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Influence of Engagement in Personal Therapy on the Perceived Therapy Competence and Self-Efficacy of Therapists-in-Training

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Influence of Engagement in Personal Therapy on the Perceived Therapy Competence and
Self-Efficacy of Therapists-in-Training

by
Alayna B. Berkowitz

Presented to the Graduate and Research Committee
of Lehigh University
in Candidacy for the Degree of
Doctor of Philosophy in
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Abstract

Previous qualitative research with professionals or clinical psychology doctoral students indicates that personal therapy is a form of self-care that facilitates counseling competence. However, the benefit of personal therapy has not been examined quantitatively for trainees in APA-accredited counseling psychology doctoral programs. Additionally, nearly 40 years have passed since training directors were surveyed regarding recommendations for trainees' engagement in personal therapy (Wampler & Strupp, 1976). The current study invited all 69 APA-accredited counseling psychology programs in the United States to participate; 35 training directors (TDs) and 124 trainees participated. Although counselor self-efficacy and skills were significantly lower for beginner trainees than advanced trainees, significant differences were not found by engagement in personal therapy. Twenty-two of the 35 TDs (62.9%), but only 35 of the 124 trainees (28.2%), indicated their programs recommend that trainees engage in personal therapy. Of these 22 TDs and 35 trainees, 14 TDs and 31 trainees stated that personal therapy is recommended to all students, 18 TDs and 16 trainees indicated that personal therapy is recommended on a case-by-case basis, and 13 TDs and nine trainees indicated that personal therapy is recommended to students on remediation. TDs and trainees reported that cost (65.7%, 71.4%, respectively) and time (57.1%, 70.7%, respectively) were the most common barriers to seeking personal therapy, followed by access to care and concerns about confidentiality. Although endorsing personal therapy on a case-by-case basis is a step toward promoting self-care, moving toward the training director and faculty advocate that all trainees engage in personal therapy might better create a culture of self-care. Finally, trainees endorsed time and cost twice as much as other barriers, suggesting that training directors may need to consider how to alleviate

these barriers to trainees' engagement. The ability to find differences in counselor outcomes based on engagement in therapy may have been limited by how the categorical variable was created and by having lower than expected statistical power due to the small effect size and small sample. Additional limitations and future research directions are discussed.

Chapter I

Introduction

The American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct, Principle A: Beneficence and Nonmaleficence (2010) requires that "psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work" (p. 1). This emphasis on self-care for psychologists was seen as early as Freud (1937), who recommended that all individuals in training to become psychoanalysts should undergo their own analysis in order to uncover unconscious or repressed material that could potentially inhibit one's ability to analyze their patients. More recent work has continued to emphasize the importance of engaging in personal therapy for therapists and therapists in training to ensure that one is performing at his or her optimal level and that personal issues do not negatively influence one's professional practice (Ciclitira, Starr, Marzano, Brunswick, & Costa, 2012; J. C. Norcross, 2000). Yet, it seems that most counseling or clinical training programs do not require or even encourage personal therapy for their students, and those trainees who elect to engage in personal therapy may face barriers to seeking help that are both similar to those in the general population (e.g., stigma) and unique to therapists in training (e.g., concerns regarding confidentiality). The current investigation explores (a) whether trainees' perceptions of their therapy competence, empathy, and counselor self-efficacy vary as a function of having engaged in personal therapy and their level of training, (b) the extent to which personal therapy is recommended by graduate training programs, (c) trainees' and training directors' perceptions of barriers to trainees engaging in personal therapy.

Importance of Self-Care

Therapists are encouraged to engage in self-care given the inherent challenges of working with demanding clients and the emotional reactions that may result on the part of the therapist (e.g., increase in frustration, anger towards client; Barnett, Baker, Elman, & Schoener, 2007). This recommendation is especially prudent given recent increases in the severity of the presenting issues (i.e., a 70.6% increase in crisis concerns requiring immediate attention, a 68.0% increase in psychiatric medication issues, and a 45.7% increase in alcohol abuse) of individuals seeking services at college counseling centers (APA, 2013). Furthermore, in 2010, the National Survey of Counseling Center Directors reported that 44% of clients at college counseling centers had severe psychological problems, of which 6.3% of these clients have impairments that are so severe that they were unable to stay in school or can only stay in school with extensive psychiatric/psychological services (ACCA, 2010). Given these increases in more severe pathology concerns in college counseling centers, therapists must also be mindful of the resulting increase in the potential hazards of clinical practice, particularly vicarious traumatization (Pearlman & Mac Ian, 1995). Vicarious traumatization is operationalized as “the transformation that occurs within the therapist (or other trauma workers) as a result of empathic engagement with clients’ trauma experiences and their sequelae” (p. 558). To assist therapists in managing this additional stress, personal therapy is among the coping mechanisms suggested by Trippany, Kress, and Wilcoxon (2004).

Similarly, personal therapy has historically been implemented as part of a remediation plan for trainees who have experienced difficulty. In fact, a review article by Forrest, Elman, Gizara, and Vacha-Haase (1999) indicated that personal therapy was the

most common approach to remediating skill deficits in trainees. Additionally, qualitative interviews of 14 training directors of APA-accredited counseling psychology programs indicated that most were likely to recommend (but not mandate) personal therapy for trainees struggling with personal issues (e.g., substance use concerns) and for skill deficits (Elman & Forrest, 2004). The majority of these training directors also reported struggles around balancing issues surrounding confidentiality of their trainees in personal therapy and the program's responsibility to insure that the trainees are providing competent treatment.

Although personal therapy seems to be a common recommendation for trainees exhibiting skill deficits or experiencing personal struggles that might interfere with one's clinical work (e.g., substance addictions), Munsey (2006) found that, in a sample of graduate students, 82.8% indicated that their training program did not offer materials on self-care and stress and 63.4% reported that their training program did not promote self-care activities. Given the level of stress that therapists experience through their clinical work, it is important for practicing therapists to be mindful regarding maladaptive coping (e.g., use of alcohol or other substances) that may occur in reaction to the demands of the profession but that may impede professional competence (Barnett et al., 2007).

One of the ten self-care strategies for therapists as outlined by Norcross (2000) is personal therapy. Research suggests that therapists who engage in personal therapy have a lower risk for burnout (Grimmer & Tribe, 2001), which is defined as "feelings of depersonalization, emotional exhaustion, and a lack of feelings of satisfaction and accomplishment" (Barnett et al., 2007, p. 604). Therapists who sought personal therapy also reported personal growth and positive changes (Linley & Joseph, 2007); further, not

engaging in self-care (e.g., personal therapy) can negatively impede psychologists' ability to provide competent treatment (Barnett et al., 2007). Phillips (2011) asserts that trainees' engagement in personal therapy is important, especially while receiving clinical supervision, because the therapy experience provides a nonjudgmental space that does not have the evaluative component associated with supervision. In a study of clinical psychology doctoral students in APA-accredited programs, the reasons that they indicated for seeking personal therapy included personal growth and wanting to improve clinical practice (Holzman, Searight, & Hughes, 1996). Lastly, graduate students would consider personal therapy as a means of enhancing professional development (Farber, 2000). Thus, the literature indicates that therapists' engagement in personal therapy is an important self-care strategy that may both prevent negative outcomes (e.g., burnout) and promote positive outcomes (e.g., personal growth and competent treatment) though training programs may not actively provide materials or promote self-care strategies to trainees. Therefore, this study focuses on personal therapy rather than the other nine self-care strategies given the potential implications for a positive relationship between perceived counseling competence, counselor self-efficacy, and empathy. That is, based upon previous research (Ciclitira et al., 2012; Farber, 2000; Grimmer & Tribe, 2001; Norcross, 2010; Peebles, 1980), personal therapy may be considered an additional training tool that training programs may be recommended as another means of strengthening trainees' clinical skills and cultivating a regimen around the importance of engaging in regular self-care practices.

Personal Therapy and Professional Development

In addition to facilitating personal development and preventing burnout, engagement in personal therapy has the potential to enhance professional development. Personal therapy may aid professional development by providing therapists with a space to reflect on being in the role as the client (Grimmer & Tribe, 2001), professional growth (Farber, 2000), and increases in empathy (Norcross, 2010). As a result, the benefits of engaging in personal therapy to trainees' professional development are investigated in this study in terms of trainees' perceived counseling competence, empathy, and counselor self-efficacy.

Several studies have evaluated the link between personal therapy and perceived counseling competence. Perceived counseling competence is a self-assessment of one's clinical skills (Torres-Rivera et al., 2011). Therapists who reported engaging in therapy are better able to apply theory to practice, to use personal therapy as a role model, and to learn the "art" of therapy (Ciclitira et al., 2012, p. 140). Peebles (1980) also found that the number of hours engaged in personal therapy is positively correlated with trainees' ability to identify empathy and genuineness in therapy sessions. Finally, therapists who report seeking personal therapy have greater ability to identify countertransference (MacDevitt, 1987) and to recognize when personal therapy is needed as compared to seeking supervision (Grimmer & Tribe, 2001). Though research has consistently demonstrated the importance of psychotherapists' engagement in personal therapy, a review of the research suggests that engagement in personal therapy while a trainee also has the potential to impede clinical skills (Macran & Shapiro, 1998). However, the studies demonstrating a negative influence for engagement in personal therapy have

serious methodological issues (e.g., small sample size, observation of group means in order to draw conclusions, poor rationale for outcome assessments; Garfield & Bergin, 1971) and ethical issues (e.g., multiple relationships; McEwan & Duncan, 1993) that may have influenced the findings.

Therapists in training who seek personal therapy may also exhibit qualities (e.g., empathy, genuineness) that are vital to cultivating the therapeutic relationship with their own clients, which research consistently supports as essential to the therapeutic process (Wampold, 2001). For the purpose of this study, empathy is comprised of cognitive and emotional reactivity (Davis, 1980). Specifically, cognitive reactivity is considered one's ability to engage in perspective-taking, and emotional reactivity is one's ability to feel warmth or compassion for another person who is going through a challenging life event (Davis, 1980). Gold and Hilsenroth (2009) found that advanced graduate students from APA-clinical psychology programs who indicated receiving personal therapy were better able to cultivate the therapeutic alliance with clients and were less likely to have clients drop out of treatment prematurely as compared to trainees who had not sought personal therapy. Additionally, Coleman's (2002) survey of a sample of social work students who reported seeking personal therapy indicated a positive relationship between greater self-reported ratings of empathy and greater emphasis on the therapeutic alliance (e.g., transference).

Another potential benefit to engaging in personal therapy while a therapist is in training may be greater counselor self-efficacy. Counselor self-efficacy is defined as one's self-assessment of performing clinical abilities including one's cognitive, affective, and behavioral reactions in one's judgment of performing actions in a hypothetical

situation (Larson & Daniels, 1998). In addition, counselor self-efficacy may also be related to career trajectories (Lent, Hill, & Hoffman, 2003). Exploration of the influence of personal therapy on counselor self-efficacy may be especially important given qualitative studies that report themes of personal therapy engagement providing a modeling experience of what to do and what not to do in therapy (Ciclitira et al., 2012; Grimmer & Tribe, 2001), although to the best of our knowledge, research has yet to explore this association.

In addition, considering that some research supports that counselor self-efficacy can change with increased training and education (Larson et al., 1992), it may be important to explore the extent to which counselor self-efficacy differs based on whether a trainee has engaged in personal therapy during her or his training. Specifically, in a study of doctoral trainees conducted by Sipps, Sugden, and Faiver (1988), a significant difference in counselor self-efficacy expectations was observed between all levels of training (i.e., first, second, third, and fourth training year). That is, third year graduate trainees had significantly greater counselor self-efficacy expectations as compared to first and second year trainees. This difference might reflect greater performance accomplishments imparted through supervised clinical experience.

In addition to the literature reviewed supporting that training and education influences counselor self-efficacy, the Integrated Developmental Model of supervision also supports such a notion (Stoltenberg, 1981). Specifically, the model highlights that trainee needs differ based upon clinical experience and clarifies the needed supervisory environment for meeting a trainee's specific needs. Stoltenberg and McNeil (1997) outline three training levels that encompass three overarching domains to assess trainee

development including self and other awareness (cognitive and affective), motivation, and autonomy. According to Stoltenberg and McNeil, Level 1 trainees are highly motivated, have greater performance anxiety, and are focused on attempting to implement the new skills learned and are dependent upon the supervisor; in contrast, Level 2 trainees will have acquired knowledge, skills, and experience, but they may be overly confident in their skills and abilities. Level 3 trainees can be characterized by increasing self-awareness and are likely to understand the client's perspective with the trainees' motivation being more stable as compared to Level 2 in which motivation tends to be contingent on how well the client may be doing (Stoltenberg & McNeil, 1997). Thus, the Integrated Developmental Model provides further credence that perceived counseling competence and counselor self-efficacy are likely to differ based upon training experience (Stoltenberg, 1981; Stoltenberg & McNeil, 1997).

Thus, the first aim of this dissertation is to examine how perceived therapy competence, empathy, and counselor self-efficacy may differ for those trainees who have engaged in personal therapy as compared to those who have not. Further, the influence of whether the trainees are in the beginning or advanced stages of their studies will also be considered when examining potential differences in counselor self-efficacy (Larson et al., 1992; Sipps et al., 1988). This study goes beyond the current literature, as it is the first to operationalize trainees' engagement in personal therapy as six sessions or more and to use multivariate statistics in evaluating group differences of trainees who seeking personal therapy as compared to those who do not in terms of their perceived counseling competency, counselor self-efficacy, and empathy.

Current Graduate Training Culture Regarding Personal Therapy for Trainees

In 1976, Wampler and Strupp surveyed 69 APA-approved clinical training directors within the United States and found that the directors were opposed to mandating that students seek personal therapy. Norcross (2005) asserted that professional psychology training programs in the United States are unlikely to mandate engagement in personal therapy with the exception of psychoanalytic training institutes, which differs from the European training system that requires trainees complete 40 hours of therapy (Orlinsky, Rønnestad, Willutki, Wiseman, & Botermans, 2005). Given that most of the 800 psychologists surveyed by Pope and Tabachnick (1994) indicated that they supported requiring personal therapy as part of training programs, it seems logical to conclude that such a mandate in the United States did not exist at that time (i.e., almost 20 years ago). However, in the 37 years since Wampler and Strupp's survey, no known research study has re-examined training directors' opinions regarding recommending personal therapy for trainees or programs' requirements that trainees seek therapy. Thus, the second aim of this dissertation is to resurvey training directors of APA-accredited counseling psychology training programs to assess what the current state of recommendations is regarding personal therapy for their trainees. Further, recommendations about trainees' engagement in personal therapy may also differ based upon the theoretical orientation of the training program and will be explored in the current investigation. Given that no known research has yet to survey APA-accredited counseling psychology programs regarding recommendations of personal therapy to trainees; the current investigation considers this an exploratory research question with no specific hypothesis.

Barriers to Trainees' Engagement in Personal Therapy

Research suggests that individuals face barriers to seeking personal therapy, irrespective of being a therapist in training. For example, according to the general help-seeking literature, individuals who report greater mental health stigma (Barney, Griffiths, Jorm, & Christensen, 2006; Corrigan, 2004; Vogel, Wade, & Hackler, 2007) and greater structural/financial barriers (i.e., cost, time, and transport; Gulliver, Griffiths, & Christensen, 2010) are less likely to seek therapy. In addition to the barriers identified in the general help-seeking literature, trainee therapists may also face additional, unique barriers to seeking personal therapy. In the 1976 survey conducted by Wampler and Strupp, clinical directors cited the need for high-quality yet low-cost therapists who could be universally available to trainees. More recent research reflects barriers that therapists in training may encounter in seeking personal therapy include being limited in time, money, quality care (e.g., qualified therapists), and potential concerns regarding confidentiality (Brimstone, Thistlethwaite, & Quirk, 2007; Dearing, Maddux, & Tangney, 2005; Farber, 2000). Specifically, therapists in training may be limited in terms of the locating a therapist who is competent and who is not associated or affiliated with the trainee's program of study in addition to apprehensions regarding the possibility of having to work with the therapist in a professional capacity in the future.

Additionally, the culture of the specific training program may prove to be a barrier to help-seeking. Depending on the values of their particular program, therapists in training may perceive stigma regarding engaging in personal therapy or they may feel a need to be self-sufficient (i.e., competent in dealing with personal problems), both of which would decrease the likelihood of trainees seeking personal therapy (Farber, 2000).

Although the training directors surveyed by Wampler and Strupp (1976) opposed mandating therapy for their students because they did not want students to feel coerced into seeking personal therapy, the researchers stated that, by not mandating or endorsing personal therapy, training programs may inadvertently imply to students that seeking personal therapy indicates poor psychological health. Therapists in training who believe their faculty has supportive views towards personal therapy generally hold more positive attitudes toward personal therapy and an increased belief in the importance of therapy to training (Dearing et al., 2005). Research suggests that academics (i.e., professors, researchers) are less likely to engage in personal therapy as compared to clinical practitioners (Norcross, Bike, & Evans, 2009). This finding is particularly alarming given that academics (e.g., professors within the program) and training directors exert a substantial impact on graduate student attitudes towards personal therapy and serve as models through personal interaction setting standards for training requirements (i.e., importance for seeking personal therapy). Thus, the third aim of this dissertation is to examine perceptions of barriers to help-seeking that might be experienced by therapists in training from the perspective of (a) training directors and (b) trainees. Trainees will specifically be asked about perceived barriers for themselves and for fellow trainees in their program.

Research Questions and Hypotheses

Given the recent move toward cultivating a culture that values self-care within the psychology profession (Barnett et al., 2007), it is important to explore the extent to which graduate programs emphasize self-care specifically through the use of personal therapy, barriers to personal therapy engagement by graduate trainees, and the influence of

engagement in personal therapy on therapy competence for graduate trainees. Research has yet to explore either trainees' perceptions of program support for seeking personal therapy or differences between trainees who seek personal therapy and those who do not in terms of therapist competency outcomes (e.g., empathy, counselor self-efficacy, and perceived counseling skills). Additionally, the majority of the research reviewed used either professional samples or clinical doctoral students. To address this research gap, the current study will sample counseling psychology doctoral trainees. Thus, the current study aims to examine the following three research questions:

1. Do perceived therapy competence outcomes, empathy, and counselor self-efficacy differ for trainees who have engaged in personal therapy as compared to those who have not? Further, do these differences vary by training level (i.e., beginner or advanced)?
 - Trainees who seek personal therapy are hypothesized to have significantly greater perceived competency skills, perceived empathy, and counselor self-efficacy than trainees who have not sought personal therapy, but this difference will be moderated by level of experience, with those considered to be advanced having a smaller difference in competency skills and counselor self-efficacy than beginning therapists.

2. What is the current state of recommendations regarding personal therapy for trainees in APA-accredited counseling psychology doctoral programs?
 - Because there has yet to be a survey of APA-accredited counseling psychology programs regarding personal therapy recommendations to

trainees, this question is considered exploratory, with no specific hypothesis made.

3. What are training directors' and trainees' perceptions of the barriers to help-seeking that might be experienced by therapists in training?
 - It is hypothesized that training directors will cite time and cost as barriers to their program's trainees seeking personal therapy.
 - It is hypothesized that trainees will report time, cost, and issues surrounding confidentiality as barriers to seeking personal therapy both for themselves as individuals and for trainees in their program.

Chapter II

Review of the Literature

“Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work”, as recommended by the American Psychological Association’s (APA) Ethical Principles of Psychologists and Code of Conduct, Principle A: Beneficence and Nonmaleficence (2010, p. 1). Freud (1937) emphasized self-care among psychologists, insisting that therapists in training undergo their own psychoanalysis so that trainees could work to uncover unconscious or repressed materials that could inhibit their clinical work with patients. More recently, Ciclitira and colleagues (2012) proclaimed that use of personal therapy amongst therapists is important for the development of therapists’ clinical skills, and Norcross (2000) insisted that personal therapy is critical for its personal and professional benefits, particularly given the stress associated with clinical work. In spite of the importance of personal therapy for therapists and therapists-in-training, it seems that training programs in the United States do not require or even encourage their trainees to engage in personal therapy. Further, trainees who do elect to seek personal therapy may experience barriers similar to those experienced by the general population (e.g., stigma, desire to be self-sufficient) as well as issues that are unique to therapists in training (e.g., concerns about confidentiality, time, and cost). This dissertation seeks to explore the use of personal therapy among trainees and the extent to which use of personal therapy is supported by training programs, perceptions of barriers to trainees seeking personal therapy, and the influence of personal therapy on trainee clinical ability (i.e., counselor self-efficacy, self-reported empathy, and perceived counseling competence).

Importance of Self-Care

Understanding the need for therapists to engage in self-care requires both an awareness of the inherent challenges of working with demanding clients and the emotional reactions that may result on the part of the therapist (e.g., increase in frustration, anger towards client) and a mindfulness regarding maladaptive coping (e.g., use of alcohol or other substances) that may impede professional competence (Barnett et al., 2007). This is especially prudent given the increase in severity of those seeking services at college counseling centers (APA, 2013). Specifically there is a 70.6% increase in crisis concerns requiring immediate attention, 68% increase in psychiatric medication issues, and a 45.7% increase in alcohol abuse concerns of individuals seeking services at college counseling centers (ACCA, 2010). Furthermore, in 2010, the National Survey of Counseling Center Directors reported that a 44% of their clients presenting at the college counseling center with severe psychological problems of which 6.3% of these clients had impairments that were so severe that they were unable to stay at school or can only stay at school with extensive psychiatric/psychological services (ACCA, 2010).

Specifically, in a study comprised of trauma therapists, those who were new to trauma work reported greater psychological challenges (Pearlman & Mac Ian, 1995). Therapist who reported a personal trauma history showed more effects that are negative from the trauma work as compared to therapists without a personal trauma history. Interestingly, therapists who reported talking about their trauma work in personal therapy and had a personal trauma history were significantly related to general difficulties and trauma-specific difficulties. Of important note is that this study used one item to assess use of personal therapy (“Have you ever addressed the effects of your trauma work in

your own personal therapy?” p. 560) and the extent to which the impact of personal therapy was not assessed. Personal therapy is among some of the coping mechanisms suggested by Trippany et al. (2004) to deal with vicarious trauma.

In addition to using personal therapy as a means of addressing the challenging aspects of clinical work, personal therapy has also been included as part of remediation plans for trainees who are personally struggling (e.g., substance use) and for skill deficits. A review conducted by Forrest et al. (1999) indicated that personal therapy was among the most common approach to remediating skill deficits in clinical trainees. Interestingly, in a qualitative interviews of 14 training directors of APA-accredited counseling programs, participants reported that they were likely to recommend personal therapy though not mandate personal therapy for trainees who were personally struggling and for skill deficits (Elman & Forrest, 2004). The majority of the training directors indicated struggling with balancing issues surrounding confidentiality of the trainees’ personal therapy and the program’s responsibility to insure quality treatment (Elman & Forest). However, Elman and Forrest indicate that training directors dealing with high risk situations in which dangerous or unethical behavior was a concern 5 training directors described 7 cases in which program required personal therapy as part of the remediation plan. Thus, it seems important that the training program determine the extent to which personal therapy will be implemented as the training directors in the aforementioned study predominantly seemed to take a hands off approach by recommending personal therapy and in rare cases mandating it when a trainee’s behavior was so egregious, potentially causing clients harm.

Norcross (2000) outlined ten self-care strategies recommended to clinicians: (1) recognize the hazards of psychological practice, (2) think strategies, as opposed to techniques or methods (e.g., exercise, peer support groups or clinical supervision for helping relationships), (3) begin with self-awareness and self-liberation (i.e., monitor one's level of distress; receptive to feedback regarding one's functioning), (4) embrace multiple strategies traditionally associated with diverse theoretical orientations (i.e., ability to utilize a variety of self-care skills), (5) employ stimulus control and counter-conditioning when possible (e.g., make the office environment fit one's needs), (6) emphasize the human element (i.e., utilize social supports – peer groups), (7) seek personal therapy, (8) avoid wishful thinking and self-blame, (9) diversify professional activities (e.g., engagement in psychotherapy, assessment, and research), and lastly, (10) appreciate the rewards (i.e., recognize the privileges inherent in the work).

With research emerging on the benefits of utilizing such self-care strategies, understanding the implications for therapy outcomes is important. For example, research suggests that therapists who engage in personal therapy may have a lower risk for burnout (Grimmer & Tribe, 2001), which is defined as “feelings of depersonalization, emotional exhaustion, and a lack of feelings of satisfaction and accomplishment, and it may result from prolonged work with emotionally challenging clients” (Barnett et al., 2007, p. 604). Further, not engaging in self-care (e.g., personal therapy) can negatively impede psychologists' ability to provide competent treatment (Barnett et al., 2007). Finally, therapists who reported seeking personal therapy reported personal growth and positive changes (Linley & Joseph, 2007). Thus, the literature indicates that engagement

in personal therapy may both prevent negative outcomes (e.g., burnout) and promote positive outcomes (e.g., competent treatment and personal growth).

Personal therapy is one type of self-care (Norcross, 2000) that research indicates has personal benefits as well as professional benefits. Specifically, engagement in personal therapy can increase empathy for clients and facilitate therapist understanding of what it is like to be vulnerable with a stranger (A. E. Norcross, 2010). Grimmer and Tribe's (2001) qualitative study of seven counseling psychology trainees who engaged in personal therapy found four themes including reflection of being in the role as the client, socialization experiences, support for the emerging professional, and interactions between personal and professional development. Similarly, in an exploratory survey of clinical doctoral students in APA-accredited programs, the reasons for seeking personal therapy that were reported included personal growth and desire to improve clinical practice (Holzman, Searight, & Hughes, 1996). Moreover, with the academic demands upon trainees, personal therapy may serve as a "buffer, container, and support system" for which trainees may benefit from especially in while in supervision, as personal therapy would provide a nonjudgmental space that does not have an evaluative component as does supervision (Phillips, 2011, p. 156). Finally, a sample of 36 graduate students in a pre-practicum class in counseling indicated that they would consider seeking personal therapy as a means of enhancing professional development (Farber, 2000). Thus, it is likely that trainees who engage in personal therapy would benefit professionally, consequently influencing their competence as a therapist.

Personal Therapy and Professional Development

Research suggests those therapists who seek personal therapy may procure professional benefits that facilitate their professional competence. These professional benefits include the ability to identify countertransference (MacDevitt, 1987) and to recognize the need for personal therapy as compared to the need for supervision (Grimmer & Tribe, 2001) as well as better clinical skills (i.e., empathy and genuineness; Peebles, 1980). Additionally, a common theme of reflectivity about the role of the client and the influence of personal therapy on professional practice seems to exist across the various qualitative studies conducted in this research area (Grimmer & Tribe, 2001; Macran, Stiles, & Smith, 1999; Murphy, 2005; Wiseman & Shefler, 2001). Given Wigg, Cushway, and Neal's (2011) assertion that training programs are attempting to produce clinicians who are reflective, it seems that research investigating the use of personal therapy on such qualities in trainees is needed. Though research has explored the use of personal therapy, Macran and Shapiro's (1998) comprehensive review of the literature indicated that the existing research has some serious methodological issues (e.g., lack of a comparison group of individuals who have not sought personal therapy). In light of the research supporting the utility of engaging in personal therapy, the current investigation seeks to explore differences in trainees' perceived counseling competence, empathy, and counselor self-efficacy based on having engaged in personal therapy or not.

Common themes among the literature include that personal therapy afforded the participants an opportunity to reflect on themselves as a professional counselor, modeling experience of the role as the client, and learning how to conduct therapy (Ciclitira et al., 2012; Grimmer & Tribe, 2001; Macran et al., 1999; Murphy, 2005; Oteiza, 2010; Rake &

Paley, 2009). Of important note, all the studies reviewed employed qualitative methodology, and the samples were from Europe where trainees are required to seek 40 hours of personal therapy per European training requirements. Further, none of these research studies used a control group (i.e., trainees who have not sought personal therapy) to which comparisons could be made.

The following research focused on reflecting on use of personal therapy as a means of reflecting on the clinical work and as the role of the client. Specifically, in a qualitative study of female counselors from the U.K. (Ciclitira et al., 2012) and in a survey study of practicing clinical psychologists from the U.K. (Nel, Pezzolesi, & Stott, 2012), personal therapy was considered imperative for their professional development as therapists (Nel et al., 2012) and for dealing with personal issues (Ciclitira et al., 2012). Specific sub-themes within professional development that emerged from the interviews in the Ciclitira et al. study included the ability to apply theory to practice, utilizing his/her therapist as a role model, and the “art” of therapy (p. 140). Similar to the finding of Ciclitira and colleagues, in a study comprised of a trainee sample, four themes emerged from the interviews including reflection of being in the role as the client, socialization experiences, support for the emerging professional, and interactions between personal and professional development (Grimmer & Tribe, 2001). These research studies point to the utility of using personal therapy to acclimate professionals and trainees to the profession of practicing therapy. Additionally, engagement in personal therapy allowed greater insight into being the client, perhaps gaining greater reflexivity, of which Wigg et al. (2011) asserts is important to trainee development.

A common theme also arises with practicing therapists indicating that personal therapy can be used as a model, in which they are able to gain enhancement of using the third ear allowing them to better attend to the process domain between themselves and their clients, thereby influencing how they conduct therapy. For example, qualitative interviews conducted with a sample of practicing therapists from the U.K. who were either currently in personal therapy or had previously been in personal therapy indicated that 12 themes emerged that fit within three domains: orienting to the therapist (humanity, power, boundaries), orienting to the client (trust, respect, patience), and listening with a third ear (Macran et al., 1999). Moreover, in a sample of practicing therapists who sought personal therapy, three master themes emerged including learning how to do therapy (therapist as a model), know oneself better, dissolving process (unhelpful remarks the therapist made; Rake & Paley, 2009). Though participants in the Rake and Paley's study at one point had to have engaged in personal therapy, the general agreement among the participants was that personal therapy was an important part to their training as a therapist. Overall, the studies reviewed suggest that engagement in personal therapy allows trainees to apply theory to practice, gain insight into the role as a client and therapist, and use the therapist as a model (Ciclitira et al., 2012; Grimmer & Tribe, 2001; Macran et al., 1999; Rake & Paley, 2009).

Although studies have explored the use of personal therapy amongst trainees as well as practicing psychologists, the gains across professional development are evident. In a qualitative study of master's counseling trainees ($N = 5$) who were mandated to seek personal therapy per training requirement, nine categories emerged that fit within four phases (Murphy, 2005) --- reflexivity phase (i.e., personal experiences influence the

counseling process), growth phase (i.e., development of empathy), authentication phase (i.e., validation of counseling field and that therapy is an effective psychological intervention), and prolongation phase (i.e., participants indicated the belief in long-term therapy after the 40 hour requirement). In a sample of 10 professionals practicing in Spain, six main themes emerged from the qualitative interviews, four of which pertain to the current investigation (Oteiza, 2010). The four themes were difference in expectations or reasons for seeking personal therapy (e.g., exploration of therapists' internal experiences), experiences of personal therapy (more awareness of personal issues), contributions of personal therapy to the therapists' professional development (e.g., therapist as a model, feeling better, increasing knowledge, professional support), and contributions of personal therapy to therapists' affective development (i.e., qualities of personal therapist that made the therapy process meaningful). Interestingly, it seems that during and after graduate training, personal therapy is perceived as important for professional development as personal therapy offers professionals and trainees an opportunity reflect upon how personal experiences might influence the ways in which they conduct therapy (Murphy, 2005; Oteiza, 2010). In contrast, trainees sought personal therapy for validation (Murphy, 2005) while professionals, perhaps having moved beyond needing professional validation, indicated they had considered what factors in the therapist contributes to the meaning of the therapy process (Oteiza, 2010).

Research supports that empathy is important in nurturing the therapeutic relationship and is an essential aspect to the therapeutic process, regardless of theoretical orientation (Wampold, 2001). Gold and Hilsenroth (2009) found that graduate students who received personal therapy were better able to cultivate a therapeutic alliance with

their own clients and were less likely to have clients prematurely drop out of treatment as compared to trainees who did not seek personal therapy. Similarly, in a sample of social work students and practicing clinicians who reported seeking personal therapy, a relationship was found between greater emphasis on the therapeutic relationship (i.e., transference and working through emotional issues) and greater self-reported ratings of empathy and warmth (Coleman, 2002). Additionally, Peebles (1980) found that, in a sample of advanced clinical psychology doctoral students, the number of hours participants indicated seeking personal therapy was positively related to empathy and genuineness in therapy sessions (Peebles, 1980). Peebles's study supports the previously reviewed research that therapists use of personal therapy increases factors imperative for cultivation of the therapeutic relationship. Based upon the literature reviewed, therapists in training who seek personal therapy may exhibit characteristics that are fundamental to the nurturing of the therapeutic alliance. To date, research on engagement in personal therapy and empathy seems to be based upon clinical students. Research has yet to explore engagement in personal therapy in a sample of counseling psychology doctoral students. For the purpose of this dissertation, empathy is comprised of cognitive and emotional reactivity (Davis, 1980). In particular, cognitive reactivity is one's ability to engage in perspective-taking, and emotional reactivity is one's ability to feel compassion and warmth for another individual who is experiencing a challenging event (Davis, 1980).

In addition to clinical skills (i.e., empathy and genuineness), research suggests that therapists who seek personal therapy have greater countertransference awareness. For example, in a sample of doctoral-level psychologists with an average of 16 years of

experience, those who reported seeking personal therapy were more apt to identify countertransference in 25 hypothetical vignettes with five possible answer choices depicting an impasse with a client (MacDevitt, 1987). Moreover, the association was stronger for therapists who reported seeking psychoanalytic personal therapy. To the best of our knowledge, this is the only study evaluating the relationship between doctoral-level psychologists seeking personal therapy and countertransference awareness, pointing to the need of research evaluating countertransference awareness in a trainee sample. Research evaluating the relationship between trainees who seek personal therapy and countertransference awareness may provide additional evidence to encourage trainees to seek personal therapy. Potentially, trainees who engage in personal therapy may incur personal awareness, thus have greater ability to identify countertransference issues. Additionally, trainees who seek personal therapy may have greater ability to realize when personal therapy or supervision may be needed (Grimmer & Tribe, 2001) as compared to trainees who have not engaged in personal therapy.

Beyond the study conducted by MacDevitt (1987), only Strupp (1955, 1958) appears to have utilized a quantitative design that employed a comparison group of therapists who had not engaged in personal therapy. An analyzed group comprised of 41 participants (25 psychiatrists, 7 psychologists, and 9 psychiatric social workers; Strupp, 1955) were compared to a non-analyzed group comprised of a total of 23 participants (16 psychiatrists, 2 psychologists, and 5 psychiatric social workers). Data were not reported for the length of personal analysis clinicians in the analyzed group had undergone though Strupp asserted that “it is safe to assume that for the most part it has been fairly extensive – certainly beyond one year” (p. 199). Participants were provided with 27 cards

containing short vignettes of patient statements taken from therapeutic interviews. Results suggested that the analyzed participants tend to be more verbally active (i.e., had a significantly smaller amount of silent responses) than the non-analyzed participants. In response to transference phenomena, analyzed therapists tend to use interpretations, silence, and structuring responses, which is consistent with the literature recommendations (Greenberg & Staller, 1981) though the results from the unanalyzed group are inconclusive, given the varying responses.

The second study conducted by Strupp (1958) utilized four groups: analyzed psychiatrists ($N = 32$), analyzed psychologists ($N = 32$), non-analyzed psychiatrists ($N = 23$), and non-analyzed psychologists ($N = 23$). Results indicated that analyzed psychiatrists differed significantly in using larger numbers of silent responses rather than exploratory questions in the initial interview as compared to non-analyzed psychiatrists. Additionally, compared to the analyzed psychiatrists and psychologists, psychiatrists tended to use more silent responses and exploratory questions as compared to psychologists. Psychologists consistently demonstrated more use of reflection of feelings.

Strupp's (1955, 1958) studies indicate that personal analysis may influence therapists' verbal responses. However, one contradiction seems to be that analyzed psychiatrists (Strupp, 1958) use more silences while the grouping of analyzed psychologists, psychologists, and social workers (Strupp, 1955) are more active. Though Macran and Shapiro (1998) note the contradiction, it is important to consider that the comparisons between the studies as the participants differ in terms of training (i.e., psychiatrists, psychologists, and social workers; Strupp, 1955) and psychiatrists (Strupp,

1958). Additionally, different methodology was employed, and the comparisons between personal therapy was based upon analysis (i.e., psychoanalysis), which may not translate to current trainees experience as therapists may not identify with only one theoretical orientation but pull from multiple orientations (eclectic, integrationist). Clearly, research in this area is lacking such that a call for research exploring current trainee use of personal therapy as compared to trainees who do not seek personal therapy on the perceived counseling competence is needed. Training programs may be able to use such evidence in advocating for use of personal therapy while in graduate school.

Negative Outcomes of Therapists' Engagement in Personal Therapy. Though positive relationships between engagement in personal therapy and therapy outcomes have been established within the literature, Macran and Shapiro (1998) point out that therapists in training who seek personal therapy may also have their therapeutic skills suffer, potentially because of conflicts or personal issues in their own therapy preoccupying the trainees. In addition, other research suggests that trainees engaged in therapy may seek personal therapy because they are experiencing issues with clinical skills (Garfield & Bergin, 1971; McEwan & Duncan, 1993). Thus, it is important to evaluate both the positive and the potentially negative outcomes of trainees' engagement in personal therapy as well as reasons for seeking personal therapy.

When considering some of the literature that points to a negative relationship between trainees' engagement in personal therapy and issues with their clinical skills, several methodological and ethical issues (e.g., multiple relationships) seem relevant. Specifically, students who were mandated to seek personal therapy from a faculty member within the training program may have experienced issues with multiple

relationships (McEwan & Duncan, 1993). According to APA (2010), multiple relationships should be deterred unless such a relationship is unavoidable. Additionally, methodological issues (e.g., small sample size, observation of group means in order to draw conclusions rather than conducting a statistical test, poor rationale for outcome assessments) are an issue when interpreting the findings from Garfield and Bergin (1971). Thus, based upon the literature reviewed, the dubious methodology may have influenced the negative findings of personal therapy.

Counselor self-efficacy. On a related note, one of the possible benefits of trainees who engage in personal therapy may also be greater counselor self-efficacy. Counselor self-efficacy (CSE) is defined by Larson and Daniels (1998) as a counselor's "beliefs or judgments about his or her capabilities to effectively counsel a client in the near future" (p. 180). CSE is thought to influence the counselor's response, effort, and persistence in times of failure. In a study of doctoral trainees, a significant difference in CSE expectations was observed between all levels of training (i.e., first, second, third, and fourth training year; Sipps et al., 1988). Specifically, third year graduate trainees had significantly greater CSE expectations as compared to first and second year trainees, potentially reflecting greater performance accomplishments imparted through supervised clinical experience. Interestingly, Sipps et al. also found that first-year trainees reported greater CSE expectations as compared to second-year trainees and that second year trainees had lower levels of efficacy than students in each of the other three levels. Sipps et al. suggest that second-year trainees may have lower CSE expectations because of the "perceived failure of the common sense approach in the 2nd-year students' early attempts at counseling" (p. 399) and that third- and fourth- year trainee groups had the highest

levels of CSE expectation because of the performance accomplishments under supervision. Based on the research that suggests that CSE is mildly positively related to clinical performance (Larson et al., 1992), it seems important to explore whether CSE differs based upon trainee engagement in personal therapy during his or her training. Additionally, given that qualitative studies support trainees' engagement in personal therapy as the experience serves as a model or a socializing experience for what to do (Ciclitira et al., 2012; Grimmer & Tribe, 2001; Murphy, 2005) and what not to do (Rake & Paley, 2009), it is likely that trainees who engage in personal therapy are able to extrapolate what is learned in personal therapy and either replicate or not integrate into their own clinical work.

In addition to the literature reviewed supporting that training and education influences counselor self-efficacy, the Integrated Developmental Model of supervision also supports such a notion (Stoltenberg, 1981). This model underscores that each trainee has specific needs that differ based upon clinical experience and describes the optimal supervisory environment for meeting these needs. Stoltenberg and McNeil (1997) outline three training levels and use three overarching domains to assess trainee development including motivation, autonomy, self and other awareness (cognitive and affective). Stoltenberg and McNeil indicate that Level 1 trainees are motivated and have greater performance anxiety because the clinical work is novel, thus they tend to focus on attempting to implement new skills they have learned and are dependent upon the supervisor. In contrast, Level 2 trainees have acquired knowledge, skills, and experience, although they tend to be overly confident with their newly acquired skills and abilities. This description from the Integrated Developmental Model (Stoltenberg & McNeil,

1997) partially supports the findings from the Sippes et al. (1988) study in which counselor self-efficacy was higher in the first year graduate student group and was lower in the second year group indicating that there may be an inflation of confidence in the first year student group. Level 2 trainees are focused on the client and integrating the affective as well as cognitive components to better understanding the client's perspective, which can create confusion for the trainees given that the previous skills now seem inadequate (Stoltenberg & McNeil, 1997). As a result, motivation can decrease during this stage given that the clinical work can be challenging and can feel ambiguous. Lastly, according to Stoltenberg and McNeil, trainees who are self-aware and are able to understand the client's perspective characterize Level 3. Additionally, motivation is more stable with fewer peaks and valleys as compared to Level 2 trainees in which motivation is often contingent upon how well the client is doing.

Of important note according to the Integrated Developmental Model, the level of the trainee can vary depending on the presenting concern (Stoltenberg & McNeil, 1997). For example, a trainee may be at Level 3 when working with an individual therapy client presenting with depression and a Level 2 when working with an interpersonal psychotherapy process group. Overall, the Integrated Developmental Model provides further support that trainees' perceived counseling competence and counselor self-efficacy may differ based upon trainees' level of experience (Stoltenberg, 1981; Stoltenberg & McNeil, 1997). Thus, counselor self-efficacy likely changes as a function of clinical training.

Based upon previous literature that suggest that personal therapy may have positive benefits to one's clinical practice, the first aim of this dissertation is to assess

how perceived therapy competence outcomes (i.e., perceived therapy competence, counselor self-efficacy, empathy) may differ for trainees who engage in personal therapy as compared to trainees who have not engaged in personal therapy. Perceived counseling competence is a self-assessment of one's clinical skills (Torres-Rivera et al., 2011). To the best of our knowledge, this would be the first study to explore differences in perceived therapy competence outcomes between therapists in training who have sought therapy and trainees who have not sought personal therapy.

Current Graduate Training Culture Regarding Personal Therapy for Trainees

Psychology graduate students incur significant stress regarding academic demands, practicum trainings, and personal lives (Munsey, 2006). The movement towards emphasizing the importance of self-care in psychology graduate training programs (Smith & Moss, 2009) has yet to translate to practice. For example, in a survey of graduate students, 83.8 % of respondents indicated that their training programs did not disseminate written materials related to issues of self-care or stress and that 63.4% of respondents indicated that their training programs do not sponsor activities endorsing self-care (Munsey, 2006). The separation between best practices and the current graduate training culture is evident and should be addressed in order to insure that trainees are meeting the standards set forth by APA Ethical Principles of Psychologists and Code of Conduct (2010) and Wigg et al.'s (2011) claim that training programs are moving towards producing trainees who are reflective.

Moreover, the current recommendations from training directors for engagement in personal therapy (or self-care) are lacking within the field. To the best of our knowledge, Wampler and Strupp (1976) is the most recent survey of training directors. Specifically,

Wampler and Strupp assessed 69 APA-approved clinical training directors within the United States and found that directors did not want to mandate that students seek personal therapy. Interestingly, since this survey conducted 37 years ago, no known research has re-examined training directors' opinions regarding personal therapy. The most recent survey conducted by Pope and Tabachnick (1994) suggests that the 800 psychologists surveyed supported that personal therapy be a requirement to graduate. Thus, it seems logical to conclude that no such mandate current exists in the United States, an assertion that is echoed by Norcross (2005). In contrast, personal therapy is a requirement within the European training system, as trainees are required to complete 40 hours of personal therapy in order to graduate (Orlinsky et al., 2005).

Furthermore, researchers assert the importance of discussing self-care within psychological training programs (Schwebel & Coster, 1998; Smith & Moss, 2009) and Barnett and Cooper (2009) maintain the value of de-stigmatizing engagement of personal therapy. Barnett and Cooper argue for the need for trainees to be aware of personal vulnerabilities within graduate training programs, peer support groups to normalize the experience of training, and to engage in positive self-care strategies including personal therapy. A disconnect between the push for self-care within the practicing psychology profession and the culture within current graduate climate needs (Barnett et al., 2007) is evident, which clearly needs to be addressed. Fostering an environment of self-care while these future psychologists are still in training may lead to an internalization of the importance of such practices once practicing. Additionally, because training programs aim to create clinicians who are reflective, it is important for trainees to be able to express his/her vulnerabilities (e.g., partner discord) so that he/she can better recognize

such issues in his/her clinical practice (e.g., working with a couple going through similar partner issues) and have tools to actively address such issues (e.g., personal therapy).

Thus, the second aim of this dissertation is to resurvey training directors of APA-accredited counseling training programs to assess what the current state of recommendations is regarding personal therapy for their trainees.

Barriers to Trainees' Engagement in Personal Therapy

Though the professional benefits to seeking personal therapy are evident, trainees may experience barriers to seeking therapy while in graduate school that are both similar to the general population and unique to their situation. For example, according to the general help-seeking literature, individuals who report greater mental health stigma (Barney et al., 2006; Corrigan, 2004; Vogel et al., 2007) and greater structural/financial barriers (i.e., cost, time, and transport; Gulliver et al., 2010) are less likely to seek therapy. A unique barrier for trainees seeking personal therapy is concern about confidentiality (Brimstone et al., 2007; Farber, 2000). Thus, when exploring the potential benefits of trainees seeking personal therapy, it is important to consider assessing the relevant barriers to seeking personal therapy that are specific to trainees.

According to the general help-seeking literature, two types of mental health stigma include perceived stigma (Barney et al., 2006; Corrigan, 2004; Vogel et al., 2007) and self-stigma (Barney et al., 2006; Corrigan, 2004; Vogel et al., 2007). Perceived stigma is described as the belief that one's society or culture holds disparaging ideas (e.g., people with psychological illness are dangerous; Barney et al., 2006; Corrigan, 2004; Vogel et al., 2007). In addition to perceived stigma, self-stigma is operationalized as an individual's negative attitudes about themselves (e.g., I am incompetent) as a result

of internalizing stigma ideas held by one's culture or society (e.g., all individuals with mental illness are incompetent; Barney et al., 2006; Corrigan, 2004; Vogel et al., 2007). In a sample of college students, Vogel and colleagues (2007) found that self-stigma is negatively related to willingness to help-seek. Thus, mental health stigma (perceived stigma and self-stigma) can present barriers for the general population in help-seeking.

Stigma Specific to Trainees. In addition to the aforementioned mental health stigma, trainees may incur stigma related to their specific training program culture. Specifically, perceived stigma from the training program may decrease the likelihood of trainees seeking personal therapy. Therapists in training may perceive stigma regarding engaging in personal therapy and the need to be self-sufficient (i.e., competent in dealing with personal problems), both of which would likely reduce the likelihood that trainees will seek personal therapy (Farber, 2000). In a sample of APA clinical graduate psychology students, a significant positive relationship was found between faculty possessing favorable views of trainees seeking personal therapy and students' positive attitudes toward personal therapy as well as the trainees' belief that personal therapy was important (Dearing et al., 2005). Thus, based upon the literature surveying trainees, it is likely that faculty attitudes toward personal therapy influence trainees' perception of the importance of personal therapy.

In a sample of training directors, Wampler and Strupp (1976) found that while training directors did not want to mandate trainees to engage in personal therapy to prevent trainees feeling pressured, the researchers note that, by not endorsing the importance of personal therapy, trainees may receive a message that personal therapy is unimportant. Norcross, Bike, and Evans (2009) indicated that academics are less likely

to seek personal therapy, which may influence the messages trainees received regarding the utility of personal therapy; specifically, the messages trainees receive about engaging in personal therapy may be negative or absent regarding the efficacy of personal therapy.

Additional Barriers: Time, Cost, Access, and Confidentiality Concerns. Time and the cost of therapy may be additional barriers for trainees who wish to seek personal therapy. In Wampler and Strupp (1976), clinical directors indicated a need for high-quality services that are also low-cost in order to make personal therapy available to trainees who lack funds but who would like to engage in personal therapy. Concerns about the cost of seeking personal therapy were also raised as a significant issue in a sample of practicing clinical psychologists (Bearse, McMinn, Seegobin, & Free, 2013) and in a sample of psychology students (Brimstone et al., 2007). Moreover, research suggests that concerns regarding having the time necessary to seek personal therapy were mixed. Specifically, Bearse et al. (2013) found that younger therapists reported that time was an obstacle to seeking personal therapy. However, Dearing et al. (2005) found that time was not significantly related to help-seeking behavior in a sample of graduate student from APA-accredited clinical programs. Given these limited and mixed results, it is important to investigate in order to assess the extent to which time is an obstacle in counseling psychology doctoral students' help-seeking behavior.

Unique concerns for trainees seeking personal therapy may include finding an appropriate therapist (Bearse et al., 2013) and related confidentiality issues (Brimstone et al., 2007; Farber, 2000). To the best of our knowledge, research has yet to explore whether finding an appropriate therapist as a barrier is a concern in a trainee sample. However, Bearse et al. (2013) indicates that practicing psychologists reported that it was

challenging to find a therapist who is competent, close in distance, and with whom they did not have a dual relationship. Given the demands of their training programs, trainees may be just as limited as practicing psychologists in whom they are able to seek personal therapy from in term of competence (e.g., wanting a therapist at the doctoral level or with greater years of experience) and location (e.g., needing to be close to one's academic responsibilities). Finding a therapist may also be challenging for trainees because local psychologists may have a potential association or affiliation with the trainee's university or the trainee may perceive the possibility of needing to work with the therapist in a professional capacity in the future, for example as a practicum student in that counseling center or agency; these dual relationships raise issues of confidentiality of the information shared in therapy and may limit the choices trainees have for competent therapists.

Interestingly, in a sample of practicing therapists employed in agencies as compared to therapists in private practice, those employed in agencies reported being reluctant to seek personal therapy for reasons such as prior relationships or the potential of having to work with them in the future in a professional capacity (Deutsch, 1985).

According to Barnett and Cooper (2009), given the demands of practicing psychology, it is important to "create a culture of self-care" in which graduate program promote the use of personal therapy as a means of self-care (p. 16). Serious financial concerns (i.e., cost and time) and concerns about confidentiality to seeking personal therapy as a trainee are current barriers, though the message of the importance of self-care to insure competent practice starting in graduate school is asserted by Barnett and Cooper (2009). Further complicating the issue, training programs may not endorse the importance of personal therapy, thereby not adhering to best practices according to

Barnett and Cooper (2009). A clear mismatch seems to exist between the emphasis placed on engaging in personal therapy when adhering to best practices and the actual practicality or accessibility of such services. Thus, the third aim of this dissertation is to examine both training directors' and trainees' perceptions of the barriers to help-seeking that might be experienced by therapists in training.

Research Questions and Hypotheses

Given the recent move toward the need to cultivate a culture that values self-care within the psychology profession (Barnett et al., 2007), it is important to explore the extent to which graduate programs emphasize self-care specifically through the use of personal therapy, barriers to personal therapy engagement by graduate trainees, and the influence of engagement in personal therapy on therapy competence for graduate trainees. Research has yet to explore either trainees' perceptions of program support for seeking personal therapy or differences between trainees who seek personal therapy and those who do not in terms of therapist competency outcomes (e.g., empathy, counselor self-efficacy, and perceived counseling skills). Thus, the current study aims to examine the following three research questions:

1. Do perceived therapy competence outcomes and counselor self-efficacy differ for trainees who have engaged in personal therapy as compared to those who have not? Further, do these differences vary by training level (i.e., beginner or advanced)?
 - Trainees who have engaged in personal therapy are hypothesized to have significantly greater perceived competency skills, perceived empathy, and counselor self-efficacy than trainees who have not

sought personal therapy, but this difference will be moderated by level of experience, with those considered to be advanced having a smaller difference in competency skills and counselor self-efficacy than beginning therapists.

2. What is the current state of recommendations regarding personal therapy for trainees in APA-accredited counseling psychology doctoral programs?
 - Because there has yet to be a survey of APA-accredited counseling psychology programs regarding personal therapy recommendations to trainees, this question is considered exploratory, with no specific hypothesis made.

3. What are training directors' and trainees' perceptions of the barriers to help-seeking that might be experienced by therapists in training?
 - It is hypothesized that training directors will cite time and cost as barriers to their program's trainees seeking personal therapy.
 - It is hypothesized that trainees will report time, cost, and issues surrounding confidentiality as barriers to seeking personal therapy both for themselves as individuals and for trainees in their program.

Chapter III

Method

Participants

Because the previous research literature regarding personal therapy for trainees and professionals has predominantly focused on clinical psychology trainees or practicing psychologists, the current study focused on counseling psychology trainees and their training programs. Two samples were recruited for participation: (a) trainees who are engaged in their doctoral studies in APA-accredited counseling psychology programs in the United States and (b) the training directors of these counseling psychology doctoral programs. Trainee participants were recruited by email requests (see Appendix A) sent to the training directors of all APA-accredited counseling psychology doctoral programs to forward to their current doctoral students. In addition, all 69 training directors of APA-accredited counseling psychology doctoral programs in the United States (i.e., excluding the two programs from Canada) were solicited for participation via an email request (see Appendix A).

Trainee sample. A total of 133 trainees accessed the survey of which two consented and then did not complete the survey. For research question one, a total of 101 trainees were used for the analyses as they completed at least 80% of the items on each of the dependent measures. For research questions two and three, a total of 124 trainees were included as they completed the surveys regarding personal therapy barriers and/or personal therapy recommendations. See Figure 1 for details of the trainee dropout frequencies. The response rate (i.e., the number of potential trainees that could have been sampled) was not possible to assess given that each program has various cohort sizes.

Upon reflection, this study could have asked the training directors to indicate the total number of current trainees in their program.

Trainees ranged in age from 23 to 59 years ($M = 29.32$, $SD = 5.39$). The majority of the counseling psychology doctoral trainee sample identified as female (73.3%), heterosexual (81.2%), as well as European American/White (75.2%). Additionally, more than half the sample identified with either working class (19.8%) or lower middle class (51.5%), with 76.2% reporting an annual household income of \$49,999 or less. The sample described their parents' social class as lower middle class (30.7%) and upper middle class (51.5%). The majority of the participants identified their parents' annual household income as \$50,000 to \$99,999 (29.7%) or \$100,000 to \$149,999 (31.7%). The most endorsed theoretical orientation was integrated (27.7%), followed by interpersonal (15.8%), and eclectic (10.9%). For detailed statistics on the demographic characteristics of the sample, see Table 1.

Training director sample. A total of 38 training directors accessed the survey about program recommendations regarding personal therapy (see Appendix C), although three counseling psychology training directors dropped from the survey after consenting. Thus, a sample of 35 counseling psychology training directors (50.7%) from the 69 counseling psychology doctoral programs accredited by APA responded to the survey.

Power analysis. According to Cohen (1988), to achieve the desired power of .80, assuming an effect size of $f^2 = 0.15$ (medium effect size) with an alpha level of 0.05 for the 2 Therapy (yes/no) X 2 Training Level (Beginner/Advanced) MANOVA (with 6 dependent variables) planned to answer research question one, a minimum of 98 participants were needed. Given an expected attrition rate of 10 - 15%, the current

investigation sought to recruit at least 120 trainees. Participation rates in each of the four cells of the design were monitored during data collection, and follow-up recruitment emails were sent twice for trainee recruitment as well as for training director recruitment.

Measures

The following list of measures is listed in the order that the measures appeared in the survey that the trainees completed, with the exception of the Training Director survey, which was administered only to training directors.

Demographic questionnaire. Information about demographic characteristics of the trainee sample was collected via the questionnaire shown in Appendix B. The items were used to describe the trainee sample including reported age, self-identified gender, and reported socioeconomic status together with parents' level of education and social class. Additional items were used to describe the sample's training experiences incorporating practicum experiences, months conducting counseling, and theoretical orientation. The variable Level of Training was created from item 13 of Appendix B, in which individuals who indicated that they have had one practicum or less were considered Beginner and all others (i.e., 2 practica, 3 practica, or pre-doctoral internship) were considered Advanced. For the full demographic questionnaire, see Appendix B.

Training director perceptions of training program recommendations regarding personal therapy and barriers to trainees seeking therapy. Training directors of doctoral counseling psychology programs were emailed a link to a brief survey assessing their program's requirements regarding current personal therapy mandates for trainees and their perception of barriers to trainees' engagement in personal therapy (see Appendix C for the measure).

Trainee perceptions of training program recommendations regarding personal therapy and barriers to seeking personal therapy. Trainees in APA-accredited doctoral counseling psychology programs were surveyed regarding whether their program has a recommendation for seeking personal therapy and about barriers to seeking personal therapy (see Appendix D for the measure).

Trainees' past and current engagement in personal therapy. Trainees were asked whether they engaged in personal therapy before doctoral studies and during counseling psychology doctoral studies. Trainees who reported having engaged in personal therapy were asked further questions regarding the number of hours of therapy, the type of therapy, reasons for seeking personal therapy (mandate from program, mood concerns, stress, personal growth, other; see Appendix E for the measure), and their satisfaction with the therapeutic experience.

Counselor Self-Efficacy. The current investigation used two measures to assess counselor self-efficacy --- the Counselor Activity Self-Efficacy Scales (CASES; Lent et al., 2003) and the Counseling Self-Estimate Inventory (COSE; Larson et al., 1992). The following subsections provide a description and psychometric properties of these two measures.

Counselor Activity Self-Efficacy Scales (CASES). Lent and colleagues (2003) developed CASES, a 41-item measure of counselor self-efficacy. Each item is rated using a 10-point Likert scale with possible answer choices 0 (“no confidence”) to 9 (“complete confidence”). Item responses are summed to create a total score, with higher scores indicating greater counselor self-efficacy; possible total scores range from 0 to 369. The measure assesses six domains: insight skills (Part I items 6, 7, 8, 9, 10, 11),

explorations skills (Part I items 1, 2, 3, 4, 5), action skills (Part I items 12, 13, 14, 15), session management (Part II items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10), relationship conflict (Part III items 7, 8, 9, 10, 11, 12, 13, 14, 15, 16), and client distress (Part III items 1, 2, 3, 4, 5, 6). For the entire measure, please see Appendix F.

Lent and colleagues (2003) found that the CASES total score had strong internal consistency (Cronbach's alpha = .97) and strong test-retest reliability over a two-week period ($r = .75$), and that the CASES total score correlated highly with the Counseling Self-Estimate Inventory (COSE) total score ($r = .76$), suggesting evidence for convergent validity. The CASES is sensitive to level of experience in that trainees with greater levels of experience reported greater levels of efficacy on all domains as compared to trainees with less experience and a sample of trainees in a master's level practicum showed a significant increase between scores at the first week and scores at week 15 (Lent et al., 2003). In the current sample, Cronbach's alpha for the CASES was 0.967.

Counseling Self-Estimate Inventory (COSE). The COSE developed by Larson and colleagues (1992) is a 37-item assessment measuring perceived counselor self-efficacy. Item responses are on a Likert scale from 1 (strong disagree) to 6 (strongly agree) and are summed to create a total score. The COSE assesses five domains: microskills (items 1, 3, 4, 5, 8, 10, 11, 12, 14, 17, 32, 34), counseling process (items 6, 9, 16, 18, 19, 21, 22, 23, 31, 33), dealing with difficult client behaviors (items 15, 20, 24, 25, 26, 27, 28), culturally competent behavior (items 29, 30, 36, 37), and values (items 2, 7, 13, 35). Nineteen items are reversed scored (i.e., items 2, 6, 7, 9, 16, 18, 19, 21, 22, 23, 24, 26, 27, 28, 31, 33, 35, 36, & 37). For the entire measure, please see Appendix G.

Larson and colleagues (1992) established the psychometric properties of the COSE, finding strong internal consistency (Cronbach's alpha = .93), strong test-retest reliability ($r = .87$), and convergent validity for the scale via a moderate correlation ($r = 0.51$) with the Tennessee Self Concept Scale (TSCS; Fitts, 1965, 1988). Further, higher COSE was related to lower levels of state and trait anxiety as measured by the STAI (State-Trait Anxiety Inventory) State Anxiety scale and the STAI Trait anxiety scale (Spielberger, 1983) and were associated with greater Problem Solving Inventory scores (PSI; Heppner, 1988) that may indicate more effective problem solvers. Lastly, the COSE demonstrated sensitivity to training level as those with greater training reported greater COSE scores (Larson et al., 1992). In the current sample, Cronbach's alpha for the COSE was 0.943.

Interpersonal Reactivity Index (IRI). The IRI, developed by Davis (1980, 1983), is a 28-item assessment measuring empathy on a five-point Likert scale anchored from 1 = "Does not describe me well" to 5 = "Describes me very well". The IRI is comprised of four domains, each of which has seven items: perspective-taking (items 8, 9, 10, 11, 12, 13, 14), fantasy (items 1, 2, 3, 4, 5, 6, 7), empathic concern (items 15, 16, 17, 18, 19, 20, 21), and personal distress (items 22, 23, 24, 25, 26, 27, 28). The perspective-taking scale assesses responders' ability to adopt a point of view of other people (cognitive empathy). A sample item is "Before criticizing somebody, I try to imagine how I would feel if I were in their place". The fantasy scale assesses responders' ability to identify with fictitious character in movies, books, or plays. A sample item is "When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me." The empathic concerns scale assesses

responders' affective response in feeling warmth or compassion for others experiencing something negative. A sample item is "When I see someone being taken advantage of, I feel kind of protective toward them". The personal distress items assess responders' feelings of anxiety or distress when viewing the negative encounters of others. A sample item is "When I see someone who badly needs help in an emergency, I go to pieces". Subscale scores are calculated through summing the items in the respective domains. For the purpose of the current investigation, only empathic concerns and perspective taking were used, though the entire measure was administered to insure psychometric integrity. As previously indicated, empathic concerns and perspective taking were used in the analysis to reflect affective and cognitive components of empathy as previous studies indicated that trainees who engage in personal therapy are able to cultivate the therapeutic alliance (Gold & Hilsenroth, 2009) and greater self-reported empathy ratings (Coleman, 2002). Affective and perspective taking are both components of the therapeutic alliance which research supports as a part of the common factors. Because the IRI was developed to measure the multidimensional aspects of empathy, the fantasy scale and personal distress were not used in the current study because they do not encompass the aspects of the therapeutic alliance.

Davis (1980) assessed internal consistency for the four domains for males and females: fantasy scale (male = 0.78; females = 0.75), perspective-taking (males = 0.75; females = 0.78), empathic concern (males = 0.72; females = 0.70), and personal distress (males = 0.78; females = 0.78). Construct validity was established in a sample of undergraduate students (Bernstein & Davis, 1982; Davis, 1983) and for female clinical dietitians and dietetic interns (Carey, Fox, & Spraggins, 1988), supporting the four

dimensions of empathy established in Davis (1980). Researchers have also used this measure to assess trainee multicultural competence (Constantine, 2000, 2001; Miville et al., 2006). Specifically, in the Constantine (2000) study, a sample of randomly selected members of the American Counseling Association and those contacted through personal relationships (training directors) reported acceptable Cronbach's alphas for the IRI-PT (.70) and IRI-EC (.77) measures. Additionally, in the Constantine (2001) study, a random sample of participants who were members of the American Counseling Association ($N = 130$) demonstrated acceptable Cronbach's alpha for the IRI-PT (.72) and IRI-EC (.63). For the full measure, see Appendix H. In the current sample, Cronbach's alpha was 0.664 for IRI-empathic concerns (IRI-EC), which was lower than recommended, and was 0.733 for IRI-perspective taking (IRI-PT), which was considered to be adequate.

Perceived Counseling Competence. Perceived counseling competence was assessed using two measures --- the Counselor Skill and Personal Development Rating Form (CSPD-RF; Torres-Rivera et al., 2002; Wilbur, 1991) and the Clinical Skills Subscale -- Development of Psychotherapists Common Core Questionnaire (DPCCQ; Orlinsky & Ronnestad, 2005). The following subsections provide a description and psychometric properties of these two measures.

Counselor Skill and Personal Development Rating Form (CSPD-RF). The CSPD-RF, developed by Wilbur (1991), is a 20-item measure assessing counselor skills of trainees. The measure's original items used a 7-point Likert scale, though more recently, researchers have changed the scale to use a 6-point Likert scale so that trainees would not be able to choose a middle point, forcing trainees to choose a side (Torres-

Rivera et al., 2002). This most recent version is used for this investigation; thus, each item was rated on a 6-point Likert scale with possible answer choices 1 (“unacceptable”) to 6 (“outstanding”). Item responses are summed with a possible range from 20 to 120 to create a total score, with higher scores indicating greater perceived trainee skill. Torres-Rivera et al. (2002) reported an internal consistency as measured by Cronbach’s alpha of 0.91 and split-half reliability of 0.83 and 0.84. For the full measure, please see Appendix I. Additionally, to improve the readability of the items, the current investigation changed the text of each item from third person to first person. Reliability for the first person version of the measure used in the current sample was calculated as Cronbach’s alpha of 0.913.

Clinical Skills Subscale -- Development of Psychotherapists Common Core Questionnaire (DPCCQ). The original DPCCQ measure was created to survey psychotherapists in how they develop as therapists and includes several scales, including the Work Involvement Scale (Orlinsky & Ronnestad, 2005), which assesses two domains: (a) Healing Involvement and (b) Stressful Involvement. The current investigation used only the Clinical Skills subscale from the Healing Involvement domain. The most recent version of the survey was obtained from its first author (D. Orlinsky, personal communication, June 26, 2013). The Clinical Skills subscale is comprised of 12 items, as shown in Appendix J, and each item uses a 5-point Likert scale with possible answer choices: 1 “not at all,” 2 “slightly,” 3 “moderately,” 4 “much,” or 5 “very much.” The Healing Involvement domain assesses the extent to which therapists are able to affirm clients, communicate such understanding, invest in the clinical work, and feel a sense of “flow” (Nissen-Lie, Monsen, & Ronnestad, 2010, p. 630); the clinical

skills subscale of this domain assesses clinicians' perceptions of their ability to engage in skills needed to be a competent clinician. In a sample of 3,795 international psychotherapists, an earlier version of the Clinical Skills subscale demonstrated good reliability (Cronbach's alpha = 0.87; Orlinsky et al., 1999); however, it should be noted that the current version of the items (received from the first author of the scale) has been modified since that publication. In a sample of German trainees from various institutes (Psychoanalytic, Cognitive-Behavioral, and Psychodynamic therapy), the entire Healing Involvement domain (25 items total, 12 of which comprise the clinical skills subscale items) had acceptable internal consistency at time one (Cronbach's alpha = 0.74) and good internal consistency at time two, three years later (Cronbach's alpha = 0.81; Taubner, Zimmermann, Kachele, Moller, & Sell, 2013). No estimates of internal consistency with trainees for only the current version of Clinical Skills subscale were identified in the literature, but in the current sample, Cronbach's alpha for the Clinical Skills subscale was 0.92.

Procedure

Following Institutional Review Board (IRB) approval, emails were sent to training directors of APA-accredited doctoral counseling programs (Ph.D.), extending an opportunity to complete a brief survey. Training directors were also asked to forward another message to their trainees inviting them to participate in an online survey about trainees' engagement in personal therapy and program support for engagement in personal therapy. Additionally, trainees were asked demographic items, surveyed regarding engagement in personal therapy, and completed counselor outcome and self-efficacy measures (order of the measures was as follows: Appendix B Demographic

form, Appendix D Trainee Perceptions of Training Program Recommendations for Personal Therapy and Barriers to Seeking Personal Therapy, Appendix E Trainees' Past and Current Engagement in Personal Therapy, Appendix F CASES, Appendix G COSE, Appendix H IRI, Appendix I CSPD-RD, and Appendix J Work Involvement – Clinical skills subscale).

Analysis Plan

For the first research question, a 2 (yes/no engagement in personal therapy) x 2 (beginning/advanced trainee) multivariate analysis of variance (MANOVA) was conducted to examine the differences in a set of six dependent variables (COSE, CASES, IRI empathic concerns, IRI perspective taking, CSPD-RF, Clinical Skills subscale from the DPCCQ) as a function of two independent variables: seeking personal therapy while in graduate school (yes/no) and level of training (beginner or advanced). Two observed measures were used in this study for each of the three dependent variable constructs (i.e., perceived counselor competence, counselor self-efficacy, and empathy) to increase the quality of measurement of the underlying construct (Schumacker & Lomax, 2010), to “obtain a more complete and detailed description of the phenomenon under investigation” (Stevens, 2009, p. 145), and to reduce the threat to construct validity of mono-operation bias (Heppner, Wampold, & Kivlighan, 2008). Hours of personal therapy prior to graduate school was significantly, but modestly, correlated with only one of the dependent measures (IRI-PT $r = 0.28$, $p = .021$) and thus was not included as a covariate. Similarly, hours of personal therapy prior to graduate school was not included as a covariate as it was not significantly correlated with any of the dependent measures (COSE $r = 0.049$, $p = .693$; CASES $r = .111$, $p = .371$; IRI-EC $r = 0.081$, $p = .515$;

CSPD_RF $r = .198, p = .108$; Clinskillsum $r = .179, p = .147$). Prior to analysis, data were checked for multivariate normality; specifically, skewness and kurtosis values were inspected to ensure they fell within the recommended values of -2.0 and +2.0 (Lomax, 2001), normal probability plots were examined for the expected straight line pattern, and scatterplots were expected to demonstrate an elliptical shape (Stevens, 2009). In addition, the assumption of homogeneity of covariance matrices was checked by inspecting Box's Test (Stevens, 2009). In the event that the MANOVA is significant, it was planned *a priori* that univariate *F*-tests would be examined.

For the second and third research questions, descriptive analysis was conducted to assess the extent to which the counseling psychology program training directors recommend personal therapy for trainees in their programs and barriers that trainees may experience in seeking personal therapy. Additionally, a descriptive analysis was similarly conducted for trainees' perceptions of program recommendations regarding seeking personal therapy and barriers to seeking personal therapy.

Chapter IV

Results

Descriptive statistics for trainee engagement in therapy

In response to item one in Appendix E regarding whether trainees had engaged in therapy while in doctoral study, 40.6% ($n = 54$) of the sample of 124 trainees used in this study responded yes, and 52.6% ($n = 70$) responded no. Trainees were also asked if they engaged in personal therapy prior to their doctoral studies; 64.7% ($n = 86$) reported yes, 27.8% ($n = 37$) reported no, and one person did not answer this question. As a reminder, trainees were able to endorse as many options as applied for them, thus the percentage of individuals reported for each option are not mutually exclusive and may overlap between values.

Therapy engagement during doctoral training: Type, satisfaction, reason for seeking therapy, and hours. Trainees who reported engaging in therapy during their doctoral program were asked a series of follow-up questions regarding the type(s) of therapy in which they had engaged and their experience with each type (as shown in Appendix E). Of the 54 trainees who engaged in therapy while in their doctoral program, 50 (40.3% of the total sample) had participated in individual therapy, nine (7.3% of the total sample) had engaged in couples therapy, and six (4.8% of the total sample) had engaged in group therapy. Trainees also reported the extent to which they were satisfied (on a scale of 1 = “not at all satisfied” to 5 = “completely satisfied”) with the therapy in which they engaged. Of the 50 trainees who had engaged in individual therapy, 19 (38%) trainees reported being completely satisfied, and 14 (28%) reported a 4 on the degree to which they were satisfied with individual therapy. Of the nine trainees who had participated in couples therapy, two trainees reported being completely satisfied (22%),

and three (33%) trainees reported a 4. Lastly, of the six trainees who participated in group therapy, two individuals (33%) reported being completely satisfied, and two individuals reported a 4 (33%). See Table 2 for all frequencies.

Of the 54 trainees who reported seeking personal therapy, none reported that it was a mandate or a program requirement, 36 reported they sought therapy for mood concerns, 41 reported seeking therapy due to stress, and 44 reported seeking therapy for personal growth. Eighteen trainees indicated “other” reasons of which seven trainees indicated seeking therapy for relationship issues and four reported seeking therapy to cope with trauma-related presenting concerns (e.g., “death of client by suicide,” “distress due to my best friend’s suicide,” “trauma,” and “sexual trauma history”). One trainee indicated seeking personal therapy because of a recommendation from an internship program, and another trainee indicated a “loose” mandate from an psychoanalytic training site, though not a mandate from his/her training program. Additionally, another trainee reported seeking a Gestalt group along with a cohort member to which professors did not agree and they had to “fight [their] professors on it who almost forbade us doing it.” Two trainees reported academic stress and/or academic adjustment. Lastly, one trainee reported “coping with physical health changes.”

Trainees who reported seeking personal therapy were asked the number of hours that they engaged in individual therapy, couples therapy, and/or group therapy. Although 50 trainees reported seeking individual therapy, only 49 trainees reported the number of hours of engagement, which ranged from one to 1,000 hours ($M = 55.88$, $SD = 143.66$). Of the nine trainees who reported seeking couples therapy, only seven reported hours of engagement, which ranged from one to 30 hours ($M = 9.57$, $SD = 10.21$). Of the six

trainees who reported seeking group therapy, only five reported hours of engagement in which ranged from eight to 70 hours ($M = 42.60$, $SD = 28.35$).

Therapy engagement prior to doctoral training: Type, satisfaction, reason for seeking therapy, and hours. Trainees were also asked whether they had engaged in personal therapy prior to doctoral study in counseling psychology. Eighty-six (69.4%) of the 124 trainees reported that they had engaged in personal therapy prior to beginning their doctoral studies, 37 had not engaged in personal therapy prior to beginning their doctoral studies, and one person did not answer the question. As shown in Table 3, of the 86 trainees who had engaged in therapy prior to their doctoral program, 84 (67.7% of the total sample) had participated in individual therapy, 10 (8.1% of the total sample) had engaged in couples therapy, and 10 (8.1% of the total sample) had engaged in group therapy. Of the 84 who reported seeking individual therapy, the majority of the sample reported their satisfaction as either a 5 ($n = 25$; 29.8%) or a 4 ($n = 28$; 33%). The mean hours of individual therapy prior to graduate school was 51.45 ($SD = 68.24$; range = 1 to 400 hours). Of the 10 who reported seeking couples counseling, one trainee reported the level of satisfaction as a 5 (1%), and two trainees reported a 4 (2%). The mean number of hours for couples therapy was 10.45 ($SD = 10.87$, range = 2 to 40 hours). Lastly, of the 10 who reported seeking group therapy, no trainee reported a 5, and four trainees reported a 4 (4%) in terms of their satisfaction. The mean number of hours for group therapy was 73.14 hours ($SD = 101.74$, range = 2 to 240 hours).

Research Question 1: Differences by engagement in therapy and training level in perceived therapy competence outcomes, empathy, and counselor self-efficacy

A 2 Therapy Engagement x 2 Level of Training MANOVA was conducted to assess differences between doctoral counseling psychology trainees who sought personal therapy while in doctoral training in counseling psychology and those who did not as well as between beginner training level and advanced training level in the set of six assessed outcomes: counselor self-efficacy (CASES; COSE), empathy perspective taking (IRI PT), empathy emotional concerns (IRI EC), and perceived clinical skills (CSPD-RF; DPCCQ clinical skills). As described previously, a sub-sample of 101 trainees were used for the analyses as they completed at least 80% of the items on each of the dependent measures. Of this sample, 36 (35.6%) had engaged in either no practicum or were in their first practicum and were classified as Beginner, while 65 (64.4%) were engaged in their second practicum, third practicum, or internship and were classified as Advanced. Further, 43 of the 101 trainees (42.6%) had engaged in personal therapy during their doctoral training. In the Beginner group, 10 had engaged in personal therapy during their doctoral program, and 26 had not; in contrast, 33 of the Advanced group had engaged in personal therapy during their doctoral program, and 32 had not. See Tables 4 and 5 for descriptive statistics for all outcome variables for the total sample as well as by training level and by engagement in personal therapy.

Additional descriptive statistics of skewness and kurtosis, which are used to assess univariate normality for all outcomes, are presented in Table 6; these values were acceptable for all of the dependent variables. Normal probability plots were evaluated and supported the univariate normality assumption due to the observed linearity in the

plots. Bivariate scatterplots were generally elliptical, supporting bivariate normality of the outcome set as well. Finally, the assumption of homogeneity of covariance matrices was met (Box's $M = 68.11$, $F(63, 4510.70) = 0.91$, $p = .68$).

The factorial MANOVA found that the multivariate main effect for engagement in therapy while in doctoral training was not statistically significant (Wilks' $\lambda = 0.939$, $F(6, 92) = 0.991$, $p = .436$), and the multivariate interaction effect was also not significant (Wilks' $\lambda = 0.966$, $F(6, 92) = .539$, $p = .777$). However, a significant multivariate main effect was found for level of training (Wilks' $\lambda = 0.761$, $F(6, 92) = 4.822$, $p < .001$). Follow up univariate ANOVAs indicated significant differences between beginner and advanced trainees in terms of their counselor self-efficacy (CASES $p < .001$; COSE $p < .001$) and perceived clinical skills (CSPD-RF $p = .003$; DPCCQ clinical skills $p < .001$). As shown in Figures 2 and 3, beginner trainees had significantly lower scores on the counselor self-efficacy measures (CASES $M = 257.75$; COSE $M = 156.62$) and significantly lower scores on the perceived clinical skills measures (CSPD-RF $M = 88.73$; DPCCQ clinical skills $M = 41.42$) than those who were advanced trainees (CASES $M = 293.35$; COSE $M = 178.11$; CSPD-RF $M = 95.55$; DPCCQ clinical skills $M = 48.83$). Differences between participants with beginner training and those with advanced training were not significant for both of the empathy measures (IRI-EC $p = .654$; IRI-PT $p = .896$).

Additional Post Hoc Analysis

For research question 1, level of training was originally defined as a two-group variable: (1) Beginners (with no practicum or in their 1st doctoral practicum) and (2) Advanced (2nd doctoral practicum, 3rd doctoral practicum, or internship). However,

because the advanced group included a wide range of experience levels, a post hoc analysis was conducted in which training level was defined as a three-group variable. Specifically, 36 trainees (35.6%) who had engaged in either no practicum or were in their first practicum continued to be classified as Beginner, while 50 trainees (49.5%) engaged in their second or third practicum were classified as Moderate, and 15 trainees (14.9%) who were engaged in their pre-doctoral internship were classified as Advanced.

A 2 Therapy Engagement x 3 Level of Training MANOVA was conducted to assess differences between doctoral counseling psychology trainees who sought personal therapy while in doctoral training in counseling psychology and those who did not as well as between beginner training level, moderate training level, and advanced training level in the set of six assessed outcomes: counselor self-efficacy (CASES; COSE), empathy perspective taking (IRI PT), empathy emotional concerns (IRI EC), and perceived clinical skills (CSPD-RF; DPCCQ clinical skills). Multivariate normality of the outcome data was already established in the prior MANOVA. However, for this analysis, it was necessary to re-test the assumption of homogeneity of covariance matrices, and the test indicated that this assumption was again met (Box's $M = 90.836$, $F(84, 5323.976) = 0.878$, $p = .779$).

The same pattern of findings for the main effects and interaction effect was found as was found in the 2 x 2 MANOVA for research question one. Specifically, this 2 x 3 MANOVA again found that the multivariate main effect for engagement in therapy while in doctoral training was not statistically significant (Wilks' $\lambda = 0.899$, $F(6, 90) = 1.694$, $p = .131$), and the multivariate interaction effect was also not significant (Wilks' $\lambda = 0.903$, $F(12, 180) = .787$, $p = .663$). However, again, a significant multivariate main effect was

found for level of training (Wilks' $\lambda = 0.693$, $F(12, 180) = 3.022$, $p = .001$). Follow up univariate ANOVAs indicated significant differences by training level in terms of their counselor self-efficacy (CASES $p < .001$; COSE $p < .001$) and perceived clinical skills (CSPD-RF $p = .017$; DPCCQ clinical skills $p < .001$), but not either of the empathy measures (IRI-EC $p = .118$; IRI-PT $p = .154$).

Tukey post hoc analysis indicated that beginner trainees had significantly lower scores on the counselor self-efficacy measures (CASES $M = 258.258$; COSE $M = 157.788$) as compared to both moderate trainees (CASES $M = 293.833$, $p < .001$; COSE $M = 176.995$, $p < .001$) and advanced trainees (CASES $M = 286.784$, $p = .007$; COSE $M = 180.366$, $p < .001$). Moderate trainees did not significantly differ on the counselor self-efficacy measures (CASES $M = 293.833$; COSE $M = 176.995$) as compared to advanced trainees (CASES $M = 286.784$, $p = .987$; COSE $M = 180.366$, $p = .597$). Additionally, beginner trainees had significantly lower scores on the perceived clinical skills measures (CSPD-RF $M = 88.077$; DPCCQ clinical skills $M = 41.565$), as compared to both the moderate trainees (CSPD-RF $M = 95.559$, $p = .016$; DPCCQ clinical skills $M = 48.922$, $p < .001$) and advanced trainees (CSPD-RF $M = 94.170$, $p = .117$; DPCCQ clinical skills $M = 47.466$, $p = .001$). Moderate trainees did not significantly differ on the perceived clinical skills measures (CSPD-RF $M = 95.559$; DPCCQ clinical skills $M = 48.922$), as compared to the advanced trainees (CSPD-RF $M = 94.170$, $p = 1.000$; DPCCQ clinical skills $M = 47.466$, $p = .997$).

Research Question 2: Current State of Recommendations for Personal Therapy for Trainees in Counseling Psychology Doctoral Programs

Training directors. Of the sample of 35 training directors, 22 (62.9%) reported that their program does “recommend that trainees engage in personal therapy as an important component for their training” while the remaining 13 (37.1%) training directors reported “personal therapy is not specifically recommended as part of training.” As shown in Appendix C, the 22 training directors who indicated that personal therapy is recommended to trainees in their program were asked a follow-up question regarding three possible cases for which personal therapy may be recommended (each training director was able to select more than one of the three options given). Of the 22 training directors who reported “yes” to recommending personal therapy, 14 (63.6%; 40% of all 35 training directors responding) indicated that personal therapy is recommended to all students, 18 (81.8%; 42.8% of all 35 training directors responding) reported that personal therapy is recommended on a case-by-case basis, and 13 (59.1%; 37.1% of all 35 training directors responding) reported that personal therapy is recommended to students who are on remediation.

Trainees. Trainees were asked “Does your program recommend that trainees engage in personal therapy as an important component of training?” to which 35 (28.2%) participants reported “yes” and 89 (66.9%) reported “no, personal therapy is not specifically recommended as part of training.” If trainees reported that personal therapy was recommended, they were asked a follow up question requesting when personal therapy would be recommended. Trainees were able to indicate multiple options to reflect their programs’ recommendations. Of the 35 participants who reported that their

program did recommend personal therapy, 31 (88.5%; 25% of all trainees) reported that “personal therapy is recommended to all students (e.g., in a course taken by all students or at orientation),” 16 (45.7%; 19.9% of all trainees) reported “on a case-by-case basis (e.g., if a student reports feeling stressed; personal growth),” and nine (25.7%; 7.3% of all trainees) stated that personal therapy is recommended “for students who are on remediation (i.e., academic probation, disciplinary concern).”

Research Question 3: Barriers to Trainees’ Help-Seeking

Training directors. The number and frequency of training directors selecting each barrier to trainees’ help-seeking are shown in Table 7. As hypothesized, cost ($n = 23$; 65.7%) and time ($n = 20$; 57.1%) were reported most frequently by training directors as barriers to trainees’ help-seeking. Access to care ($n = 15$; 42.9%) and concerns about confidentiality ($n = 14$; 40%) were also frequently endorsed by training directors as barriers to trainees engaging in personal therapy. In addition, a total of seven training directors selected Other (see Appendix D) and wrote in responses of which five training directors reported that seeking personal therapy at the college counseling center would decrease training sites and increase multiple relationships. For example, one training director explained that the “program is somewhat geographically isolated making it tough to find counseling with whom students do not interact as part of their training.” Additionally, one training director explained that there is an attempt to refer students to therapists who “will take their insurance or work with them financially”; this response appears to be relevant to both the Cost and Access options. One training director reported that a barrier for trainees seeking personal therapy is that trainees would “see it as a personal failure” pointing to the issue of stigma. Generally, the write-in responses

mirrored the categories provided (concerns about confidentiality, access to competent care) though elucidated further the issues with trainees engaging in personal therapy may decrease training sites.

Trainees. The number and frequency of trainees selecting each barrier for themselves as well as for other trainees are shown in Table 8. As hypothesized, cost and time were endorsed most often by trainees. Specifically, 71.4% of trainees reported cost as a barrier to seeking personal therapy for themselves ($n = 95$) and for other trainees (70.7%; $n = 94$). Additionally, trainees indicated that having the time to seek personal therapy was a barrier to seeking personal therapy for themselves (70.7%; $n = 94$) as well as for other trainees (66.2%; $n = 88$). In contrast, 51 (38.3%) of the trainees reported “access to competent care” as a barrier to seeking personal therapy for themselves, and 42 (31.6%) reported access as a barrier for other trainees. Fifty (37.6%) trainees indicated concerns about confidentiality as a barrier for themselves, and 53 (39.8%) reported this barrier for other trainees.

Inspection of the write-in responses suggested that 16 trainees were concerned with seeking personal therapy at the counseling center or local agencies because it would limit their practicum placements due to multiple relationships and concerns about confidentiality. Trainees also indicated that they were concerned about the connectedness of the field. Additionally, three trainees reported worry regarding perceptions from faculty and stigma.

Chapter V

Discussion

To the best of this author's knowledge, this dissertation is the first study to exclusively survey counseling psychology doctoral trainees regarding perceived barriers to help-seeking behavior and to examine the extent to which perceived competence may differ on the basis of a trainee's engagement in personal therapy. Furthermore, this study also surveyed training directors of APA-accredited counseling psychology doctoral programs regarding their perceptions of barriers for trainees seeking personal therapy and when personal therapy may be recommended to trainees.

Research Question 1: Differences by engagement in therapy and training level in perceived therapy competence outcomes, empathy, and counselor self-efficacy

Differences by training level. Partial support was found for hypothesis one regarding training level differences. In support of the hypothesis, trainees who were advanced reported having significantly greater counselor self-efficacy and perceived clinical skills than trainees who were beginners; however, contrary to the hypothesis, these groups did not differ in empathy. The significant finding for training level differences in self-efficacy is consistent with previous research indicating that trainees with more clinical experiences are more likely to rate their counselor self-efficacy greater as compared to beginning trainees with fewer clinical experiences (Larson et al., 1992; Sipps et al., 1988). In addition to literature supporting that training and education positively influence counselor self-efficacy, supervision models such as the Integrated Developmental Model of supervision also assert such a claim and underscore the idea that trainee needs may differ based upon their level of clinical experiences (Stoltenberg, 1981). Moreover, developmental differences may also account differences found in that

trainees may differ in terms of their motivation to personal therapy. Specifically, beginning trainees may be more likely to seek personal therapy for personal reasons (e.g., stress; lack of confidence) whereas advanced professionals may be more likely to seek personal therapy for both personal and professional reasons given that research suggests that they integrate their personal and professional lives more so than beginning trainees (Moss, Gibson, & Dollarhide, 2014). Specifically, beginning trainees see their work and personal life as distinct whereas more advanced professionals learn to integrate their personal and professional lives. Finally, given that both empathy measures (empathy perspective taking and empathy emotional concerns) had low correlations with the other dependent measures and that the Cronbach's alpha was especially low for empathic concerns, the lack of significant differences in empathy may need to be interpreted with caution. Additionally, the measure used to assess the empathy construct was not developed explicitly to assess a counselor's ability to use empathy in therapy sessions, but rather developed to measure empathy as a general multidimensional construct. Thus, if a different empathy was used that explicitly evaluates a trainee's ability to empathize such as observer ratings of therapy sessions in the Peebles (1980) study, results may have been different.

Differences by engagement in therapy. Contrary to the hypothesis, trainees who engaged in personal therapy while in their doctoral program did not differ significantly from trainees who did not engage in personal therapy in terms of counselor self-efficacy, perceived therapy competence, or empathy. To the best of this author's knowledge, this study is the first to use quantitative methodology to examine this issue; previous research has typically implemented qualitative methods (Grimmer & Tribe,

2001; Macran et al., 1999; Murphy, 2005; Wiseman & Shefler, 2001) with a few, notably older, exceptions (Strupp, 1955, 1958). Qualitative research can be considered more subjective and context dependent and may have allowed prior investigators to detect an influence of personal therapy on clinical practice that could not be found with a purely quantitative, survey-based approach. For example, Strupp (1955) used short vignettes of patient statements and analyzed the participants' verbal responses using an interaction process analysis, and Strupp (1958) used video stimuli of a patient interview and had the psychotherapists indicate what they would have said at preselected points throughout the video as well as fill out questionnaires on various other factors including diagnostic impressions and treatment plan after the video. If vignettes or write-in responses had been used in the current study, rather than only questionnaires, they may have yielded different findings regarding how engaging in personal therapy as a trainee may influence perceived clinical competence.

Another potential factor that may explain the lack of significant differences between those who engaged in therapy and those who did not is the type and size of the sample used in this analysis. This study surveyed a sample of counseling psychology doctoral trainees drawn exclusively from programs in the United States. Although the Strupp studies compared those who engaged in psychoanalysis to those who did not, their samples were comprised of individuals with diverse training backgrounds, including psychologists, psychiatrists, and social workers in the 1955 study. Thus, differences found in practicing psychotherapists may not yet be evident in trainees or the fact that all trainees were in the field of counseling psychology may have limited variability in the sample relative to previous research. In addition, because Europe requires that therapists

in training engage in personal therapy, many of the existing studies in the literature used samples of European trainees (Ciclitira et al., 2012; Grimmer & Tribe, 2001; Nel et al., 2012; Rake & Paley, 2009). The cultural expectation that European trainees engage in personal therapy in order to earn their degree may change the perceived barriers (time, cost, etc.) and fears regarding how faculty will perceive the trainee for seeking personal therapy. Making personal therapy a requirement for trainees implies that it is an important form of self-care and that this form of self-care may be utilized in the future, even after graduation. In addition, a post hoc power analysis indicated that the effect size for engagement in therapy was small (i.e., $f^2 = .065$), and a sample of 218 trainees would have been necessary to have sufficient power (i.e., power of .80) to detect this effect. Thus, future studies should seek to obtain larger samples when studying this difference.

Considering that this study is the first known study to assess explicitly counseling psychology doctoral trainees' engagement in personal therapy, the ability to assume that the rates of help-seeking are comparable to counseling psychology trainees as a whole is unable to be determined. However, research suggests that those who identify as female (Leong & Zachar, 1999; Zartaloudi & Madianos, 2010) and Caucasian/White (Diala et al., 2000) have higher rates of help-seeking as compared to non-white males, and these characteristics describe the majority of the current trainee sample.

Research Question 2: Current State of Recommendations for Personal Therapy for Trainees in Counseling Psychology Doctoral Programs

Given that research has yet to sample APA-accredited counseling psychology programs regarding recommendations for personal therapy, the hypothesis for this research question was exploratory. To the best of this author's knowledge, the last

survey to assess training directors was Wampler and Strupp (1976) who surveyed APA-accredited clinical psychology programs. In the current study, more than half (62.9%) of the 35 training directors who responded indicated that their program does recommend personal therapy for their trainees, although only 26% of the trainees indicated that personal therapy was recommended by their program. Similarly, 40% of all training directors but only 25% of all trainees indicated that personal therapy was recommended to *all* trainees. Thus, what trainees perceive as recommendations regarding personal therapy appears to differ as compared to the training directors, which may reflect a lack of overt recommendations to cohorts or to the program as an entity. Specifically, recommendations for personal therapy may be made in passing, rather than as a clear self-care mechanism, and may or may not reiterated each cohort year.

When comparing only those training directors and trainees who responded affirmatively to whether their program recommends personal therapy to the students, other interesting findings emerge. The option that personal therapy was recommended for “all” students was endorsed by a smaller percentage of training directors (63.6%) who indicated therapy was recommended by the program than the percentage of trainees (88.5%) who indicated therapy was recommended by their program. In contrast, “case-by-case” and “as part of a remediation” were endorsed more often by training directors in this subsample (81.8% and 59.1%, respectively) than by trainees (45.7% and 25.7%, respectively). These findings may indicate that those trainees who perceive their programs’ recommendation of personal therapy as more universal (i.e., for “all” students) while training directors may view these recommendations as more individualized (i.e., only for specific students). This difference may be due to training directors being more

likely than trainees in the program to know that particular students have been recommended to seek personal therapy as part of a remediation plan. Perhaps this difference is further indicative that the training directors are doing a good job at keep students' remediation plan confidential.

Although recommending personal therapy on a case-by-case basis may be a step in the right direction, it alone does not create a culture of self-care (Barnett et al., 2007) and may suggest to those trainees that something is inherently wrong with them. Trainees who are recommended to seek personal therapy as part of a remediation plan in a program where personal therapy is not recommended to all trainees may feel stigmatized and shamed. In order to create a culture of self-care within training programs, which in turn would foster reflective trainees, per Barnett et al.'s (2007) recommendations, perhaps recommending personal therapy broadly to all trainees and following up with trainees who need additional support may decrease shame around seeking treatment.

The reasons why training directors reported that their program does not recommend personal therapy were not explored in this study. However, research suggests that counseling education programs are less inclined to terminate a student because it opens themselves and their institutions to litigation (Kerl, Garcia, McCullough, & Maxwell, 2002); thus, it seems possible that one reason training directors and programs may be less inclined to include personal therapy as part of a remediation plan is to avoid litigation. Further, Boxley, Drew, and Rangel (1986) found that personality disorders was the most cited reason why trainees were on remediation, and given that personality disorders typically are harder to treat and usually take more time as compared

to mood disorders (Lawton & Oltmanns, 2013), the effectiveness of recommending personal therapy as part of a remediation may be perceived as inconclusive.

Furthermore, with such ambiguous findings (Vacha-Haase, Davenport, & Kerewsky, 2004), a disgruntled trainee can insinuate that his/her rights were stripped when forced to enter treatment against his/her will.

Another factor to consider in training director's recommendations of personal therapy is the training model of the program. Specifically, a difference may exist in recommending personal therapy between programs that use a scientist-practitioner model as compared to programs that are more focused on the practitioner-scientist model. Although not examined in the current study, it may be important to examine differences between Ph.D. and Psy.D. training programs. Perhaps, trainees from scientist-practitioner programs are less likely to have recommendations from faculty regarding the importance of personal therapy because of the emphasis placed upon research as compared to trainees of programs from practitioner-scientist programs who may be more inclined to recommend personal therapy given the emphasis placed upon practicing therapy.

Research Question 3: Barriers to Trainees' Help-Seeking

Structural/financial barriers including cost and time were most often endorsed by the trainees for themselves as well as for other trainees, which is supported by previous research (Gulliver et al., 2010). Additionally, more than one third of the trainee sample cited access to competent care and concerns about confidentiality as barriers to seeking personal therapy. A potential reason as to why access to competent care was endorsed less frequently than time or cost as a barrier to seeking personal therapy may be that

trainees aware of the availability of competent care at university/college counseling centers or local agencies, even if they choose not to utilize those particular sites. Using these services can decrease potential training sites for trainees, a barrier that was endorsed by 16 trainees in the write-in responses. Additionally, supported by previous research (Brimstone et al., 2007; Dearing et al., 2005; Farber, 2000) pointing to the connectedness of the field, trainees endorsed concerns about confidentiality. Specifically, trainees may worry that a potential therapist could be hired as an adjunct instructor at the institution the trainee attends or that trainees' supervisors in the field may be professionally connected to a potential clinician from whom a trainee is seeking personal therapy. These factors may serve as barriers to seeking personal therapy, because trainees may worry about limiting potential training sites and are concerned that professionals in the area would know one another.

In addition to concerns regarding confidentiality and connectedness of the field, stigma was also endorsed as a perceived barrier. Stigma is documented in the field as a barrier to seeking help within the general population. Moreover, stigma has been studied as two separate constructs: self-stigma (e.g., If I have a mental illness, then I am incompetent ; Barney et al., 2006; Corrigan, 2004; Vogel et al., 2007) and perceived stigma (e.g., others believe that individuals with mental illness are unsafe; Barney et al., 2006; Corrigan, 2004; Vogel et al., 2007). In a systematic review of qualitative and quantitative studies, perceived stigma, difficulty recognizing mental health symptoms, and embarrassment were barriers to help-seeking (Gulliver et al., 2010). The current study's write-in responses support previous research that trainees want to be perceived as self-sufficient and that trainees worry about how they would be perceived by their faculty

(Farber, 2000). Additionally and specific to the current investigation's focus on therapists-in-training, stigma related to help-seeking may be exacerbated by the fact that academics and professors are less likely to engage in personal therapy as compared to clinical practitioners (Norcross, Bike, & Evans, 2009). Given that trainees are in constant contact with their faculty through mentorship, teaching, and supervision, a lack of professional role models who also seek personal therapy may hinder trainees from seeking counseling for themselves.

As hypothesized, training directors endorsed cost and time with greater frequency as barriers to trainees' likelihood of help-seeking, which supports what the trainees indicated most frequently. Consistent with trainee reports, training directors also stated that seeking personal therapy at counseling centers or local agencies would decrease training sites and increase multiple relationships. Lastly, one training director suggests that stigma may also be a barrier. Taken together, concerns with limiting practicum training sites and issues surrounding stigma were endorsed by both training directors and trainees. Thus, efforts could be made at the program level to reduce any stigma attached to trainees' help-seeking; for example, faculty in the training program could speak to students about the benefits, both professional and personal, of engaging in personal therapy (Barnett & Cooper, 2009; Dearing et al., 2005; Farber, 2000). These efforts could help to normalize the experience of engaging in personal therapy. It is also evident that there is a call for programs to locate services for trainees that do not impede potential training sites for trainees, do not breach confidentiality, and are low cost though high quality services for trainees.

Finally, although trainees and training directors both reported time and cost with greater frequency than access or confidentiality concerns, trainees endorsed cost and time as barriers twice as often (71.4%, 70.7% respectively) as compared the other two barriers (i.e., access to competent care 38.3% and concerns about confidentiality 37.6%). In contrast, the training directors' endorsement of barriers was more evenly distributed (cost (65.7%), time (57.1%), access to care (42.9%), and concerns about confidentiality (40%) suggesting that training directors may see the barriers as more similar than trainees do.

An important consideration with access to care is the expansion of mental health coverage through the Affordable Care Act (MentalHealth.gov). Specifically, the Affordable Care Act expanded mental health and substance use disorder coverage by requiring health insurance plans to cover services (MentalHealth.gov). This expansion is expected to affect 62 million Americans and for most health insurance plans, one cannot be denied coverage due to a pre-existing mental health issue. With the expansion of mental health coverage, cost may not be as large as a barrier to trainees engaging in personal therapy, although one must consider the copay. Additionally, programs may want to provide students with programs around financial planning and the importance of reserving funds to engage in personal therapy. Moreover, training programs and even counseling centers of the trainees' institutions may also want to advocate for their students to receive free care to all of their students and that perhaps setting up programs with local practitioners may facilitate students' ability to access care.

It is also of note that trainees perceived barriers to help-seeking slightly differently for themselves versus for other trainees. Except for concerns about confidentiality, trainees tended to endorse these barriers at higher rates for themselves

than for other trainees. Though the differences were small, trainees' perceptions may be that other trainees have more time, more money, and greater access to competent care, which may be due to an attribution error. Attribution theory explains how people explain other people's behavior (Tetlock, 1985), and research (Jones & Nisbett, 1971) suggests that individuals will overestimate personality to explain others' behavior rather than the influence of context. Potentially, the trainees in this study inferred that other trainees have more time, money, and greater access to competent care because they may have more resources/privileges or less obstacles. Another potential explanation of this small difference is that trainees may not be speaking about these issues with one another and thus are not aware of what could be potential barriers for their respective peers.

Limitations and Threats to Validity

One limitation of the present study concerned the measurement of some constructs used in the analyses. First, although the item used for engagement in personal therapy specifically asked if trainees had engaged in at least six sessions of personal therapy, this categorical item grouped everyone together as "yes" regardless of how much therapy the individual engaged in beyond those six sessions. For example, in this study, an individual who had just six sessions of personal therapy and an individual who had 100 sessions were both included in the "yes" group, reflecting a wide range of variability among those who reported engaging in therapy. The loss of information by categorizing this continuous variable may have reduced the study's statistical power and the ability to find that engaging in personal therapy as a trainee is important for professional development (Wampold & Freund, 1987). Also, mono-operation bias may be present because engagement in therapy was based on a single item, and the entire construct may

not be able to be captured with one measure, leading to compromised construct validity (Heppner et al., 2008). Future research may address this issue by using a continuous variable for how much therapy a trainee engaged in; in addition, information about the reason for engaging in therapy could also be utilized in the analysis; using a more nuanced definition of engagement in therapy that considered the type and/or length of the therapeutic experience may have yielded different results. Finally, future research may consider examining the therapeutic alliance developed between the trainee and his or her therapist as a more important predictor of the trainee's competence than just a single yes/no item of engagement in personal therapy.

The second construct that demonstrated some measurement issues was empathy. The IRI-EC subscale had demonstrated good reliability in past studies (Bernstein & Davis, 1982; Carey et al., 1988; Davis, 1980, 1983), but in the current sample, only achieved a Cronbach's alpha value of .664. In addition, contrary to hypotheses, empathy showed no significant differences by either training level or engagement in therapy. Examining the items of the two measures used to assess empathy also revealed that they may not have been specific enough to the counseling setting to be sensitive to the expected group differences. Instead, although some items could be relevant to the counseling setting (e.g., "I am often quite touched by things that I see happen"), other items seem to address empathy in a more general setting (e.g., "I sometimes try to understand my friends better by imagining how things look from their perspective" or "When I'm upset at someone, I usually try to "put myself in his shoes" for a while"). Future research may want to use empathy measures that are used in the helping profession. For example, the Therapists Empathy Scale (TES; Decker, Nich, Carroll, &

Martino, 2014) and the Helping Questionnaire Response (HQR; Miller, Hedrick, & Orlosky, 1999) are potential measures. The TES is a measure in which therapists are evaluated by an independent rater in terms of their tone of voice and speech and on behaviors that could be evaluated from an audiotape. The HRQ does not require client therapist tapes, which would be difficult to use in a survey-based study such as this one, but rather asks participants to respond to six vignettes (Miller et al., 1999). By using measures such as the HQR and the TES, future research could better assess whether differences exist in terms of their empathy between trainees who have engaged in therapy as compared to those who have no engaged in personal therapy.

Self-report bias must also be considered with regards to the extent to which trainees accurately indicated their ability level (i.e., self-efficacy, perceived competence, and empathy). Some might under or over report self-efficacy, perceived competence, and empathy; this study could not validate or verify any of the self-reported information. However, the current investigation did attempt to mitigate potential bias by using multiple measures for each dependent variable. Although use of a method other than self-report would have minimized this self-report bias, doing so was impractical for a study such as this one.

An additional limitation was possible selection bias that could limit the generalizability of these findings. First, this study relied on training directors to both send the study request to trainees and to respond to the training director survey. Although all 69 APA-accredited counseling programs were contacted for participation, only 35 training directors responded to the training director survey, and it cannot be determined with 100% accuracy how many distributed the survey to their program's

trainees. Second, the sample of trainees who choose to complete the study measures was self-selected (i.e., a convenience sample rather than a random sample and thus may differ from a random sample of trainees in terms of important variables including investment in the research topic and the availability of the necessary time to take the survey.

Other concerns relate to the overall sample size and to the distribution of help-seeking behavior across the two training levels examined. Even though the required sample size for the analysis was met, this sample size is relatively small. If a larger sample size had been obtained, the probability of finding significant differences between those who engaged in therapy and those who did not would have been higher. In addition, help-seeking was unevenly reported by those in the Beginner versus Advanced training groups. Specifically, only 10 of the 36 individuals (27.7%) in the Beginner group had engaged in personal therapy while in graduate school as compared to 33 of the 65 individuals (50.8%) in the Advanced group. Because the Beginner group was defined as trainees who had either not yet begun doctoral practicum or were in their first practicum, it is logical that they also had less time and opportunity to have sought personal therapy during their program than those trainees in the Advanced group. The uneven cell sizes may have further reduced this study's ability to find help-seeking behavior to be related to the clinical competence outcomes.

Finally, issues of internal validity should also be considered including the potential that a third variable (e.g., openness to help-seeking) could have influenced the relationship between engagement in personal therapy and counselor self-efficacy. For example, trainees who elect to seek personal therapy may be more open to help-seeking and adhere to beliefs that to do insight oriented therapy work, one must also seek therapy.

Thus, counselor self-efficacy may be related to various third variables including openness to help-seeking and beliefs about the efficacy of personal therapy in relation to one's therapy work.

Future Directions

A relatively new branch of research has evaluated therapist effects on client outcomes, as previous research supports that theoretical orientation does not imbue better client outcomes as much as the therapeutic alliance (Wampold, 2001). In particular, professional self-doubt has been linked to better client outcomes in several recent studies. For example, Nissen-Lie et al. (2010) studied therapists in a naturalistic setting and found that therapists who reported greater professional self-doubt had more positive patient evaluations of the working alliance. In a more recent study, professional self-doubt was positively associated with positive changes in clients' interpersonal problem scores (Nissen-Lie, Monsen, Ulleberg, & Ronnestad, 2012). Likewise, graduate students who received personal therapy were better at cultivating the therapeutic alliance as compared to trainees who did not partake in personal therapy (Gold & Hilsenroth, 2009). Specifically, future research should evaluate therapists in training who elect to participate in personal therapy and the attributes they may have upon client outcomes and the therapeutic alliance (e.g., professional self-doubt). Although trainees in this sample were not found to differ on the perceived professional competence outcomes based on whether or not they had engaged in therapy, future research could investigate whether these groups differ in terms of professional self-doubt given its possible link to better client outcomes. Perhaps such evaluations may shed light on the findings from the qualitative literature, which suggest that personal therapy provided a modeling experience (Rake &

Paley, 2009) and provided a space in which trainees were able to explore themselves (Oteiza, 2010).

In addition to investigating variables such as professional self-doubt, future research should evaluate whether trainees who elect to engage in personal therapy as compared to trainees who do not engage in personal therapy show any differences in client outcomes (e.g., symptom checklist and therapeutic alliance). Given that prior qualitative studies suggest that personal therapy may facilitate self-awareness as a professional counselor (Ciclitira et al., 2012; Grimmer & Tribe, 2001; Macran et al., 1999; Murphy, 2005; Oteiza, 2010; Rake & Paley, 2009), future research should examine the extent to which trainees who do engage in personal therapy report greater self-awareness and evaluate if increased self-awareness is related to client outcomes (e.g., therapeutic alliance). Adding to the rich qualitative research that has already been conducted, further exploration could ask focus groups of trainees who have engaged in personal therapy about how this experience has informed their clinical work. This information could then be used to create measures based on those experiences to better translate the findings from qualitative research about the benefits of personal therapy for trainees to facilitate the emerging quantitative research on the utility of personal therapy as a means of encouraging clinical competence. Additionally, conducting qualitative research in the United States with trainees, early career professionals, and professionals may shed further light on the potential for cultural differences between European samples and samples in the United States. Furthermore, given that personal therapy is not mandated or even recommended to some trainees, it would be important to use qualitative

methodology to better understand the training context and the messages sent to students as well as the potential benefits to seek personal therapy.

In addition to considering the influence of other variables, research should also consider utilizing various methodological approaches including vignettes as conducted in the MacDevitt (1987) in which his study demonstrated that those who had therapy were more likely to identify countertransference in short vignettes. Second, other ways to operationalize engagement in personal therapy should also be considered given that quantitative research is emergent as compared to the rich qualitative research on clinicians engagement in personal therapy. Third, the issue of burnout is also important as per Barnett et al. (2007), and longitudinal research should systematically evaluate the use of therapy over a clinicians' tenure as well as the extent to which personal therapy attenuates burnout. Lastly, given that this is the first study to sample trainees from APA-accredited counseling psychology doctoral programs, it is important for the findings to be replicated and to evaluate additional samples including clinical psychology doctoral programs and master's level programs.

Finally, future research should consider replicating findings regarding program recommendations regarding trainees' engaging in personal therapy and barriers to doing so. Specifically, research could evaluate in greater detail when training directors recommend therapy given that the training directors had only three options in the current investigation. In addition, asking training directors to indicate why their program does *not* recommend that trainees seek therapy would be an important avenue to explore. Furthermore, research could evaluate additional perceived barriers to seeking therapy given that training directors and trainees had four options in the current study.

Specifically, training directors and trainees cited stigma as a barrier for trainees seeking personal therapy, which warrants further study. Given that most research has predominantly focused on the general populations' attitudes about help-seeking, it seems that wanting to be perceived as self-sufficient and worrying how one may be perceived in the program may serve as a noteworthy barrier.

Implications and Conclusions

As stated previously, this study is the first to exclusively survey training directors and trainees of APA-accredited counseling psychology doctoral programs. The findings for hypothesis one inform practice specifically regarding the usefulness of personal therapy for trainees. Based upon the results, the notion that if one seeks personal therapy, then they will be a better therapist is called into question, as the issue does seem more complex. Based on this study, any differences between trainees who engage in personal therapy as compared to trainees who do not engage in personal therapy appear to be non-significant. Specifically, the current study calls into questioning the practice of training directors who mandate or recommend personal therapy on the basis that those trainees will be better therapists or see themselves as more competent. Moreover, this study also points out that the effects of personal therapy may not be as large as originally suggested by the qualitative studies. Thus, mandating therapy as part of a remediation plan may not invoke the desired outcome, which would likely be a more competent clinician.

Although Smith and Moss (2009) suggest that graduate training programs are moving toward highlighting the importance of self-care, previous research (Munsey, 2006) and the current investigation suggest that training programs have not yet implemented this into practice. Advocating that trainees seek personal therapy

contributes to training programs' ability to create a culture of self-care. Furthermore, based upon trainees and training directors' responses, programs should openly encourage and advocate for the usefulness of engaging in personal therapy (Barnett & Cooper, 2009), as qualitative research suggests that personal therapy provides an opportunity to reflect on one's own issues and increase self-awareness (Grimmer & Tribe, 2001; Macran et al., 1999; Murphy, 2005; Wiseman & Shefler, 2001).

Based upon the results, trainees are concerned about time, cost, connectedness of the field, confidentiality, and stigma related to help-seeking while engaged in their doctoral study. These barriers are serious issues and need to be actively addressed by faculty in counseling psychology training programs. Specifically, creating a culture of self-care involves advocating for trainees to be able to seek personal therapy and to normalize the experience. Effort should focus on training directors finding high quality, low cost services to students that insure confidentiality and that do not impede upon potential training sites. Moreover, if one of the ultimate goals of training programs is to foster clinicians who are self-reflective per Wigg et al. (2013), a cultural shift is needed in how personal therapy is discussed in counseling psychology training programs, thereby decreasing barriers (stigma, cost, time, etc.) for trainees. In an effort to create a culture of self-care, in addition to advocating for trainees, modeling through self-disclosure that training staff have also sought personal therapy and can attest to how important it was for their development may also imbue the importance of self-care.

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Table 1

Demographics of Counseling Psychology Doctoral Trainee Sample (N = 101)

Demographic Variable			
Gender	Female	73.3%	
	Male	26.7%	
Age	<i>M</i>	29.32	
	<i>SD</i>	5.39	
Sexual Orientation	Heterosexual	81.2%	
	Gay	2.0%	
	Lesbian	5.0%	
	Bisexual	4.0%	
	Queer	5.0%	
	Questioning	2.0%	
	Other	1%	“pansexual”
Race/Ethnicity	African American/Black American	8.9%	
	American Indian/Alaskan Native	2.0%	
	Asian American/Pacific Islander	5.0%	
	European American/White	75.2%	
	Hispanic/Latino	5.0%	
	Multi-racial	1.0%	
	Other	2.0%	“Jewish;” “Southeast Asian

(table continues)

Table 1, continued

Demographic Variable		
Annual Household Income	Under \$15,000	35.6%
	\$15,001 to \$24,999	24.8%
	\$25,000 to \$49,999	15.8%
	\$50,000 to \$99,999	19.8%
	\$100,000 to \$149,999	3.0%
	\$150,000 to \$199,999	1.0%
	Social Class	Working Class
	Lower Middle Class	51.5%
	Upper Middle Class	28.7%
Parents' Annual Household Income	Under \$15,000	3.0%
	\$15,001 to \$24,999	5.0%
	\$25,000 to \$49,999	8.9%
	\$50,000 to \$99,999	29.7%
	\$100,000 to \$149,999	31.7%
	\$150,000 to \$199,999	11.9%

(table continues)

Table 1, continued

Demographic Variable		
	\$200,000 to \$249,999	3.0%
	\$250,000 to more	3.0%
Parents' Social Class	Working Class	11.9%
	Lower Middle Class	30.7%
	Upper Middle Class	51.5%
	Upper Class	4.0%
Year of Graduate School	1 st	16.8%
	2 nd	15.8%
	3 rd	16.8%
	4 th	21.8%
	5 th	18.8%
	6 th or beyond	9.9%
Doctoral Practicum Training	No doctoral level practicum	13.9%
	1 st doctoral practicum	21.8%
	2 nd doctoral practicum	19.8%
	3 rd doctoral practicum	29.7%
	Pre-doctoral internship	17.9%

Table 2

Trainees' Engagement in and Satisfaction with Types of Personal Therapy while in Their Doctoral Program (N = 124)

Engagement in Therapy	Satisfaction	Individual Therapy	Couples Therapy	Group Therapy
Yes		50 (40.3%)	9 (7.3%)	6 (4.8%)
	1 = Not at all satisfied	1 (2%)	1 (11%)	0 (0%)
	2	2 (4%)	1 (11%)	1 (17%)
	3	14 (28%)	2 (22%)	1 (16.7%)
	4	14 (28%)	3 (33%)	2 (33%)
	5 = Completely satisfied	19 (38%)	2 (22%)	2 (33%)
No		74 (59.7%)	115 (92.7%)	118 (95.2%)

Note. Satisfaction with each type of therapy was rated on a five-point Likert scale (1 = Not at all satisfied, 5 = Completely satisfied).

Table 3

Trainees' Satisfaction with Types of Personal Therapy Engaged in Prior to Their Doctoral Program (N = 124)

Engagement in Therapy	Satisfaction	Individual Therapy	Couples Therapy	Group Therapy
Yes		84 (67.7%)	10 (8.1%)	10 (8.1%)
	1	4 (5%)	1 (1%)	1 (1%)
	2	12 (14%)	3 (3%)	3 (3%)
	3	15 (17.9%)	3 (3%)	2 (2%)
	4	28 (33%)	2 (2%)	4 (4%)
	5	25 (29.8%)	1 (1%)	0 (0%)
No		39 (32.3%)	113 (91.9%)	113 (91.9%)
Missing		1	1	1

Note. Satisfaction with each type of therapy was rated on a five-point Likert scale (1 = Not at all satisfied, 5 = Completely satisfied).

Table 4

Descriptive Statistics for the Total Sample and by Training Level (N = 101)

Outcome Variable		Total (N = 101)	Training Level	
			Beginner (n = 36)	Advanced (n = 65)
CASES	<i>M</i>	280.88	257.75	293.35
	<i>SD</i>	39.83	43.63	31.15
	<i>n</i>	101	36	65
COSE	<i>M</i>	170.45	156.62	178.11
	<i>SD</i>	23.33	22.37	18.39
	<i>n</i>	101	36	65
IRI-PT	<i>M</i>	21.80	21.61	21.90
	<i>SD</i>	3.71	4.20	3.43
	<i>n</i>	101	36	65
IRI-EC	<i>M</i>	22.56	22.50	22.60
	<i>SD</i>	3.08	3.44	2.89
	<i>n</i>	101	36	65
CSPD-RF	<i>M</i>	93.12	88.73	95.55
	<i>SD</i>	11.32	11.09	10.78
	<i>n</i>	101	36	65
DPCCQ Clinical Skills	<i>M</i>	46.19	41.42	48.83
	<i>SD</i>	7.16	7.10	5.90
	<i>n</i>	101	36	65

Note. Training Level is defined by responding to the item “What is your current level of doctoral practicum experience” in which responding “no doctoral level practicum and first doctoral practicum was categorized as Beginner and “second doctoral practicum,” “third doctoral practicum,” and “pre-doctoral internship” was categorized as Advanced.

Table 5

Descriptive Statistics for the Total Sample and by Engagement in Personal Therapy

During Doctoral Training (N = 101)

Outcome Variable		Total (N = 101)	Engagement in Personal Therapy During Doctoral Training	
			Yes (n = 43)	No (n = 58)
CASES	<i>M</i>	280.88	286.05	277.05
	<i>SD</i>	39.83	37.71	41.24
	<i>n</i>	101	43	58
COSE	<i>M</i>	170.45	176.07	166.29
	<i>SD</i>	23.33	21.91	21.90
	<i>n</i>	101	43	58
IRI-PT	<i>M</i>	21.80	22.51	21.27
	<i>SD</i>	3.71	3.40	3.87
	<i>n</i>	101	43	58
IRI-EC	<i>M</i>	22.56	23.07	22.19
	<i>SD</i>	3.08	3.13	3.02
	<i>n</i>	101	43	58
CSPD-RF	<i>M</i>	93.12	93.88	92.55
	<i>SD</i>	11.32	12.36	10.56
	<i>n</i>	101	43	58
DPCCQ Clinical Skills	<i>M</i>	46.19	47.85	44.97
	<i>SD</i>	7.26	7.09	7.20
	<i>n</i>	101	43	58

Note. Engagement in personal therapy is defined by responding “yes” or “no” to the item “During your doctoral training in counseling psychology, have you engaged in personal therapy for at least six sessions with the same clinician?”.

Table 6

Correlation Matrix for Dependent Variables in the MANOVA (N = 101)

	1	2	3	4	5	6
1. CASES	1.00					
2. COSE	0.79**	1.00				
3. IRI-PT	0.26**	0.27**	1.00			
4. IRI-EC	0.05	0.14	0.44**	1.00		
5. CSPD-RF	0.68**	0.68**	0.30*	0.25*	1.00	
6. DPCCQ Clinical Skills	0.78**	0.80**	0.31**	0.14	0.72**	1.00
<i>M</i>	280.88	170.45	21.80	22.56	93.12	46.19
<i>SD</i>	39.83	22.33	3.71	3.08	11.32	7.26
Skewness	-0.54	-0.33	-0.43	-0.41	-0.37	-0.42
Kurtosis	-0.27	-0.47	-0.15	-0.16	0.36	-0.17

* $p < 0.05$; ** $p < 0.01$.

Table 7

Training Directors' Perceptions of Barriers for Trainees Seeking Personal Therapy (N = 32)

Barrier	Percent Yes	Percent No
Cost	23 (65.7%)	12 (34.3%)
Time	20 (57.1%)	15(42.9%)
Access to Care	15 (42.9%)	20 (57.1%)
Concerns about confidentiality	14 (40%)	21 (60%)

Note. Only 32 of the 35 training directors responding to this survey reported about barriers for trainees who elect to seek personal therapy.

Table 8

Trainees' Perceptions of Barriers to Seeking Personal Therapy for Self and Peers (N = 124)

Barrier	Percent Yes (for self)	Percent Yes (for other trainees)
Cost	95 (71.4%)	94 (70.7%)
Time	94 (70.7%)	88 (66.2%)
Access to competent care	51 (38.3%)	42 (31.6%)
Concerns about confidentiality	50 (37.6%)	53 (39.8%)

Figure 1. *Trainee Sample Dropout*

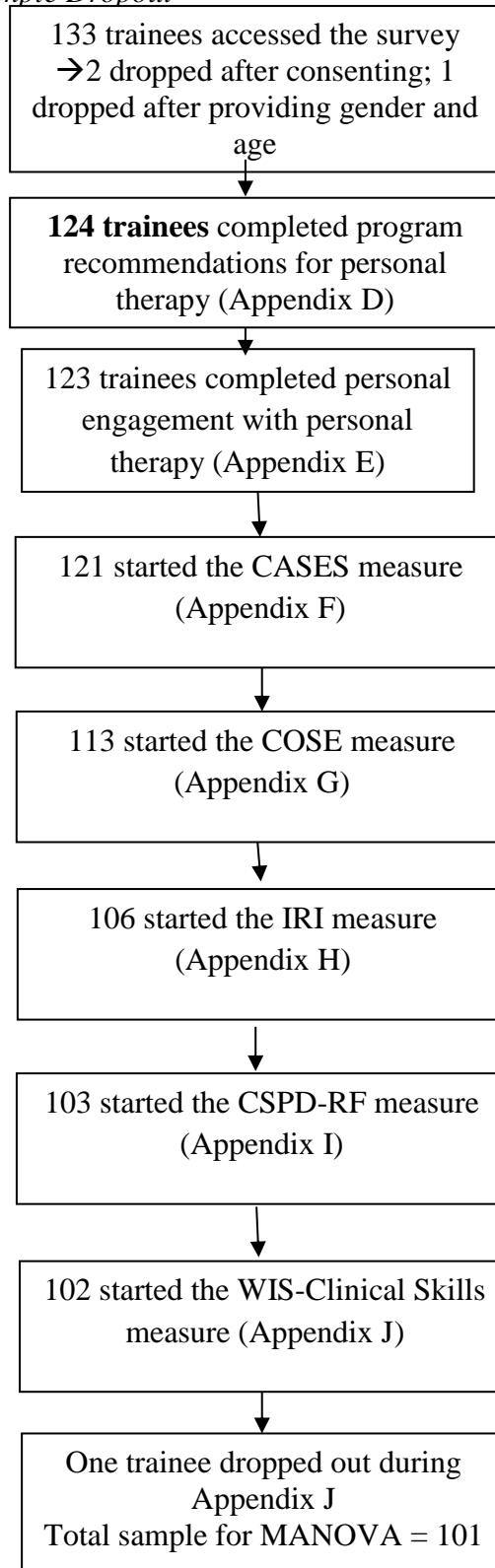


Figure 2.

Group Means for Counselor Self-Efficacy Measures

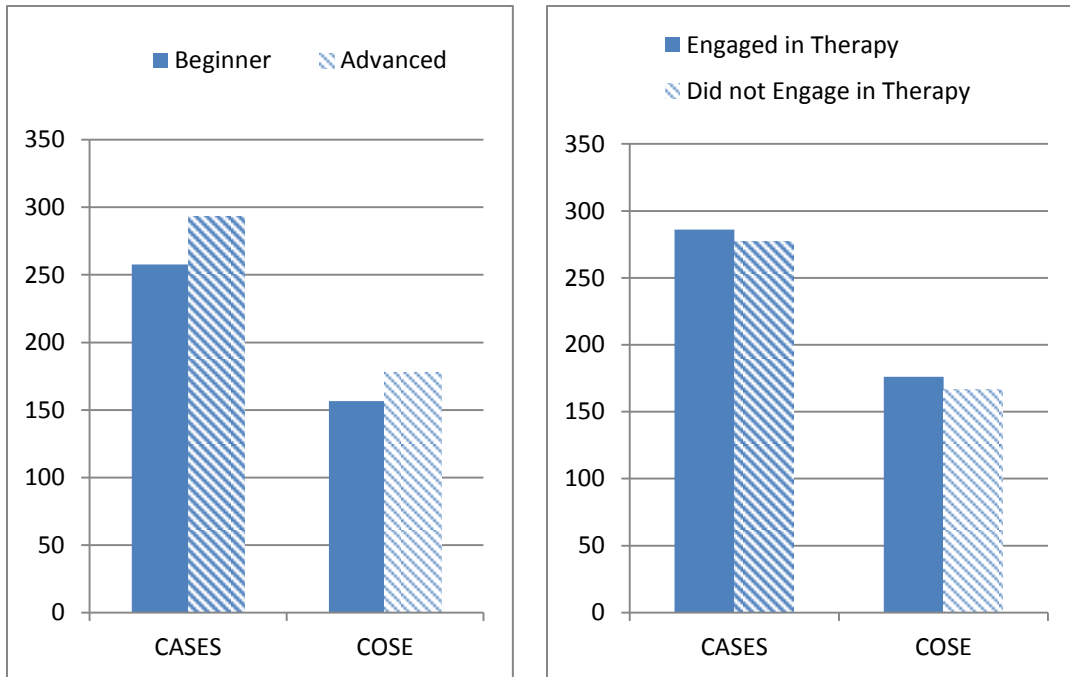
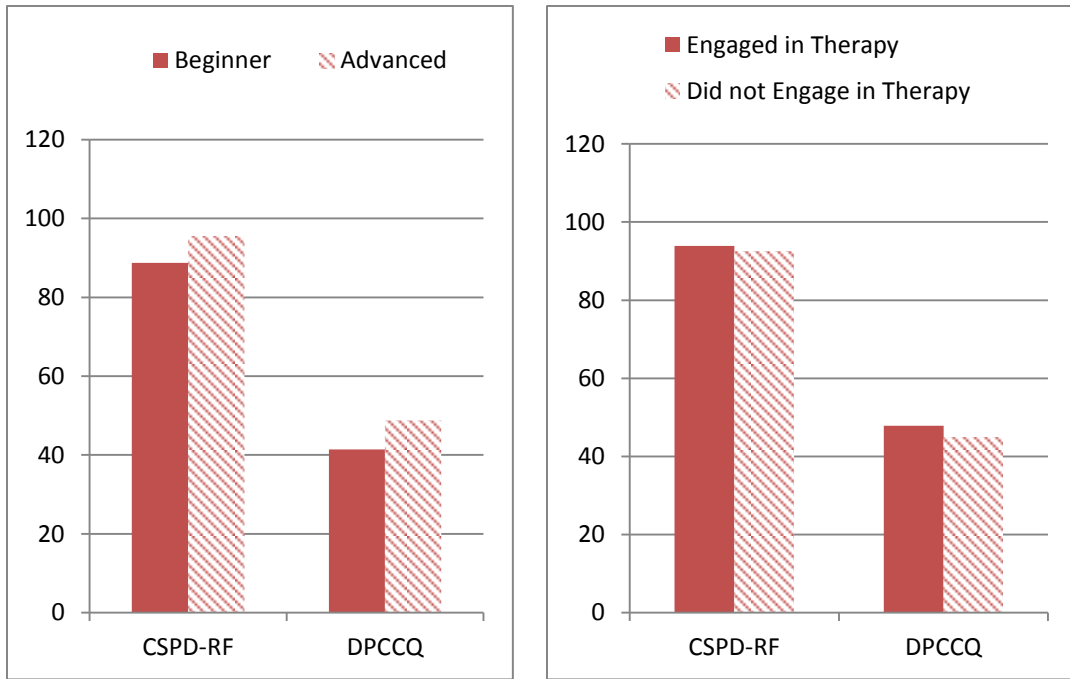


Figure 3.

Group Means for Perceived Clinical Skill Measures



Appendix A

Email Sent to Training Director for Trainee Recruitment and Training Director Recruitment

Dear [TRAINING DIRECTOR NAME]:

I am a Ph.D. candidate at Lehigh University conducting my dissertation project on barriers to seeking personal therapy while in training and the potential professional benefits to doing so. I am seeking current Counseling Psychology doctoral trainees of all levels of experience who are in APA-accredited programs. Will you please kindly forward this email to current Counseling Psychology doctoral trainees in your program?

The Institutional Review Board at Lehigh University 576340-1 approved this study. If you have any questions or concerns, you may contact me at alb510@lehigh.edu or my academic advisor, Dr. Grace Caskie (caskie@lehigh.edu).

Sincerely,

Alayna Berkowitz, M.A.
Doctoral Candidate
Lehigh University

Invitation to Counseling Psychology Doctoral students

Dear current Counseling Psychology doctoral student:

I am seeking current doctoral students in APA-accredited Counseling Psychology programs to participate in my dissertation research, which seeks to evaluate the extent to which trainees engage in personal therapy, the potential benefits for doing so, and potential barriers to seeking personal therapy. This survey will take approximately 20 – 25 minutes of your time.

I greatly appreciate your time and choosing to assist in this dissertation. If you are willing to participate, the survey can be accessed here:

https://lehigh.co1.qualtrics.com/SE/?SID=SV_5v6b1FuPKeME6O1

Sincerely,

Alayna Berkowitz, M.A.
Doctoral Candidate
Lehigh University

Appendix A, continued

Training Director Recruitment Email

Dear [Training Director]:

As part of my dissertation, I am seeking 2 minutes of your time (only 3 quick questions) assessing your recommendations and perceptions of barriers for trainees who seek personal therapy. Please click on this link if you are willing to participate:

https://lehigh.co1.qualtrics.com/SE/?SID=SV_4H1U460J5G44M7z

The Institutional Review Board at Lehigh University has approved this study (576340-1). If you have any questions or concerns, you may contact me at alb510@lehigh.edu or my academic advisor, Dr. Grace Caskie (caskie@lehigh.edu).

I greatly appreciate your time and consideration.

Sincerely,
Alayna Berkowitz, M.A.
Doctoral Candidate, Counseling Psychology
Lehigh University

Appendix B

Demographic Form

1. Gender:
 - a. Female
 - b. Male
 - c. Transgender: Male-to-Female
 - d. Transgender: Female-to-Male
 - e. Other please specify
2. Age:_____
3. Sexual Orientation
 - a. Heterosexual
 - b. Gay
 - c. Lesbian
 - d. Bisexual
 - e. Queer
 - f. Questioning
 - g. Other (please specify)
4. Your Race
 - a. African American/Black
 - b. American Indian or Alaskan Native
 - c. Asian American or Pacific Islander
 - d. European American/White
 - e. Hispanic/Latino
 - f. Multi-racial
 - g. Other please specify
5. What is your Annual Household Income?
 - a. Under \$15,000
 - b. \$15,001 to \$24,999
 - c. \$25,000 to \$49,999
 - d. \$50,000 to \$99,999
 - e. \$100,000 to \$149,999
 - f. 150,000 to \$199,999
 - g. \$200,000 to \$249,999
 - h. \$250,000 and more

(Appendix continues)

Appendix B, continued

6. How would you identify your social class?
 - a. Working Class
 - b. Lower Middle Class
 - c. Upper Middle Class
 - d. Upper Class
7. What is your parents' Annual Household Income?
 - a. Under \$15,000
 - b. \$15,001 to \$24,999
 - c. \$25,000 to \$49,999
 - d. \$50,000 to \$99,999
 - e. \$100,000 to \$149,999
 - f. 150,000 to \$199,999
 - g. \$200,000 to \$249,999
 - h. \$250,000 and more
8. How would you identify your parents' social class?
 - a. Working Class
 - b. Lower Middle Class
 - c. Upper Middle Class
 - d. Upper Class
9. What is your mother's highest level of education?
 - a. No schooling completed
 - b. Less than 8th grade
 - c. Some high school (no diploma)
 - d. High school graduate or equivalent
 - e. Some college
 - f. Associate's degree (AA, AS)
 - g. Bachelor's degree (BA, BS, AB)
 - h. Master's degree (MA, MS, M.Ed.)
 - i. Professional degree (MD, DDS, DVM)
 - j. Doctorate degree (Ph.D., Ed.D.)

(Appendix continues)

Appendix B, continued

10. What is your father's highest level of education?
 - a. No schooling completed
 - b. Less than 8th grade
 - c. Some high school (no diploma)
 - d. High school graduate or equivalent
 - e. Some college
 - f. Associate's degree (AA, AS)
 - g. Bachelor's degree (BA, BS, AB)
 - h. Master's degree (MA, MS, M.Ed.)
 - i. Professional degree (MD, DDS, DVM)
 - j. Doctorate degree (Ph.D., Ed.D.)
11. Current year of study in graduate school
 - a. 1st
 - b. 2nd
 - c. 3rd
 - d. 4th
 - e. 5th
 - f. 6th or beyond
12. Number of months you have conducted counseling or therapy with individual clients:
13. What is your current level of doctoral practicum training experience?
 - a. No doctoral level practicum
 - b. First doctoral practicum
 - c. Second doctoral practicum
 - d. Third doctoral practicum
 - e. Pre-doctoral internship
14. Total number of hours of individual therapy that you have provided:
15. Training setting(s) that you have worked in (choose all that apply):
 - a. College counseling center
 - b. Community mental health agency
 - c. Private hospital
 - d. State hospital
 - e. Veterans administration hospital
 - f. Other setting

(Appendix continues)

Appendix B, continued

16. What is your theoretical orientation?

- a. Psychodynamic
- b. Cognitive behavioral
- c. Interpersonal
- d. Person-centered
- e. Eclectic
- f. Integration
- g. Other, please specify:

Appendix C

APA Training Directors Survey

Item

Does your program ever **recommend** that trainees engage in personal therapy as an important component of their training?

Yes

If yes, to whom is personal therapy recommended? Check all that apply.

- To all students (e.g., in a course taken by all students or at orientation).
- On a case-by-case basis (e.g., if a student reports feeling stressed; personal growth)
- For students who are on remediation (i.e., academic probation; disciplinary concern)

No, personal therapy is not specifically recommended as part of training.

Are there barriers for trainees who would like to engage in personal therapy? Check all that apply for your students.

Cost

Time

Access to care

Concerns about confidentiality

Other issues, please specify:

Does your program adhere to any of the following theoretical orientations? (1 not at all to 5 strongly adhere)

Psychodynamic

Cognitive behavioral

Interpersonal

Person-centered

Eclectic

Integrated

Other, please specify:

Appendix D

Trainee Perceptions of Training Program Recommendations for Personal Therapy and Barriers to Seeking Personal Therapy

Does your program **recommend** that trainees engage in personal therapy as an important component of their training?

- Yes
If yes, to whom is personal therapy recommended? Check all that apply.
 - To all students (e.g., in a course taken by all students or at orientation).
 - On a case-by-case basis (e.g., if a student reports feeling stressed; personal growth)
 - For students who are on remediation (i.e., academic probation; disciplinary concern)
- No, personal therapy is not specifically recommended as part of training.

Which of the following represent barriers to you and to other trainee colleagues seeking personal therapy? Please select all that apply.

	For you	For other trainees
Cost	<input type="checkbox"/>	<input type="checkbox"/>
Time	<input type="checkbox"/>	<input type="checkbox"/>
Access to competent care	<input type="checkbox"/>	<input type="checkbox"/>
Concerns about confidentiality	<input type="checkbox"/>	<input type="checkbox"/>
Other – please specify:	<input type="checkbox"/>	<input type="checkbox"/>

Appendix E

Trainees' Past and Current Engagement in Personal Therapy

1. During your doctoral training in counseling psychology, have you engaged in personal therapy for **at least six sessions** with the same clinician?
- Yes (If yes, then the participant continues in the electronic survey to the follow-up questions shown below.)
 - No (If no, then the survey will automatically skip to question 2.)

Did you engage in: (select all that apply)	# of hrs engaged in this therapy type	Overall satisfaction with experience				
		Not at all Satisfied			Completely Satisfied	
<input type="checkbox"/> Individual	___	1	2	3	4	5
<input type="checkbox"/> Couples	___	1	2	3	4	5
<input type="checkbox"/> Group	___	1	2	3	4	5
<input type="checkbox"/> Other, please specify: ___	___	1	2	3	4	5

What were the reasons you sought personal therapy during your doctoral training in counseling psychology? (Select all that apply.)

- Mandate from program for disciplinary concern
- Program requirement
- Mood concerns (e.g., depression, anxiety)
- Stress (e.g., academic stress)
- Personal growth
- Other - please specify:

(Appendix continues)

Appendix E, continued

Prior to beginning your doctoral studies, did you engage in personal therapy?

- Yes (If yes, then the participant continues in the electronic survey to the follow-up questions shown below)
- No (If no, then the survey will automatically skips to the next questionnaire.)

Did you engage in: (select all that apply)	# of hrs engaged in this therapy type	Overall satisfaction with experience				
		Not at all Satisfied		Completely Satisfied		
<input type="checkbox"/> Individual	___	1	2	3	4	5
<input type="checkbox"/> Couples	___	1	2	3	4	5
<input type="checkbox"/> Group	___	1	2	3	4	5
<input type="checkbox"/> Other, please specify:	___	1	2	3	4	5

Appendix F

CASES

(Lent, Hill, & Hoffman, 2003; used with permission)

General Instructions: The following questionnaire consists of three parts. Each part asks about your beliefs about your ability to perform various counselor behaviors or to deal with particular issues in counseling. We are looking for your honest, candid responses that reflect your beliefs about your current capabilities, rather than how you would like to be seen or how you might look in the future. There are no right or wrong answers to the following questions.

0 (“No confidence at all”) to 9 (“Complete confidence”)

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(Appendix continues)

Appendix F, continued

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Appendix F, continued

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Appendix G

COSE

(Larson et al., 1992; used with permission)

Directions: This is not a test. There are no right or wrong answers. Rather—it is an inventory that attempts to measure how you feel you will behave as a counselor in a counseling situation. Please respond to the items as honestly as you can so as to most accurately portray how you think you will behave as a counselor. Do not respond with how you wish you could perform each item—rather answer in a way that reflects your actual estimate of how you will perform as a counselor at the present time.

Below is a list of 37 statements. Read each statement, and then indicate the extent to which you agree or disagree with that statement, using the following alternatives:

- 1 = Strongly Disagree
- 2 = Moderately Disagree
- 3 = Slightly Disagree
- 4 = Slightly Agree
- 5 = Moderately Agree
- 6 = Strongly Agree

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Appendix G, continued

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Appendix G, continued

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Appendix H

IRI

(Davis, 1980, 1983; used with permission)

Directions: The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate number on the scale at the top of the page: Possible answer choices 0 (“does not describe me well”) to 4 (“describes me very well”). When you have decided on your answer, fill in the number on the answer sheet next to the item number. **READ EACH ITEM CAREFULLY BEFORE RESPONDING.** Answer as honestly as you can.
R = reverse scored

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Appendix H, continued

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Appendix I

CSPD-RF

(Torres-Rivera et al., 1995, used with permission)

Directions: Using the following 20 items, rate your personal and/or skill development (depending on the personal development or skill focus of the item) based on your observation of your most recent counseling session with your client. Each of the 20 items is to be rated, using the following Likert-type scale, from 1 (“unacceptable” – lowest rating) to 6 (“outstanding”—highest rating). Circle a number, for each of the 20 items that best indicates your rating of your personal and/or skill development in the session with your client.

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Appendix I, continued

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Appendix J

Work Involvement Scale (WIS) --- Clinical Skills Subscale

(Orlinsky & Ronnestad, 2005; used with permission)

Directions: Currently, in doing therapy...

1 “not at all,” 2 “slightly,” 3 “moderately,” 4 “much,” 5 “very much”

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Alayna B. Berkowitz
Curriculum Vitae

Education

Lehigh University, Bethlehem, PA Fall 2010 - August 2015

- Ph.D., Counseling Psychology
- Accredited by the American Psychological Association
- Advisor: Grace Caskie, Ph.D.

Dissertation: Influence of Engagement in Personal Therapy on the Perceived Therapy Competence and Self-Efficacy of Therapists-in-Training

Montclair State University, Montclair, New Jersey Fall 2008 - Spring 2010

- M.A., General Psychology
- Cumulative GPA: 4.0

Rutgers University, New Brunswick, New Jersey Fall 2003 - Spring 2007

- B.A., Psychology, Honors (Departmental and Rutgers College Honors)
- Minor: Music
- Cumulative GPA: 3.5, Psychology GPA: 3.75

Clinical Experience

University of Maryland, College Park, MD (accredited by the American Psychological Association)

Pre-doctoral Intern (7/2014 – present)

Supervisors: Pepper Phillips, Ph.D. and Rashanta Bledman, Ph.D.

- Conduct short-term individual therapy, career counseling, intakes, crisis intervention, and outreach with undergraduate/graduate students
- Administer and interpret the Strong Interest Inventory; MBTI; MMPI-2; PHQ9; BHM43; BHM20
- Co-facilitate a process-oriented therapy group
- Complete an assessment rotation with the LGBT Equity Center
- Serve as the intern representative on the Training Committee in which I evaluate pre-doctoral intern APPIC applications, sit in on internship interviews, and field applicants' inquiries about the internship experience

Lenape Valley Foundation Partial Hospital, Doylestown, PA

Practicum Trainee (6/2013 - 04/2014)

Supervisor: Phillip Braun, Ph.D.

- Facilitated psycho-educational groups (e.g., mindfulness, yoga, positive attitudes, relaxation, family relationships, healthy boundaries, leisure planning, etc.) and process groups
- Provided individual therapy and crisis intervention

- Conducted intake assessments and treatment planning
- Attended and participated in daily treatment team meetings

Lehigh University - University Counseling & Psychological Services, Bethlehem, PA

Practicum Trainee (9/2012 – 5/2013):

Supervisors: pre-doctoral interns, Elizabeth DeBoer Kreider, M.Ed. and Amanda Neri Luchansky, M.A.

- Provided individual therapy and conducted intakes
- Conducted individual therapy to clients who were mandated for treatment and informed case manager of attendance
- Co-facilitator for ongoing alcohol and other drug (AoD) process group for the fall and spring semester
- Conducted substance abuse intervention sessions with mandated clients using the SASSI-3 and AUDIT
- Used the NEO-PI-R and the MCMI in treatment planning with individual therapy clients

Kutztown University – Counseling Services, Kutztown, PA

Practicum Trainee (9/2011 - 5/10/2012):

Supervisor: Lisa Coulter, Ph.D.

- Provided individual therapy to Kutztown University students
- Utilized the Outcome Questionnaire-45 to track client progress
- Attended weekly didactic trainings and group supervision
- Developed and implemented outreach programming to students (e.g., stress management, health body image)

Supervisory Experience

University of Maryland, College Park, MD (accredited by the American Psychological Association)

Pre-doctoral Intern (7/2014 – present)

Supervisor: David Peterson, Ph.D.

- Supervise two practicum trainee
- Meet weekly for supervision of supervision
- Provide feedback on audio tape therapy sessions and clinical notes

Lenape Valley Foundation Partial Hospital, Doylestown, PA

Practicum Trainee (6/2013- 04/2014)

Supervisor: Phillip Braun, Ph.D.

- Served as a secondary supervisor to two masters level trainees
- Met with supervisees weekly
- Observed supervisees clinical work via live observations and provided feedback on interventions as well as case conceptualization

Lehigh University, Counseling Psychology Doctoral Program, Bethlehem, PA

Doctoral Supervisor (9/2012 – 4/2013)

Supervisor: Arpana Inman, Ph.D.

- Provided weekly individual supervision to two masters level counselor trainees on internship in a mental health clinic and international school
- Reviewed supervisees' clinical sessions each week, transcribed sessions, and provided feedback on clinical skills
- Conducted mid and final semester evaluations of trainees
- Co-facilitated group supervision of trainees on practicum placement in the Spring 2013 semester
- Participated in weekly group supervision of supervision seminar

Teaching

Lehigh University

Summer 2012

Teaching Apprenticeship: Diversity and Multicultural Perspectives Course

Under the direction of Dr. Timothy Silvestri

- Delivered lectures on LGBT issues and classism
- Provided assistance to graduate students in their course projects and academic development.

Sussex County Community College

Summer 2012, Summer 2011, and Fall 2010

Adjunct Instructor: Introduction to Psychology

- Prepared lecture material based upon the Sussex County Community College core standards
- Lectured on neuroscience, sensation and perception, cognition, development, and social psychology
- * Student evaluations available upon request

Lehigh University - University Counseling & Psychological Services

Fall 2012

Teaching Assistant: Sport Psychology

- Updated online course portal
- Consulted with students regarding comprehensive research project
- Graded assignments
- Prepared course content including literature review and prepared presentation materials using Prezis and PowerPoint

Lehigh University - University Counseling & Psychological Services

Fall 2011

Teaching Assistant: Two sections of graduate level Human Development Across the Lifespan course.

- Managed and updated online course portal, graded quizzes, and papers
- Assisted graduate students with any concerns related to research papers and presentations

Teaching Assistant for Health Psychology, Rutgers University

Summer 2008

Volunteer TA under the direction of Dr. Tami Musumeci-Szabo.

- Graded exams and assignments
- Assisted undergraduate students with research projects

Research Experience

Lehigh University – Center for Adolescent Research in Schools (CARS), Bethlehem, PA

Research Assistant (9/2013 – 5/2014)

Principal Investigator: Lee Kern, Ph.D.

- Conducted data entry and management for school-based intervention study
- Provided CBT-group training to high school staff in order to empower staff to implement interventions to students with social, emotional, and behavioral issues
- Attended weekly meetings to discuss research questions and proposals, as well as school-based interventions progress

Lehigh University – University Counseling & Psychological Services, Bethlehem, PA

Graduate Assistant (8/2011 - 7/2013)

Supervisor: Ian Birky, Ph.D.

- Participated in weekly case conference presentations and outreach meetings
- Developed and implemented outreach programming that served the unique needs of the Lehigh student community (e.g., Resident Advising Training, Alcohol & Hooking Up, Stress Management & Test Preparation, Speed-Friending)
- Developed, implemented, and co-facilitated biweekly outreach programming for international students scholars
- Assisted in conceptualizing research studies (e.g., college counseling intake research study and speed-friending study), data management, analysis, and IRB modifications
- Produced write-ups for on-going research projects for submission to psychological conferences including APA, MPA, and EPA

Lehigh University – College of Education, Bethlehem, PA

Graduate Assistant (9/2010 - 5/2011)

Supervisor: Grace Caskie, Ph.D.

- Organized class materials
- Assistant editor for the Division 20 APA newsletter
- Conducted data entry for growth curve models
- Assisted with pilot study evaluating counseling trainees' conceptions of working with the elderly, entered survey items into surveymonkey
- Reviewed doctoral and master students' application materials
- Corresponded with prospective applicants who expressed interest in the counseling psychology programs and answered questions
- Coordinated transportation and housing accommodations for doctoral applicants

Montclair State University - Parent-Infant Interaction Lab, Montclair, NJ

Graduate Assistant (9/2008 - 07/2010)

Principal Investigator: Peter Vietze, Ph.D.

- Conducted IRB alterations

- Coordinated three studies, recruited parents, conducted parent intakes, videotaped parent-infant interaction, and developed as well as implemented protocols
- Analyzed data using SPSS
- Interviewed, trained, and managed research assistants.

Graduate Assistant (9/2009-05/2010)

Under the direction of Katherine Ellison, Ph.D.

- Compiled and organized literature
- Teaching Assistant responsibilities including lecturing for Introduction to Psychology course when professor was absent

Rutgers University - Institute for Health, Health Care Policy, and Aging Research, Center for the Study of Health Beliefs and Behavior, New Brunswick, NJ

Research Assistant (9/2007 – 08/2010)

Principal Investigator: Howard Leventhal, Ph.D.

- Transcribed patient/doctor clinic visits
- Recruited and interviewed subjects for Processes of Illness Management (PRIM) study, "Practice Styles for Communicating with Patients" lab study, and Cardiac-Anxiety Study
- Constructed matrix for PRIM study
- Presented PRIM cases reflecting the "common sense model of self-regulation" at lab meetings
- Assisted in the development of interventions based on PRIM data
- Conducted data analyses for various projects using SPSS and assisted in various administrative tasks as needed
- Operated SNAP interviewing software

Rutgers University - Cognitive Development Lab, New Brunswick, NJ

Undergraduate Research Assistant (6/2005 – 5/2006)

Principal Investigator: Alan Leslie, Ph.D. and doctoral candidate, Marian Chen

- Recruited subjects, set up and observed experiments, and rescored looking times

Rutgers University - Cognitive Development Lab, New Brunswick, NJ

Lab Manager (9/2007 – 6/2008)

Principal Investigator: Alan Leslie, Ph.D.

- Recruited and trained undergraduate research assistants in subject recruitment and setting up and observing experiments
- Served as experimenter for two number studies that evaluated 9 month-olds' abilities to "count" using looking time paradigms

Rutgers University - Behavioral Neuroscience Laboratory, New Brunswick, NJ

Honors Student (1/2006 – 6/2007)

Principal Investigator: Mark West, Ph.D.

- Coordinated self-administration sessions and reinstatement testing among undergraduate research assistants

- Conducted reinstatement testing and conducted technician duties (repaired lab animal catheter tubing, back pressure checks, etc.)
- Collated files, analyzed data, developed data entry system, and developed potential analysis
- Coordinated schedules for research assistants
- Trained students on the project
- Presented updates at weekly lab meetings
- Used Sigma Stat and Sigma Plot for entry/graphing.

Other Professional Experience

21st Century Community Learning Centers Program, Paul Robeson Community Theme School for the Arts, New Brunswick, New Jersey

Paraprofessional (9/2005 – 6/2008)

Supervisor: Nicole Wines

- Prepared content and presentation materials for after school programming (e.g., video technology club) to at-risk fourth and fifth graders
- Prepared comprehensive materials for students' final projects presented to the community and family
- Assisted in homework
- Remediated behavioral altercations and provided remedies for problem behaviors

Publications

- Fabbriatore, A.T., Pawlak, A.P., Root, D.H., Harding, C.S., **Berkowitz, A.B.**, Kim, S.H., West, M.O. (in press). Contingent versus Non-contingent Conditioned Stimulus Reinstatement Models of Cocaine-Seeking Behavior Following 30d Abstinence in the Rat. *PLOS*, Retrieved from <http://www.plosone.org/home.action>
- Mora, P. A., **Berkowitz, A.**, Contrada, R. J., Wisnivesky, J. P., Horne, R., Leventhal, H., & Halm, E. A. (2011). Factor structure and longitudinal invariance of the Medical Adherence Rating Scale-Asthma (MARS-A). *Psychology & Health, 26*, 713-727. doi: 10.1080/08870446.2010.490585
- Mora, P.A., Contrada, R.J, **Berkowitz, A.**, Musumeci-Szabo T., Wisnivesky J., and Halm E.A. (2009). Measurement invariance of the Mini Asthma Quality of Life Questionnaire across African-American and Latino adult asthma patients. *Quality of Life Research, 18*, 371-380. doi: 10.1007/s11136-009-9443-9

Presentations

- **Berkowitz, A.B.** & Caskie, G.I.L. (August 2015). Does personal therapy influence trainees' perceived competence and self-efficacy? Poster session at American Psychological Association, Toronto, Ontario.
- Kivilighan, M., Jung, A.K., & **Berkowitz, A.** & Hammer, J.H. (2015). Are some therapists more effective at engaging clients in treatment than others? A multilevel analysis of therapist effect. Poster session at Big 10 Conference, Lincoln, Nebraska.

- **Berkowitz, A.** & Caskie, G.I.L. (August 2014). Factors that differentiate HIV-Positive individuals in help-seeking behavior and perceived need for help. Poster session at American Psychological Association, Washington, DC.
- Birky, I., Akamine, K., & **Berkowitz, A.** (August 2014). Living the Paradox: Feminine Women and Perceived Athletic Competence. . Poster session at American Psychological Association, Washington, DC.
- Birky, I., Spektor, E., & **Berkowitz, A.** (August 2013). Combination effect of sleep and social support on affect variables among college students. Poster session at American Psychological Association, Honolulu, Hawaii.
- Birky, I., **Berkowitz, A.**, & Spektor, E. (August 2013). Effects of sleep and social support in combination affecting student athlete mood states. Poster session at American Psychological Association, Honolulu, Hawaii.
- Spektor, E., **Berkowitz, A.** & Birky, I.B. (March 2013). Buffering effects of sleep quality and social support in the combination on academic distress of college students. Poster session at Eastern Psychological Association.
- Birky, I., **Berkowitz, A.**, & Spektor, E. (May 2013). Cluster effect of sleep quality and social support on college student academic distress. Poster session at Midwestern Psychological Association.
- **Berkowitz, A.**, Bedics, J., & Lee, S. (2012). How to Effectively Balance Clinical and Research Activities in Graduate School. Discussion session at American Psychological Association, Orlando, FL.
- Birky, I., Spektor, E., Sterba, A., & **Berkowitz, A.** (2012). Exercise and its Relation to College Student Emotional Wellbeing. Poster session at American Psychological Association, Orlando, FL.
- Bertsch, K. & **Berkowitz, A.** (March 2012). Leadership in a Diverse World: Highlighting Mindfulness, Awareness, and Cultural Sensitivity. Altitude Leadership Conference, Bethlehem PA.
- Caskie, G.I.L., **Berkowitz, A.**, & Margett, J.A. (2011). Directionality of the Longitudinal Relationship Between Objective and Subjective Health. The Gerontological Society of America, Boston, MA.
- Sutton, M.S., Caskie, G.I.L., & **Berkowitz, A.** (2011). Counseling Trainees' Attitudes Toward and Desire to Work with Older Adult Clients. Poster session at American Psychological Association, Washington, DC.
- **Berkowitz, A.B.**, Phillips, A., Leventhal, H., Leventhal, E.A. (2010). The Relationship Between Lifestyle-Related and Medication Adherence Factors in Hypertensive Patients. Poster session at The Gerontological Society of America, New Orleans, Louisiana.
- **Berkowitz, A.B.**, Kamhi, K.K., Lax, L.E., Diviney, E.A., Brodzicki, M.L. (2009). Applied Behavior Analysis to treat toddlers with Autism Spectrum Disorder. Poster session at the Eastern Psychological Association, Pittsburgh, PA.
- **Berkowitz, A.B.** (2007). Reinstatement of Cocaine Seeking Behavior in Rats by Non-Contingent Presentation of a Conditioned Stimulus. Psychology Honors Thesis. Advisor: Dr. Mark West.

Honors and Affiliations

- American Psychological Association of Graduate Students (Summer 2011-present)
- Certified Positive Parent Discipline Educator (Spring 2013)
- Lehigh University, Teacher Development Certification (Fall 2010)
- Association for Women in Psychology – Student Affiliate (Fall 2010)
- Montclair State University, Phi Kappa Phi (Spring 2010-present)
- Montclair State University, Alpha Epsilon Lambda Honor Society (Fall 2009-present)
- Montclair State University, Graduate Assistant. Award included tuition remission and stipend. (Fall 2008-Spring 2010).
- Rutgers University, Henry Rutgers Scholars Program and stipend (Fall 2006-Spring 2007).
- Rutgers University: Dean's List (Fall 2005-Spring 2007).
- Selected by undergraduate advisor, Dr. West, to be a part of the Aresty Research for Undergraduate Video Project. (Fall 2008).
- Rutgers University: awarded funding from Aresty Research for Undergraduate Students and selected to present honors thesis poster at the Aresty Undergraduate Research Symposium (Fall 2006-Spring 2008).
- EPA Associate 2006-2007; 2008-2009.

Volunteer Work

Lehigh University, Women's Center

Fall 2010- Spring 2011

Supervisor: Rita Jones, Ph.D.

- Assisted in planning and coordinating Healthy Body Image week, including running discussions and participating in weekly meetings.

Lehigh University, University Counseling & Psychological Service Spring 2011

- Coordinated and facilitated collaboration with the Women's Center for Health Body Image Week; specifically co-running a mindful eating workshop. Created and co-facilitated alcohol awareness workshops for an on-campus fraternity and several sororities.

America Reads/ America Counts:

September 2010 – December 2010

Broughal Middle School, Bethlehem PA

- Tutored reading and math in an emotional support classroom for students in 6th, 7th, and 8th grade.

McKinley Elementary School, New Brunswick, NJ

Fall/2005

- Citizen School Teacher- instructor for video technology with at risk-youth between ten and thirteen years of age.