups used personal psychotherapy the most while the Hispanic/Latinx and other ethnic groups used personal psychotherapy the least. When these groups were recoded as non- European American and European American ethnic groups, there were also significant statistical differences. However, this statistical

difference was slightly less significant than when each ethnic group was compared. Therefore the null hypothesis was rejected.

For the second part of RQ1, the different ethnic groups were compared on the number of courses of therapy since becoming a psychologist. Because the dependent variable was highly skewed and leptokurtic, the data were examined parametrically and non-parametrically. No significant differences were found in the number of courses of therapy between the different ethnic groups, and the null hypothesis was accepted.

For the first part of RQ2, analyses were conducted to examine what independent variables influenced help-seeking, coded as Yes/No. The results revealed that age and years in practice were significantly correlated with each other and the decision to seek help**.** Years in practice were chosen as the most meaningful variable for inclusion.

Independent samples t-tests were calculated for continuous independent variables, years in practice, number of therapy appointments per month, and number of assessments per month. Only the number of years in practice was statistically significant, indicating that participants with more years in practice were more likely to seek help.

Cross-tabs were computed for the categorical independent variables, and there were significant differences among different work settings for help seeking. Private practice participants sought help the most frequently, while government/industry and medical work were the least likely to do so. There were significant differences among different work locations for help seeking. The suburban location had the highest number of respondents who sought help, while the rural location had the lowest number of respondents who sought help. There were significant differences among different

theoretical orientations for help seeking. Psychodynamic orientation had the highest number of respondents who sought help, while cognitive behavioral orientation had the least who sought help. In both analyses, some cell sizes were less than 5, and these results should be interpreted with caution.

For the number of courses of therapy (the second dependent variable of RQ2), a regression analysis testing the professional stressors and personal barriers revealed that burnout and countertransference were significant predictors. However, these variables only explained a relatively small amount of variance. Interestingly, the standardized coefficients revealed that burnout predicts the number of courses of therapy negatively while countertransference predicts this variable positively.

The dependent variable for this research question measured the number of times respondents identified therapy benefits but did not seek help. This variable was extremely skewed and leptokurtic and was recoded to remove the potential effects of the extremely non-normal distribution. Examination of the continuous demographic variables found that the number of psychotherapy sessions per month was a predictor for those who thought of therapy benefit of therapy but did not seek help. The categorical variables work setting, work location, and theoretical orientation were not significantly different on the decision not to seek help. Most importantly, the variable measuring ethnicity was not statistically significant in the parametric and non-parametric analyses.

For the final model, a multivariate regression analysis was calculated for the one significant demographic (number of psychotherapy sections a month) and the predictors of professional stressors and personal barriers. The results revealed that lack of time,

difficulty finding an acceptable therapist, and the number of psychotherapy sections a month were significant predictors. These predictors accounted for almost 20% of the variance. Lack of time and difficulty finding a therapist predicted this dependent variable positively, while the number of therapy sessions a month was negatively predictive. These results were interpreted in light of the previous literature and the theoretical framework in Chapter 5. The limitations of this study and recommendations for future research will be examined in the following chapter. Implications for practice and positive social change within psychology will be discussed in Chapter 5 as well.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to examine the relationships between demographic variables, professional stressors, and barriers to treatment and help-seeking behaviors among psychologists. I used a nonexperimental, correlational design to collect online survey data using the RBS (2016) and the ProQOL (2005) as instruments in an online application. The RSB (2016) was modified to capture ethnic differences and the use of psychotherapy during a psychologist's career. The instrument asked how often psychotherapy was used or not used by psychologists during their tenure.

A comparison between the original Bearse (2013) questionnaire and the RBQ (2016) was done with descriptive statistics. The first research question was analyzed with a multivariate analysis of variance. The second and third research questions were analyzed with hierarchical multiple linear regression.

The results of the first research question indicated that European American and Asian/Pacific Islanders ethnic groups used personal psychotherapy more often than Hispanic/Latinx and other ethnic groups that used psychotherapy the least. Despite a fairly skewed distribution, there were significant statistical differences between ethnic groups on psychotherapy, with European Americans using therapy most often compared to non-European Americans but no differences in the number of therapy courses received. There were also statistical differences between non-European and European ethnic groups.

The results of the second research question revealed that age and years in practice were significantly correlated with the decision to seek help. In addition, those participants

who worked in private practice were more likely to seek help. Conversely, participants in government/industry and medical settings were the least likely to use psychotherapy. Participants with a psychodynamic orientation were the most likely to seek help, while those with a cognitive behavioral orientation were the least likely to use psychotherapy. Moreover, burnout and countertransference were significant predictors of therapy courses but explained a relatively small amount of variance. Burnout was a negative predictor, and countertransference was a positive predictor.

The third research question examined those participants who reported the benefits of psychotherapy but did not seek it out. The analysis found that participants who conducted more psychotherapy sessions at work were more likely not to seek out psychotherapy treatment for themselves. Ethnicity, work setting, work location, and theoretical orientation were not significant predictors of the decision to seek help.

Lack of time, difficulty finding a therapist, and the number of psychotherapy sessions performed per month were significant predictors for not seeking help. These variables accounted for 20% of the variance. The number of psychotherapy sessions performed per month was negatively predictive, while lack of time and difficulty finding a therapist were positively predictive.

Interpretation of Findings

The comparison with Bearse et al. (2013) and the APA (2010c, 2018) workforce study was examined in Chapter 4. Several key comparisons illustrated the diversity found in the current study that represents current practicing psychologists. This study had fewer respondents identified as European American (63.2%) than Bearse et al. (2013), at about

87%. The current study captured enough respondents who identified with different ethnicities to compare them, whereas Bearse et al. (2013) could not. Recent APA (2010c, 2018) studies have indicated that psychology is becoming more diverse and representing different ethnicities in numbers that allow for statistical comparison.

The Bearse et al. (2013) study average for years in practice was higher at 23.7 years; in comparison, the current study captured more psychologists in the early and middle stages of their career. Similarly, the average age of respondents was younger in the current study (M = 50.6, *SD* = 14.278) and the APA (2018) study (M = 50.8, no *SD* reported), while older in the Bearse et al. (2013) study by about 7 years. The current study captured psychologists from a greater variety of workplace settings (private practice, 56.7%) compared to Bearse et al.'s (2013) study with 70% in private practice and more in line with the APA (2010c) at 51%.

The major findings from the regression analysis for this current study revealed several key points. The psychologists who identified as European American used psychotherapy significantly more than psychologists who identified as non-European American. Psychologists who were older, more experienced, in private practice, and those with a psychodynamic orientation were significantly more likely to seek help. The most significant barriers to seeking help were lack of time and difficulty finding a therapist; those who conducted more psychotherapy sessions were less likely to seek out psychotherapy for themselves. Difficulty finding a therapist and lack of time were the highest rated barriers to seeking psychotherapy in the Bearse et al. (2013) study.

The Bearse et al. (2013) study reported that 87% of participants had used personal psychotherapy but did not identify it during their careers. The current study reported that 78.7% of participants had used personal therapy during their professional tenure. Martin (2010) found that 64% of psychologists have used psychotherapy or counseling as a coping strategy to deal with issues related to work-life balance. Other research related to help seeking is sparse. In the most recent study, Tay et al. (2018) studied 678 psychologists in the United Kingdom. Tay et al. found that 83.9% sought help for depression, anxiety, and eating disorders, while 88.2 % sought help for psychosis and addiction. However, not all sought help with psychotherapy, and 53.2% sought help through their primary care doctor. In Tay et al., 45.6% of respondents sought help through psychotherapy, which is lower than the current study and Martin (2010). The Tay et al. (2018) study lacked diversity in their participants, with 91.6% identifying as White and 82.2% female, and an age range spanning 30 to 59 years of age. The current study and Martin (2010) reflect U.S. psychologists' help seeking. Tay et al. (2018) reflected help-seeking habits of psychologists in the United Kingdom that present contextual and environmental variables not examined between countries that could significantly alter outcomes.

Most other researchers have dealt with workers from all mental health fields combined, including training programs, social workers, and counseling, and reported only rates of therapy use during a participant's lifetime. McCarthy et al. (2009) found that 44% of mental health counseling trainees had used therapy during their life. Dearing et al. (2005) found 70% rates of psychotherapy treatment within other clinical training

programs during their life. Holzman et al. (1996) found rates at 75% in the clinical programs during a participant's life. Goodyear et al.'s (2008) sample reported rates of therapy used at 86% during the participants' lifetime.

Bearse et al. (2013) were the first to ask psychologists how many psychotherapy courses they participated in and reported 2.7 courses of therapy during the participants' lifetime. The current study reported an average of 15.88 courses of therapy for psychologists during the tenure of their profession. The Bearse et al. (2013) study did not have enough ethnic diversity to compare how psychologists of different ethnic groups differ in help-seeking behavior. Previous researchers have examined the rates at that the general population uses therapy (25%) and the rates that mental health workers use therapy (75%; Bike et al., 2009, Norcoss & Guy, 2005). Bearse et al. (2013) were the first to attempt ethnic differences in help seeking among psychologists specifically but could not do so. Tay et al. (2018) also were unable to capture ethnic differences despite a larger number of participants (n = 678) compared to the current study (n = 235).

The current research improved on capturing ethnic diversity among psychologists in their help-seeking behavior and did capture ethnic differences between significant groups in the study. For perspective, Goodyear et al. (2008) reported an increase in total minority respondents from 5% to 10.6% over the 15 years that Asian/Pacific Islander and Hispanic/Latinx ethnic groups were included with much smaller representation. However, these groups were too small to be statistically compared.

This study found that the more years in practice a psychologist has, the more likely they will seek help. Primary work setting was a significant variable influencing

help seeking, with the highest number of participants in private practice seeking help. This is similar to a recent study of 119 psychologists in their late careers (Dorociak et al., 2017). Psychologists in the first group studied (n = 133) were more likely to engage in self-care (Dorociak et al., 2017). However, in the second group of 277 psychologists at the beginning of their careers, Dorociak et al. (2017) found they performed more self-care activities than psychologists with more career experience. Interestingly, 41.2% of late-stage psychologists worked in private practice in the Dorociak et al. (2017) study.

This research was based on Rupert and Dorociak's (2015) research overview of burnout experienced by psychologists and Dettle's (2014) dissertation examining psychologists' self-care throughout their careers (n =167).

Dettle (2014) was the first to group psychologists into early, mid and late career stages and compare their self-care usage. The use of psychotherapy for self-care was not an option on the scales or worksheets used in the Dettle (2014) study but was available as a write in response. In the Dettle (2014) study, psychotherapy was not listed in any top 10 frequently engaged self-care activity career tables.

Bearse et al. (2013) reported that the older a psychologist was, the more likely they were to seek help and perceived time and money as lesser obstacles. Likewise, Bearse et al. (2013) reported that the participants in the study reported that compassion fatigue significantly impacted their performance as a therapist. While Bearse et al. (2013) collected data on theoretical orientation, the study did not analyze the data to see if it was predictive of help seeking behavior. This research did not analyze if compassion fatigue influenced help seeking behavior.

In the current study, work location was significant where those participants working in a suburban area were more likely to seek help. Theoretical orientation was also significant, with those who identified with psychodynamic orientation being the most likely to seek help. While burnout and countertransference were significant predictors for the number of courses of therapy participants experience, they only explain a small percent of the likelihood of participating in courses of therapy. Burnout was negatively predictive, while countertransference was negatively predictive.

Burnout was another variable that Bearse et al. (2013) found to impact participant's performance as a therapist significantly but did not report any analysis of this data regarding any influence on help seeking behavior. Dorociak et al. (2017) found that burnout was experienced most strongly by psychologists in the early stage of their career (n = 108) and that this reduced self-care activities for the first group of psychologists they studied (n = 333). Similar findings were reported in the Dettle (2014) study (n = 78) that did not include psychotherapy as a self-care option in its scales or worksheets. They reported that psychologists practice fewer self–care activities in the early stage of their career. No other research examined these particular variables for their bearing on help seeking behavior or the decision to seek help from psychologists.

Bearse et al. (2013) found that 59% of the psychologists reported that they did not seek help with psychotherapy even when they thought it could have benefitted them over a lifetime. The current study found that 21.3% of participants did not seek therapy when they perceived it could have helped them during their professional tenure. This percentage does appear low, but it is the only research that asked if the therapy occurred

during the psychologist's professional career. Bearse et al. (2013) findings were higher for both those psychologists who sought psychotherapy and those who did not during their lifetime compared to previous research that focused on psychologists as a subgroup among mental health workers or psychologists specifically (Pope & Tabachnick, 1994; Bike et al., 2009). However, these studies only asked if the mental health worker had used therapy throughout their life and not specifically during their professional career span as was done in this current study.

Tay et al. (2018) reported that the psychologists that identified as having a psychological problem (n = 425) 68 indicated that they did not seek help. Their analysis found that these participants demonstrated higher levels of professional stigma and more negative attitudes towards seeking help than those psychologists who did seek help.

For those who did not seek help in the current study, the more years a therapist experienced, the more likely they were to seek help. Not seeking help seems more likely for the psychologist that has less experience. Dorociak et al. (2017) and Dettle (2014) found that psychologists in their first group in the early stage of their career practice self-care at lower rates. However, the second group countered this trend with early-stage psychologists practicing self-care at a higher rate than their more experienced counterparts. However, psychotherapy was not one of the self-care activities they examined.

In this current study, the number of psychotherapy sessions performed by the psychologist per month was positively correlated to the decision not to seek help. The analysis found it to be a significant predictor of this behavior, but the variance was small.

This means, and it only explained a small amount to the likelihood of this behavior. Burnout, depression, compassion fatigue was significantly correlated to the decision not to seek help. Further, professional stigma, difficulty admitting distress, and lack of financial resources were significantly correlated to seeking help. Difficulty finding a therapist and lack of time were highly correlated with the dependent variable for those who chose not to seek help when it was thought beneficial.

Lack of time, difficulty finding an acceptable therapist, and the number of psychotherapy sessions per month were significant predictors, with nearly 20% of the variance explained. Lack of time and difficulty finding a therapist positively predicts the number of times personal psychotherapy was not sought out. The number of psychotherapy sessions per month negatively predicts the number of times personal psychotherapy was not sought out.

The Bearse et al. (2013) study indicated that difficulty finding a therapist was the highest rated deterrent to seeking help. That lack of time was the second highest rated deterrent to seeking help. The study also rated burnout as the strongest influence on therapeutic efficacy, followed by countertransference, compassion fatigue, and depression. An important difference is that Bearse et al. (2013) reported that professional stigma was the next to last reported deterrent to impact seeking therapy, with personal stigma as the least impactful barrier to therapy. Tay et al. (2018) (n = 678) also found that most psychologists (89.2%) were not affected by professional stigma in seeking help, in disclosing it at the workplace, or in disclosing within their personal life for psychologists experiencing depression, anxiety, eating disorders, psychosis or addiction.

Comparison with Theoretical Framework

CSDT was used as the theoretical framework for this study. CSDT is most closely related to trauma histories, countertransference, and compassion fatigue experienced by a psychotherapist. Shifts in a therapist's orientation can manifest in their reduced resiliency, lowering of tolerance, increases in psychological needs with possible changes in beliefs about who they are and how they see others to be (Pearlman & Saakvitne, 1995). Possible outcomes, should this happen, could encompass burnout and depression. Since trauma histories, countertransference, compassion fatigue, burnout, and depression were the stressors included in the current study, CSDT seemed a good fit for the current research.

However, the study results found that burnout and countertransference were significant predictors for the number of therapy courses and not whether or not help was sought. These variables accounted for a very small percentage of the variance and only explained a small percent of the likelihood of help seeking behavior. Burnout was negatively predictive, while countertransference was positively predictive. Further, while burnout, depression, compassion fatigue were significantly correlated to the decision not to seek help in the final regression analysis, these variables did not account for the likelihood of participants not seeking out therapy. Stressors included in the study were weak predictors for the number of courses of therapy and did not significantly predict seeking help behavior. Due to this finding, CDST does not seem to be a good model for why psychologists do or do not seek out psychotherapy during their professional tenure.

This suggests that CSDT may be weakly related to how many therapy courses a psychologist may experience during their career.

Limitations

This study had some acknowledged limitations. This current study cannot claim to generalize to the population of practicing psychologists because this was a convenience sample. However, the response and participant responses rates are similar to the Bearse et al. (2013) and APA Workforce Studies (2007, 2010c, 2017, 2018).

Of greater import were the efforts to diversify the sample across ethnic groups to create meaningful comparisons. The researcher went to great lengths to identify ethnically professional organizations; however, the resulting sample sizes were insufficient for the proposed comparisons. This limited the ability to make inferential comparisons across groups and combine groups with exploring possible differences.

The findings of this study were similar to the original Bearse et al. (2013) and ProQOL (2005) that supports the consistency and reliability of results. Proper sampling protocols, dependable instrument measures, and statistical procedures were used to increase the statistical validity of conclusions (Fowler, 2014). The internal validity of these instrument measures has been well documented, supporting statistical conclusion validity and the assumptions made to carry out the analyses (Fowler, 2014; Litwin, 1995).

Self-selection bias occurs when participants can choose to identify with a group in a study themselves and choose to participate or not on their own. This may have caused a biased sample and non-probability sampling, but this was unavoidable as the random selection was not feasible for this study. This was an online survey, and self-reporting

may not be representative of authentic behavior. The initial response rate was low, and the length of time to gather data was extended, contributing to sampling bias. Weekly email invitations reminders were included for the duration of data collection to reduce the effects of non-response on these study estimates (Creswell, 2009). The Association of Black Psychologists received only one invitation and no reminders for participation due to their contact procedures and protocols. This may have been directly responsible for the very low numbers of participants who identified with the African American ethnic group and why the current study was not more representative of this ethnic group.

Recommendations for Future Research

While this study found a significant difference between non-European American and European American ethnic groups, more diversity is needed in studies like these to more reliably explore ethnic and racial differences in help seeking among licensed psychologists. In this study, the Hispanic/Latinx and other ethnic groups used therapy much less than the European and Asian /Pacific Islander ethnic groups. Future research should further investigate these differences to reveal why these ethnic groups use therapy less among psychologists during their careers, particularly as there has been a steady increase in diversity within the profession of psychology (APA, 2010 and APA, 2018). Future survey research may be able to capture and represent this diversity with both its similarities and differences.

Further research is needed to confirm that demographic variables are predictive of help seeking. This study found that private practice and psychodynamic orientation increased the likelihood of seeking help while government/industry setting and cognitive

behavioral orientation decreased seeking help. Future research is needed to confirm this finding and possibly find other work-related variables that also increase or decrease the likelihood of help seeking.

The professional stressors of burnout and countertransference were predictive for the number of psychotherapy courses but only explained the variance. Future research should examine burnout and countertransference to investigate more closely the effect on the number of times help is sought out and if help seeking leads to a reduction in distress.

Burnout negatively predicts the number of therapy courses, and countertransference was positively predictive of the number of therapy courses. Further research is needed to see if these trends are repeated. If so, this could have value to psychologists in gauging self-care. This is also recommended that qualitative approaches be used to investigate burnout and countertransference, as survey research is unlikely to pick practitioners' nuances and unique experiences.

Lack of time, difficulty finding a therapist, and the number of psychotherapy sessions performed per month were significant predictors for not seeking help. These variables should be included in future research because they accounted for a significant part of the variance. Lack of time, difficulty finding a therapist was positively predictive and the number of psychotherapy sessions performed per month was negatively predictive. Future research is needed to see if these trends are repeated. If so, these variables may also hold importance for psychologists in gauging their self-care needs.

Overall, the majority of psychologists in the study do seem to be using psychotherapy during their careers. Martin (2010) and Bearse et al. (2013) cited stressors

related to home life that may also be contributing to this trend. Experiences such as personal loss, family strife, and interpersonal conflict were not included in this study and could be an area for future research.

Significance

The study reveals that the profession of a psychologist is becoming more ethnically diverse. This is promising for clients who need more culturally aware and sensitive practitioners. The study also reveals that this diversity can sometimes be difficult to capture, even when reaching out to psychological associations. Some associations have protocols that can make recruitment more difficult, resulting in a lower representation of ethnic groups. Still, this is not the only reason for this to occur. There remain some ethnic groups that are underrepresented in the field, such as the Native American ethnic group, while efforts for more diversity in the field remain ongoing (APA, 2010c). There is hoped that these obstacles will be surmounted as diversity abounds in the field with each passing year.

It is encouraging that both Asian/ Pacific Islanders and Hispanic/ Latinx ethnic groups were large enough to be statistically compared. There were studies not that long ago, such as the Bearse et al. (2013), where there was not enough diversity to happen, or these ethnic groups would be subsumed into a minority ethnic group.

This study also offered participants the choice to choose as many ethnic groups they felt applied to them. Several participants availed themselves of this option, but there were too few of each combined ethnic group, and these participants were included in the other ethnic group. There remains hope that this opportunity for participants continues.

With a large enough group of participants, such responders who identify with multiple ethnic groups will be in such amounts that they can be statistically compared and more fully represented in research.

Far fewer than suggested in the Bearse et al. (2013) study choose not to seek help. The findings are encouraging because most of the psychologists in this study have used psychotherapy. However, it is important to note that Hispanic/Latinx and the other ethnic group used therapy far less than those in the European American and Asian Pacific Islander ethnic group. More investigation is needed to understand why and to discover appropriate measures to improve this.

Conclusion

While variables were significantly associated with the decision to seek help and participate in therapy courses, not enough variance has been accounted for with the variables chosen for this study. Other variables may influence psychologists' help-seeking during their professional careers. These variables may lie in their personal history and have more to do with work-life balance (Martin. 2010).

The news is encouraging. According to the participants in this study, more psychologists use psychotherapy as a personal management tool during their careers. More work is needed to assess why Hispanic/ Latinx and other ethnic groups do not use psychotherapy at rates similar to participants from the European American and Asian/ Pacific Islander ethnic groups.

It is important to note that Hispanic/ Latinx and other ethnic groups had usage ranges that were close in percentage and about 20% less than European American and

Asian/ Pacific Islander ethnic groups. The Hispanic/ Latinx and other ethnic groups' rates for help seeking among psychologists is still more than double rates in the general population (Bike, Norcross & Schatz, 2009) that is promising. The European American and Asian/ Pacific Islander ethnic groups' use of psychotherapy was very close to the findings in the Bearse et al. (2013) study at 83.1% and 85.7%, respectively. The results of this study support the findings regarding ethnic diversity as expanding in the field of psychology. The diversity that now exists is large enough to allow statistical comparison of differences in help seeking behavior among psychologists and limit the scope of self–care to the breadth of their professional experience. With a much larger number of participants and time research, it will reveal much more about the self-care habits among psychologists and where their ethnic group similarities and differences lie.

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Appendix A: Invitation

Hello,

I am Lisa Paliotta, a Ph. D. Clinical Psychology student at Walden University and I am inviting you to participate in an online research study. This research examines gender and ethnic differences among licensed practicing psychologists in their experience of professional stressors (e.g., burnout) and barriers (e.g. financial, geographic) to accessing psychotherapy for personal use when they feel it could be beneficial. My intent is to replicate and expand on the 2013 Bearse Study by including a more diverse sample to better understand ethnic and racial differences in help-seeking among psychologists.

This is an anonymous survey. If you would like to participate, please click on this link, which will introduce the survey and provide the details of the Informed Consent process. At this time, or anytime during the research, you may opt out without any concern for personal or professional disclosure.

LINK TO SURVEY: (to be arranged)

Please feel free to email me (lisa.paliotta@xxxx.xxxx) or my dissertation chair (xxxx.xxxx@xxxx.xxxx) if you have any questions.

IRB Approval #: 08-29-17-0067560

IRB@xxxx.xxxx

Appendix B: ProQOL

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

1. I am happy.

2. I am preoccupied with more than one person I [help].

3. I get satisfaction from being able to [help] people.

4. I feel connected to others.

5. I jump or am startled by unexpected sounds.

6. I feel invigorated after working with those I [help].

7. I find it difficult to separate my personal life from my life as a [helper].

8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].

9. I think that I might have been affected by the traumatic stress of those I [help].

10. I feel trapped by my job as a [helper].

11. Because of my [helping], I have felt "on edge" about various things.

12. I like my work as a [helper].

13. I feel depressed because of the traumatic experiences of the people I [help].

14. I feel as though I am experiencing the trauma of someone I have [helped].

15. I have beliefs that sustain me.

16. I am pleased with how I am able to keep up with [helping] techniques and protocols.

17. I am the person I always wanted to be.

18. My work makes me feel satisfied.

19. I feel worn out because of my work as a [helper].

20. I have happy thoughts and feelings about those I [help] and how I could help them.

21. I feel overwhelmed because my case [work] load seems endless.

22. I believe I can make a difference through my work.

23. I avoid certain activities or situations because they remind me of frightening experiences

of the people I [help].

24. I am proud of what I can do to [help].

25. As a result of my [helping], I have intrusive, frightening thoughts.

26. I feel "bogged down" by the system.

27. I have thoughts that I am a "success" as a [helper].

28. I can't recall important parts of my work with trauma victims.

29. I am a very caring person.

30. I am happy that I chose to do this work.

Appendix C: Revised Bearse Survey (2016)

To what degree do you feel that the following stressors have affected your ability to function as effectively as you desire as a psychologist? (1 being the least and 5 being the most)

1. Burnout 1 2 3 4 5
2. Depression 1 2 3 4 5
3. Countertransference 1 2 3 4 5
4. Vicarious Traumatization/Compassion Fatigue 1 2 3 4 5
5. Personal history/Trauma 1 2 3 4 5

To what degree have the following factors deterred you from seeking personal psychotherapy (1 being the least and 5 being the most)

1. Professional stigma 1 2 3 4 5
(might affect reputation in professional community)
2. Difficulty in admitting distress 1 2 3 4 5
3. Difficulty selecting an acceptable therapist 1 2 3 4 5
4. Lack of time 1 2 3 4 5
5. Lack of financial resources 1 2 3 4 5

1. How many courses of personal therapy have you participated in after becoming a psychologist? _____

(a course is defined as a series of sessions that occurred during a particular period/ answer may be 0 or any other number)

2. During your tenure as a psychologist how many times could you have benefited from therapy but did not seek it out? (a time is defined as a period of 2 weeks or more during which you experienced concerns, personal issues or symptoms/answer may be 0 or any other number) _____

Please provide the following information by checking the appropriate option or writing in the appropriate response:

Sex: Female ___ Male ___ Age: _____

Ethnicity:

African-American ___ Asian/Pacific Islander ___ European American ___

Hispanic/Latinx ____ American Indian ___ Other ___

Are you a licensed psychologist? Yes ___ No ___

Highest degree: PhD __ PsyD __ Other ___ Year degree was awarded:

_____

How many years have you been in practice? _____

Theoretical orientation:

Cognitive-Behavioral ___ Humanistic ___ Psychodynamic ___ Systemic ___

Other ___

Primary work location: Rural ___ Urban ___ Suburban ___

Primary work setting:

Private Practice ___ Community Mental Health ___ Medical ____

Academic ___ Government/Industry ___ Other ___

Approximate number of psychotherapy appointments per month: _____

Approximate number of psychological assessments per month: _____

Thank you for completing this questionnaire. No personal identifying information will be available to the investigators at any time. Use of this Survey authorized by Jenifer Bearse.