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Barriers to care: what stops psychologists from seeking mental health services

Jennifer Lynn Barse
George Fox University

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Barriers to Care: What Stops Psychologists From
Seeking Mental Health Services

by

Jennifer Lynn Bearse

Presented to the Faculty of the
Graduate Department of Clinical Psychology

George Fox University

In partial fulfillment

Of the requirements for the degree of

Doctor of Psychology

in Clinical Psychology

Newberg, Oregon

March 9, 2012

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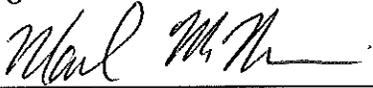
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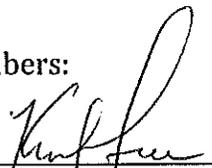
Signatures:



Mark McMinn, Ph.D., Chair

Date: 3/9/12

Members:



Kurt Free, Ph.D.

Date: 3/9/12



Winston Seegobin, Psy.D.

Date: 03/09/12

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Jennifer Lynn Bearse

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Abstract

Psychologists have been working for many years to eliminate the obstacles that prevent individuals in need of psychotherapy from seeking it out. The stigma of receiving mental health services is a deterrent for some, and the fear of sharing intimate details of their lives inhibits others. Financial constraints, lack of time, and a lack of knowledge are other reasons why people fail to acquire help from psychologists. But psychologists themselves are also sometimes hesitant to seek out help in times of mental distress. Some of the reasons are similar to those of the general population, whereas others differ, including the expectation that psychologists should be able to treat themselves, or the challenge of finding a therapist with whom there is no existing relationship (e.g., as a colleague or a competitor). In order to preserve the effectiveness of those in the mental health care field, it is important to identify these barriers and to seek ways of eliminating them. The primary purpose of the current study was to investigate possible barriers for

psychologists in seeking mental health services. A profile analysis revealed that difficulty finding an acceptable therapist and lack of time had significantly greater impact than other factors. Additionally, burnout was identified as the stressor most impacting therapeutic efficacy.

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Chapter 1

Introduction

Psychologists have been striving for many years to eliminate barriers that deter people from seeking mental health care, and efforts have been made to reduce the stigma of psychotherapy as well as to increase public awareness of its benefits. But when those who care for the mental health of others are in need of care, how willing are they themselves to seek it out? Are the very ones who provide mental health services sometimes resistant to obtain those services for themselves? Psychologists are quick to encourage others to avail themselves of the mental health services they offer, but whether they are as prompt to pursue personal therapy for their own needs may depend on a variety of factors.

Before considering these factors, it is fitting to discuss risk factors for psychologists that may at times require them to seek personal therapy. Psychologists are trained to recognize dysfunctional relational patterns, emotional problems, and sources of psychological distress in their clients that lead to depression, anxiety, and other mentally unhealthy outcomes. Some within the field think it is reasonable to expect that they should be able to recognize those conditions in themselves and deal with them accordingly (Deutsch, 1985). But for those who practice psychotherapy, the field is infused with risk factors that often go beyond the scope of self-diagnosis and treatment. The mental and

emotional toll of working with those who are struggling can eventually become debilitating as the resources that are often used in personal coping are expended on the needs of those who are being served.

Risk Factors for Psychologists

The risk factors inherent in the practice of psychotherapy are varied. The nature of clinical work is such that many psychologists are working on a consistent basis with individuals who are, in essence, unloading their psychological and emotional burdens in therapy in the hope of finding relief from pain, distress, and dysfunctional behaviors. Over time, the psychotherapist's role of at least temporarily sharing these burdens can cause distress ultimately leading to burnout, depression, and even suicidality. Additionally, vicarious traumatization and compassion fatigue, countertransference, and a history of personal trauma can also take their toll on those practicing in the field of mental health.

Burnout. A common nemesis to mental healthcare providers is burnout. As defined by Jenaro, Flores, and Arias (2007), it is the result of:

chronic labor stress that is composed of negative attitudes and feelings toward coworkers and one's job role, as well as feelings of emotional exhaustion. It is commonly conceptualized as a syndrome composed of emotional exhaustion, depersonalization, and a reduction of personal accomplishment. (p. 80)

O'Connor (2001) identified a number of factors that can lead to burnout, including placing the needs of others before one's own, the ability to control one's emotions when faced with reported trauma and intense emotion, increased sensitivity to people and the environment, and isolation. Other potential issues affecting burnout are negative client behaviors, lack of

therapeutic success, and the demands of paperwork and administrative duties (Norcross, Guy, & Laidig, 2007). The cost of burnout in a mental health practitioner can be quite high, including personal distress for the person experiencing the burnout, employee turnover costs for the agency, and potential harm to the client who is receiving services from a therapist who is working in a diminished capacity (Rupert & Morgan, 2005).

Depression and suicidality. Depression has been identified as a prevalent symptom of distress in psychologists. In a study by Pope and Tabachnick (1994), the majority of the psychologists surveyed (61%, $n = 476$) indicated they had experienced at least one episode of clinical depression. In another study, 62% ($n = 425$) of the APA Division 17 (Counseling) members surveyed identified themselves as depressed, with a sense of withdrawal and isolation from colleagues being cited as the most frequent issues associated with the depression (Gilroy, Carroll, & Murra, 2002).

Perhaps most troubling is the rate of suicidality among psychologists. In the same study by Pope and Tabachnick (1994), more than one-fourth (29%) of those surveyed indicated they had felt suicidal, and almost 4% indicated they had made at least one suicide attempt. In the study by Gilroy et al. (2002), 42% of the respondents reported experiencing suicidal ideation or behavior. Furthermore, of more than 230 occupations analyzed by epidemiologists at the National Institute of Occupational Safety and Health (NIOSH), male psychologists were the most likely to commit suicide, with an odds ratio of 3.47 times greater than the general public (Ukens, 1995).

Vicarious traumatization and compassion fatigue. In addition to the complications associated with burnout, psychologists are at risk for vicarious traumatization and compassion fatigue related to the events their clients have experienced. Vicarious traumatization refers to the effects of graphic and traumatic material presented by clients, and compassion fatigue can occur as the result of repeated exposure to the experiences of victims of traumatic events. According to Figley (2002), there are several contributing factors to compassion fatigue in psychotherapists, including empathic ability to recognize the pain of others, the motivation to respond to it, and the extent to which the therapist actually experiences the painful emotions of the client in an attempt to empathically understand them. Direct exposure to the client's emotional suffering and a prolonged sense of responsibility for the client's care also contribute to compassion fatigue.

Countertransference issues. Another risk factor for mental health practitioners is in the area of countertransference, a phenomenon in therapy that can impact cognitive, affective, and behavioral responses to particular clients. Countertransference can manifest itself in a variety of ways, but the ones that are most problematic occur: (a) when psychologists do not recognize the potential therapeutic benefits of understanding countertransference and assume that all such feelings are to be avoided, (b) when countertransference is poorly managed because of the psychologist's own unresolved issues, and (c) when countertransference feelings turn into behaviors, particularly in the areas of sexualized or hostile behaviors (Burwell-Pender & Halinski, 2008).

Background issues. Finally, it is a common conception that people who go into psychology are those who are trying to figure out their own issues. Though this sounds like

a sweeping generalization, it may be true that a portion of psychologists are predisposed to mental illness prior to entering the field. Some might see a career in psychotherapy as a way of working through their own psychological problems. Others may view psychotherapy as a way to reduce loneliness, and some may enjoy the sense of power and control that they experience in the therapy setting (Guy, 1987).

Research indicates that mental health professionals are often raised in dysfunctional families, resulting in adult psychological distress. One study revealed that 66% of women in mental health professions have experienced childhood trauma compared to 49% of other female professionals (Elliott & Guy, 1993). Though traumatic childhood experiences may enable therapists to be more empathetic toward troubled clients as “wounded healers,” an internal motivation for personal healing will place the therapeutic relationship at risk (Guy, 1987).

Potential Benefits of Psychotherapy for Psychologists

Although there are multiple risks of mental health problems among psychologists, the benefits of personal therapy are also substantial. A discussion with a research team consisting of a licensed psychologist and several students in a doctorate of clinical psychology program produced a list of possible benefits. By participating in therapy during times of psychological distress, psychologists are likely to extend their careers, improve their own clinical skills, attain a greater sense of competence, and gain a sense of camaraderie with one who can relate to the pressures of mental health work.

Longevity. Having identified burnout and compassion fatigue as inherent risk factors in the work of a psychologist, one of the major benefits of engaging in

psychotherapy can be the extension of the career. By reducing or even eliminating these factors, it is reasonable to assume that the strain on the mental and emotional capacities of therapists would be minimized, thereby increasing the ability to continue in the profession for a greater period of time.

Effectiveness. In addition to being able to practice longer, research shows that experiential learning allows clinicians who engage in personal therapy to gain a greater understanding of the nature of their work and as a result to become more effective in meeting the needs of their clients (Daw & Joseph, 2007). Some master's and doctoral programs even require that their students participate in psychotherapy as part of their training.

Competence. A noteworthy benefit of engaging in psychotherapy is that psychologists gain a greater sense of competence in their own ability to help others by having dealt successfully with personal issues of their own (Pope & Tabachnick, 1994). A mental health professional who is struggling with anxiety or depression may have doubts about his or her ability to be effective in working with clients who battle these same issues. By addressing them in therapy and achieving success in overcoming them, these clinicians may attain a level of confidence that would otherwise elude them.

Camaraderie. Another benefit of seeking psychotherapy lies in the fact that help is being sought from a colleague in the field who understands and can relate to many of the challenges of an occupation in mental health care. This sense of camaraderie and shared experience can help to diminish feelings of isolation for therapists who feel that they alone

are unable to deal with the emotionally demanding nature of the work (Coster & Schwebel, 1997).

Deterrents to Seeking Psychological Help

One of the biggest limitations to psychotherapy is that in order to benefit from it, a person must seek it out and engage in the process. Unfortunately, for many who are suffering from psychological distress, several deterrents keep this from happening. A number of these barriers have previously been identified in the literature, including social stigma (Komiya, Good, & Sherrod, 2000), treatment fears (Deane & Todd, 1996; Kushner & Sher, 1989), fear of emotion (Komiya et al., 2000), anticipated utility and risks (Vogel & Wester, 2003; Vogel, Wester, Wei, & Boysen, 2005), and self-disclosure (Hinson & Swanson, 1993; Vogel & Wester, 2003). Social norms and self-esteem have also been proposed as factors that impact the decision to seek therapy (Vogel, Wester, & Larson, 2007). Although some of these barriers exist for almost everyone, literature supports the proposal that others may have specific components that are unique to mental health professionals.

Stigma. Stigma is a deterrent that may exist to some degree for almost all individuals considering psychotherapy. In spite of all of the work that has been done to remove its impact on seeking out mental health care, stigma continues to be a deterrent. It is likely that this is also true within the community of mental health professionals who may be viewed negatively not only by family and friends but also by clients, employers, and colleagues who may question the ability of a psychologist who is struggling with his or her own psychological distress (Barnett, Baker, Elman, & Schoener, 2007). A psychological

diagnosis can also lead to problems in the area of insurance, where certain diagnoses can impact the ability to get adequate coverage.

Unwillingness to admit distress. In addition to the perception of others, another obstacle to treatment for mental health practitioners is their potential unwillingness to admit to themselves that they are experiencing distress. This admission, and subsequently the acknowledgement that they are unable to handle the problem on their own, can lead to a sense of incompetence and inadequacy as a clinician. Another component of admitting distress is the fear of being unable to contain the emotions once they are expressed (Walsh & Cormack, 1994). A third stumbling block related to self-disclosure associated with admitting personal distress exists in the form of legislation such as Oregon's "Duty to Report" law, passed in 2009, which requires licensed health professionals to report "prohibited or unprofessional conduct" of other health licensees to their professional licensing boards ([Duty to report, 2009](#)). Though protection is provided for information obtained in a therapy session, fear and uncertainty still exist with regard to confidentiality.

Therapist selection. Another challenge can be in the selection of a therapist. Whereas therapist selection factors such as location, availability, qualifications, language barriers, and theoretical orientation may be of concern for anyone seeking therapy, other factors are specific to mental health care providers. One of these is the problem of dual relationships, where potentially all clinicians within a reasonable distance could be colleagues, peers, mentors, mentees, supervisors, or teachers (Deutsch, 1985). Another complicating factor might be the matter of competition between practitioners, the presence

of which would make the establishment of a safe and trusting relationship between client and therapist a near impossibility.

Lack of time and/or financial resources. On a practical note, many psychologists face a lack of time and/or money. A career in psychology requires continual education, working around client schedules, sometimes traveling between practice sites, staying up to date on current literature, and carrying client loads that may exceed 10-12 hours per day. Additionally, most early-career psychologists are paying off educational loans. According to the 2007 Doctorate Employment Survey produced by the APA Center for Workforce Studies, 84% of graduates with a PsyD in Clinical Psychology reported some debt, with a median reported debt level of \$100,000 (APA, 2007). In light of these limitations and demands, the commitment of time and financial resources required for psychotherapy can be excessively burdensome.

Purpose of the Current Study

One challenge to this discussion of potential obstacles to treatment is that very little systematic research has addressed this issue. The point of the current study was to identify the prominent barriers to treatment among psychologists. A list of possible barriers was presented to psychologists who rated the relative salience of each when deciding about personal therapy. Given the lack of systematic research in this area, no specific hypotheses were offered as to which barriers would be rated most highly. Identifying the most prominent barriers will be helpful both for future research, and so barriers can be addressed in such a way that seeking mental health care, when needed, becomes an obvious choice without stigma or consequence.

Chapter 2

Methods

Participants

Participants for this study were male and female members of the American Psychological Association. The study included only those who had indicated clinical psychology as both their current major field and their area of interest on their APA profile. Five hundred names were randomly drawn from the APA Membership Directory, available online.

Two hundred sixty individuals participated in the study, resulting in a 52% response rate. The gender of the participants was fairly evenly split, with 134 females (52%) and 122 males (48%) responding. Ethnic diversity was limited within the group, with 87% of respondents (220) identifying themselves as European American. Seven participants identified as Hispanic/Latino, 6 as Asian/Pacific Islander, 3 as African American, and 15 endorsed "Other," possibly suggesting a multiracial ethnicity. The mean age was 58 years, with a range of 30 years old to 95 years old, and the mean number of years in practice was 24. The majority of respondents indicated that they work in an urban setting (44%), whereas 38% endorsed working in a suburban setting, and the remainder noted working in either a rural area (15%), or a combination of two or more of these locations (7%). Seventy percent of participants indicated that they are practitioners in a

private practice, with the remaining 30% fairly evenly divided amongst community mental health, medical settings, academic settings, government/industry, other, or a combination of two or more of these settings. Respondents reported a mean number of years in practice of 23.67 ($SD = 11.32$). They also reported a mean of 73.95 ($SD = 50.56$) appointments per month, with a mode of 100 and a range of 0 to 250.

Instruments

Participants were asked to fill out a survey (Appendix A) regarding stressors that may have affected their ability to function effectively. The item choices were consistent with the literature and included burnout, depression, countertransference, vicarious traumatization/compassion fatigue, and personal history/trauma. They were also asked to identify factors that have affected their decision to seek personal psychotherapy, including stigma, unwillingness to admit distress, difficulty selecting a therapist, lack of time, lack of financial resources, and a preference to rely on spiritual means of coping. These choices were also consistent with the literature. Participants rated these items on a five-point Likert-type scale, ranging from 1 (*Never*) to 5 (*Often*). In addition, participants were asked to provide information regarding if and when they have participated in personal therapy. They were also asked about their own theoretical orientation as well as the theoretical orientation that they would prefer in a therapist. Demographic information was requested in this survey.

Procedures

Participants were contacted by mail with a letter explaining the study, a copy of the survey, and a pre-addressed, stamped envelope. A small incentive of \$2 was also included.

Information regarding informed consent was included in the cover letter, and consent was inferred when participants returned the survey. The envelopes were marked with identification numbers for the purpose of follow-up, but the actual surveys were kept anonymous by having a third party separate them from the envelopes immediately upon receipt. Participants who were interested in the outcome of the study were provided an e-mail address where they could send a request for a copy of the results.

Chapter 3

Results

Descriptive statistics were used to explore response trends among psychologists. Repeated measures ANOVA followed by profile analyses using paired sample t-tests were implemented to rank order factors impacting therapeutic efficacy and obstacles that deter psychotherapists from seeking therapy. A Mann-Whitney U test was used to determine the significance of the difference between genders regarding the median number of sessions attended.

Table 1 summarizes the ratings on five stressors that may impact therapeutic efficacy. The items are listed in order of the overall impact ratings, with the highest rated items at the top of the list. An overall difference was found among the five stressors, Wilks' $\lambda(4, 251) = .82, p < .001$, which justified profile analyses using paired sample t-tests to determine which items were significantly lower than the preceding item on a rank-ordered list, using a conservative α of .01 to control for Type I error.

Overall, participants did not report feeling that the five stressors listed were substantially impacting their ability to function effectively as a therapist. However, on a Likert-type scale of 1 (*Never*) to 5 (*Often*), participants indicated that burnout (mean of 2.18) had the greatest impact on their therapeutic work. They were least affected by

personal trauma (mean of 1.71). Respondents frequently noted other stressors, including family issues, personal health, the death of a family member or friend, and the administrative challenges of running a practice as having an impact on their therapeutic functioning.

Table 1

Stressors that Impact Therapeutic Efficacy

	Overall
Burnout	2.2
Countertransference*	1.9
Vicarious Traumatization/Compassion Fatigue	1.9
Depression	1.9
Personal Trauma**	1.7

Notes. All items were rated on a 5-point Likert scale, ranging from 1 (*Never*) to 5 (*Often*). Items are arranged in descending order based on overall impact ratings. * indicates items rated significantly lower than the preceding item ($p < .01$). ** indicates items rated significantly lower than the preceding item ($p < .001$).

With regard to seeking therapy, survey results suggest that most clinical psychologists have engaged in their own personal therapy. Out of 258 responses, 221 participants (86%) indicated they had participated in psychotherapy at some point in their lives, with a mean of 12.69 years ($SD = 11.15$) having passed since their last session.

Respondents reported taking part in means of 221.69 sessions ($SD = 450.41$), and 2.7 courses of therapy ($SD = 1.82$). The majority of those reporting past participation in psychotherapy viewed it positively, with 84% indicating some level of satisfaction with the experience and nearly half (47%) reporting feeling “very satisfied.” Only 7 respondents (3%) reported any degree of dissatisfaction. Nevertheless, when asked if there was a time when they may have benefitted from therapy but did not seek it out, 59% of respondents answered affirmatively. These results indicate that, although clinical psychologists are open to seeking therapy and usually find it beneficial when they do, there are factors that deter them from doing so.

Survey participants were asked to rate the degree to which six specific factors have functioned as a deterrent in their decision to seek personal therapy. Table 2 summarizes the ratings on these items, with the items having the most impact at the top of the list. Overall differences were found, Wilks' $\lambda (6, 243) = .51, p < .001$, again justifying profile analyses using paired sample t -tests to determine which items were significantly lower than the preceding item on a rank-ordered list, using a conservative α of .01 to control for Type I error.

Results suggest clinical psychologists are not unreasonably hindered by any of the factors that were identified in the survey, but some items influence them more than others. Using the same Likert-type scale previously described, the majority of respondents reported that difficulty finding an acceptable therapist had deterred them the most (mean of 2.6). Some noted a lack of available therapists in their area, while others frankly stated they did not believe they could find a therapist that would be as competent as themselves.

Still others indicated they believe they have the necessary knowledge to help themselves. Lack of time and financial resources appeared to play a lesser role in determining whether mental health professionals seek therapy, along with difficulty admitting distress. Professional and personal stigma were identified as having the least impact on the decision to seek therapy. Some participants also noted poor mental health coverage from their insurance companies or a hesitance to use their insurance due to confidentiality concerns as additional deterrents.

Table 2

Barriers to Seeking Therapy

	Overall
Difficulty selecting an acceptable therapist	2.6
Lack of time*	2.4
Lack of financial resources**	2.0
Difficulty admitting distress	1.7
Professional stigma (might affect professional reputation)	1.7
Personal stigma (my view of self or others' view of me)**	1.4

Notes. All items were rated on a 5-point Likert scale, ranging from 1 (*Never*) to 5 (*Often*). Items are arranged in descending order based on overall impact ratings. * indicates items rated significantly lower than the preceding item ($p < .01$). ** indicates items rated significantly lower than the preceding item ($p < .001$).

Respondents were asked to identify their therapeutic orientation, and also to indicate the therapeutic orientation they would prefer in a therapist. The responses to these questions are displayed in Table 3. The largest group of respondents reported that they use a Cognitive/Behavioral Therapy (CBT) approach, and 61% of those indicated they

Table 3

Therapeutic Orientation Comparison

Respondent Orientation	Preferred Therapist Orientation						Total
	CBT	Humanistic	Psychodynamic	Systemic	Other	Combined	
CBT	59	7	9	2	12	8	97
Humanistic	1	18	1	0	1	0	21
Psychodynamic	3	0	65	0	3	3	74
Systemic	0	0	0	4	2	0	6
Other	1	6	1	0	14	0	22
Combined	0	1	8	1	1	19	30
Total	64	32	84	7	33	30	250

would prefer to work with a CBT therapist. The second largest group identified themselves as using a Psychodynamic approach to therapy, and 88% of those said they would choose to work with a Psychodynamic therapist. Several respondents (12%) indicated that they utilize more than one therapeutic modality in their work, and 63% of those said they would

seek a therapist who would use a similarly eclectic approach. A Humanistic approach was endorsed by a small group, most of whom would also seek a Humanistic therapist, and another group of similar size indicated they use some other modality than those listed on the survey, e.g. EMDR, Biopsychosocial, Integrative.

Various demographic variables, including ethnicity, age, gender, practice type, and setting, were evaluated to determine group differences among respondents. The lack of diverse ethnicity within the group eliminated the possibility of finding significant ethnic differences, and no notable differences were discovered based on type or setting of practice. Significant age correlations occurred, with younger respondents reporting time ($r = -.290, p < .001$) and money ($r = -.234, p < .001$) being more of an obstacle to seeking psychotherapy than older participants. An evaluation of gender produced some interesting results. Significant differences were found between men and women with regard to the impact of vicarious traumatization and compassion fatigue on therapeutic efficacy, $t(251) = 2.26, p = .024$, with women identifying those issues as having a slightly greater impact than men (female mean = 2.04, male mean = 1.8). Women also reported being significantly more influenced by three of the barriers to seeking personal therapy, including difficulty selecting a therapist, $t(248) = 2.88, p = .004$, lack of time, $t(249) = 2.68, p = .008$, and lack of financial resources, $t(249) = 2.08, p = .039$. Women were significantly more likely to have engaged in personal therapy, $t(253) = 3.27, p = .001$, with 93% of females reporting past therapy experience compared to 79% of males. Finally, due to the skewed distribution of responses, a Mann-Whitney U test was used to determine differences between men and women with regard to the number of sessions in which each had participated, and a

significant difference was found, $U = 3967.5, p = .037$. Women as a group reported engaging in a higher number of sessions than men, with a median of 80 sessions for women compared to a median of 50 sessions for men.

Chapter 4

Discussion

The purpose of this study was to determine whether or not clinical psychologists seek out mental health services for themselves when they are in distress, and to identify the prominent barriers that deter them from doing so. Results from the survey overwhelmingly suggest that psychologists do seek treatment, with 221 respondents indicating they have participated in personal therapy, and only 37 indicating they have not. This participation rate of 86% is quite similar to that of the Pope and Tabachnick study (1994) in which 84% of the psychologists surveyed had participated in psychotherapy. This may appear quite encouraging at first glance, and one might think that as a group, psychologists should be among the most mentally healthy of all professionals. But previously noted data on depression and suicidality among psychologists indicate there is trouble lurking in the shadows. Though 86% of respondents reported having engaged in therapy at some point in their lives, and 47% indicated they were “very satisfied” with the experience, still 59% revealed there was a time when they may have benefitted from therapy but did not seek it out. This is an increase from the 34% of respondents in the Deutsch (1985) study who indicated they did not seek out psychotherapy or other forms of treatment when needed. As a profession, clinical psychology relies on its clinicians’ ability

to be engaged, empathic, objective, and in tune with their clients, all skills that require sound mental health and fitness on the part of the clinician. Consistently applying these skills can be mentally and emotionally taxing in the best of circumstances, but attempting to implement them in the midst of personal distress can be overwhelming and ultimately destructive to the client, the therapist, and the relationship between the two. Principle A, Beneficence and Nonmaleficence, of the aspirational General Principles of the APA Ethics Code (APA, 2002), states 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. 3). Therefore, the field of clinical psychology must surely be attentive to issues that deter clinicians from engaging in therapy to curtail personal distress and enhance their capacity to carry out these directives.

Participants reported that the factor having the greatest impact on their decision to seek therapy was difficulty finding an acceptable therapist, a finding also noted in the Deutsch (1985) study. A variety of reasons were indicated, including the youthfulness of available therapists, incompetence, distance, dual relationships, lack of therapists of the same ethnicity, and disappointment with previous therapists. It is likely that these deterrents exist for the general population when contemplating whether or not to pursue mental health services to address personal distress, but the concern of dual relationships is particularly challenging for psychologists, particularly in small towns and rural communities, where the only other available therapists may also serve as a supervisor, a colleague, a mentor, or a competitor. Several respondents stated quite clearly they did not feel they could find a therapist who would be able to help them better than they could help

themselves. One participant stated, "I feel like I already have the answers and knowledge to treat myself," while another said, "I know too much . . . I believe I would know as much as any therapist I could see." Still others stated, "I would have a hard time finding someone as good as me!" and "I understand the issues better than most therapists would, so who would I see? I'm the best therapist I know." Though it is somewhat common to view one's abilities as better or more developed than one's peers, it is unfortunate this perception restricts some mental health professionals from engaging in the healing dialogue that psychotherapy can provide.

It was encouraging to note that personal and professional stigma were identified as having the least impact on seeking therapy, a concern that has been raised in previous literature (Barnett et al., 2007). Though the stigma of participating in psychotherapy seems to still impact the general population to some degree, it appears that, at least within the profession itself, these concerns have been predominantly eradicated. As previous research has indicated, the experiential aspect of personal psychotherapy can have a positive impact on one's professional effectiveness (Daw & Joseph, 2007); one respondent indicated her experience with therapy had helped her not only on a personal level but also professionally, stating, "it helped me to become a good therapist myself." Still, another respondent indicated she "would not want a colleague to see me upset," suggesting that some concerns may still exist over the impact of therapy on one's reputation.

Perhaps most surprising was the number of respondents who indicated they did not feel psychotherapy was the only or the best way of dealing with distress, or perhaps even helpful at all. I expected that, when surveying clinical psychologists, the benefits of therapy

would be consistently stated. However, this was not true, as made clear by multiple statements to the contrary. Participants reported having “the perspective that therapy may not be as useful as exercise, social support, meditation and R & R,” feeling that “professional therapy is not the only way to be helped,” having “found other means of coping,” feeling “more in control and empowered by my own self-care,” utilizing “other therapeutically effective means,” and “desiring to solve problems by self-examination.” Statements such as these suggest that although they may see some value in the work done in psychotherapy, some believe other means of dealing with problems and distress may be more beneficial. And yet, these responses may conceal the fact that, though some psychologists refrain from engaging in actual psychotherapy, they may seek unofficial therapy through engagement with peers. This is supported by survey responses such as “I have good friends who are also good psychologists. I’ve never needed to pay for a pro – I have a good supportive network,” and “I meet in weekly consult groups with four other psychologists,” and “My wife is a therapist. We support each other.”

Results of the survey clearly indicated that clinical psychologists experience stress from a variety of sources, though none of the stressors named on the survey were reportedly impacting their ability to perform as a therapist to a great degree. Burnout was identified as having the greatest ramifications, and this makes sense in light of the mental and emotional strain of working in the field of mental health. But perhaps more telling with regard to the impact of stressors on professional functioning is the fact that out of 260 surveys returned, 160 respondents named additional stressors they felt had to some degree impacted their ability to function effectively as a psychologist. These difficulties

varied widely, ranging from suicidal patients to conflicts with coworkers. However, the bulk of these responses fell into four major categories, including (a) difficulty working with insurance companies, (b) personal losses, (c) family strife, and (d) financial difficulties. The frequency of these unprompted responses suggests that psychologists are consistently operating under the strain of life circumstances that are burdensome and intrusive.

Differences between male and female respondents with regard to stressors affecting therapeutic efficacy suggest female psychologists struggle more with the effects of vicarious traumatization and compassion fatigue than their male counterparts. Though reasons for this are not certain, a third-wave feminist perspective leaves open the possibility of gender differences that foster different leadership and interpersonal styles. For example, it may be that women experience a stronger natural caregiver response to their clients, making it more difficult to maintain emotional distance from the impact of traumatic events experienced by their clients.

Results of the survey also seem to indicate that women are impacted by some of the deterrents to seeking therapy to a greater degree than men. Finding an acceptable therapist appears to be more problematic for women, as well as are the challenges of limited time and money. The explanations for these differences are unknown, but one possibility is that women may have a higher expectation for the relationship and rapport between practitioner and client, qualities that can be difficult to establish in an introductory session or through a review of credentials. This premise is supported by research indicating women tend to be more empathic than men, a characteristic that may lead to an increased level of expectation for this quality in a therapist (DiLalla, Hull, &

Dorsey, 2004). Research by Shapiro, Ingols and Blake-Beard (2008) indicated many working women face a career/family double bind in which they are impossibly expected to invest in both. This conflict would seemingly increase the need for therapeutic help, but it is also likely to make the time commitment of therapy unfeasible (Shapiro et al., 2008). Concerns about financial limitations may be related to this as well, as women with a greater burden of responsibilities at home may work fewer clinical hours than men resulting in less disposable income. In addition, greater financial concerns among female psychologists may be related to the disparity in compensation between equally qualified women and men—the 2009 Doctorate Employee Survey revealed that the median starting salaries for graduates receiving their doctorate in psychology the previous year was \$8000 lower for women than for men (Michalski, Kohout, Wicherski, & Hart, 2011).

In spite of these concerns, female psychologists are much more likely to engage in psychotherapy at some point in their lives, suggesting the anticipated personal benefit of doing so is worth overcoming the perceived barriers. Not only are women more likely to participate in personal therapy, they are also likely to engage in more sessions than men. Reasons for this are speculative, but it may be that men need to reach a greater level of distress than women before they seek help, or perhaps the dialoguing nature of therapy is more comfortable for women than for men. Also, the increased difficulty women experience in finding a therapist may translate into a longer course of therapy with more frequent sessions once they commit to an acceptable practitioner.

Implications

These findings support the importance of introducing and encouraging personal therapy as early as during the doctoral training process for new clinicians. Though there is little documented research comparing the effectiveness and well being of therapists who do and do not engage in their own personal therapy, the plethora of research demonstrating the positive effects of therapy in general suggests that psychologists who take part in their own therapy will benefit both personally and professionally. Simply encouraging young clinicians to engage in therapy is not enough, however. The factors deterring individuals from pursuing therapy must be addressed, particularly the difficulty of finding an acceptable therapist. Though this is not an easy task, possible resources are emerging that may provide opportunities that have not existed in the past, including technological advances that make long distance psychotherapy possible, such as Internet-based videoconferencing (e.g., Skype). This rather recent innovation alone opens up opportunities for psychologists practicing in small towns and rural settings where other mental health professionals are scarce or non-existent. Though concerns still exist regarding the ethics and confidentiality of using technology in the therapy office, the benefits may outweigh the risks (McMinn, Bearse, Heyne, Smithberger, & Erb, 2011).

Other prohibiting factors need also be addressed. The pursuit for parity in compensation for mental health services must continue so psychologists who are 20 years into their career are not still citing the repayment of college loans as a financial deterrent for seeking therapy. Reported differences in compensation between men and women suggests this parity battle must also extend to within the profession itself, ensuring that

comparably qualified practitioners are compensated equally, regardless of gender. New psychologists must be supportively mentored and reminded of the importance of self-care and personal time in the midst of the frenzied rush to establish a practice and build a full client base. Admission of distress should be encouraged and respected as a sign of maturity and the taking of responsibility for one's own health and ability to function effectively as a therapist. Therapies should be designed for the communication style and problem-solving techniques of men rather than relying on a "one-size fits all" mentality.

Limitations

There are several limitations to this study. The first is that the mean age of participants was 58.2 years. A recent study by Michalski and Kohout (2011) reported the mean age of psychology health service providers as 53 years old, a five-year difference indicating younger clinicians were not adequately represented among the survey respondents of the present study. One possible implication of this is that, whereas the participants of this particular study demonstrated a high rate of participation in psychotherapy, a younger group of clinicians may reveal less participation due to greater financial constraints, larger client loads, and less time in which to have engaged in therapy. This may mean the results are not generalizable to that population.

Another limitation was the lack of ethnic diversity in the group of participants. Though the field of psychology as a whole is heavily weighted towards practitioners of European American descent, this does not reduce the need to determine the barriers that deter clinicians of other ethnicities from seeking therapy. On the contrary, the lack of

clinicians from diverse ethnic and cultural backgrounds is even more reason to identify and eradicate all obstacles that may be restricting their numbers.

The lack of a clear definition of the term “therapy” may have led to uncertainty and inconsistent responses from those participants who were not sure whether to include participation in couples, family, and/or group therapy in addition to personal therapy. Future research would benefit from greater clarity regarding the term “therapy.”

Also, there was no way to control for response bias. Those recipients of the survey who chose to participate in the study may differ in systematic ways from those who did not.

Similarly, demand characteristics may have affected the participants’ responses. It may be difficult for professionals within the field of psychology to admit they do not actively engage in the process themselves, thereby undermining the value of their own work. As a result, they may have responded to items the way they felt a psychologist should, rather than according to their true feelings and behaviors.

Finally, this study relied on the self-report of participants with regard to how they viewed their own feelings and behaviors. This may not be an accurate reflection of the respondents’ actual behavior or attitudes, but rather their perspective on how they are feeling.

Further Research

This current study contributes to the research relating to the ability of psychologists to function effectively and barriers that impact their ability to do so. Further research is needed. Specifically, a study focusing on the deterrents that impact early career clinicians

would highlight the factors most salient at that phase of professional life. A similar study with ethnic minorities would also be beneficial. More research to validate the effect of participating in personal therapy on one's ability to provide more efficacious therapy over a longer period of time would be useful. Additionally, further research may be useful to add support to the finding that Cognitive-Behavioral therapists are more likely to seek therapy from a therapist of a different theoretical orientation.

Conclusion

The discipline of psychology is replete with research studying why individuals do what they do, how it affects them, and how we can better help them in addressing the areas of dysfunction that have negatively impacted their lives. However, we are not always so quick to turn the spotlight on ourselves. This study leaves many questions unanswered but reveals some of the factors that limit participation in therapy. The fact that most clinical psychologists have participated in personal therapy and found it satisfactory, yet the majority have still failed to engage in it at other times in their lives when they may have benefitted from it is concerning, especially in light of the high rates of depression and suicidal behavior among psychologists. My hope is that this study will spark interest in addressing and eradicating that discrepancy. The benefits of psychotherapy are many, and the mental and emotional health of those who provide it are foundational to its success.

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Appendix A

Barriers to Seeking Personal Therapy Questionnaire

Barriers to Seeking Personal Therapy Questionnaire

To what degree do you feel that the following stressors have affected your ability to function as effectively as you desire as a psychotherapist?

1. Burnout

Never 1 2 3 4 5 Often

2. Depression

Never 1 2 3 4 5 Often

3. Countertransference

Never 1 2 3 4 5 Often

4. Vicarious Traumatization/Compassion Fatigue

Never 1 2 3 4 5 Often

5. Personal history/trauma

Never 1 2 3 4 5 Often

Please indicate other stressors that have affected your work as a therapist:

To what degree have the following factors deterred you from seeking personal psychotherapy?

1. Personal stigma (my view of self, or family/friends' view of me)

Never 1 2 3 4 5 Often

2. Professional stigma (might affect reputation in professional community)

Never 1 2 3 4 5 Often

3. Difficulty in admitting distress

Never 1 2 3 4 5 Often

4. Difficulty selecting an acceptable therapist

Never 1 2 3 4 5 Often

5. Lack of time

Never 1 2 3 4 5 Often

6. Lack of financial resources

Never 1 2 3 4 5 Often

7. Primarily rely on spiritual means of coping

Never 1 2 3 4 5 Often

Please indicate other barriers that have negatively impacted your decision to seek therapy:

Have you ever participated in therapy for yourself? _____

If yes...

1. How many courses of personal therapy have you participated in? _____
(a course is defined as a series of sessions that occurred during a particular period in your life)

2. Approximately how many sessions have you attended (including all courses of therapy)? _____
3. How much time has passed since your last session? _____
4. In general, how satisfied have you been with your experience(s) in personal therapy?

Not at All	1	2	3	4	5	Very Satisfied
------------	---	---	---	---	---	----------------
5. During the time since your last personal therapy session, was there a time that you may have benefited from therapy but did not seek it out?

Yes	No
-----	----
6. Have you ever participated in therapy that was not mandated as part of the requirements for your doctoral degree?

Yes	No
-----	----

Which of the following best describes your primary psychotherapeutic orientation?

- | | | |
|----------------------|-------------|---------------|
| Cognitive-Behavioral | Humanistic | Psychodynamic |
| Systemic | Other _____ | |

If seeking a personal therapist, to what extent would you consider the therapist's theoretical orientation?

- | | | | | | | |
|------------|---|---|---|---|---|--------------|
| Not at All | 1 | 2 | 3 | 4 | 5 | A Great Deal |
|------------|---|---|---|---|---|--------------|

If theoretical orientation would matter to you (a 2 or greater on the previous question), what orientation would you seek in your psychotherapist?

- | | | |
|----------------------|-------------|---------------|
| Cognitive-Behavioral | Humanistic | Psychodynamic |
| Systemic | Other _____ | |

Please provide the following information by circling the appropriate option or writing in the appropriate response.

Sex: Female Male

Age: _____

Ethnicity:

African-American Asian/Pacific Islander European American

Hispanic/Latino American Indian Other _____

Are you a licensed psychologist? Yes No

Highest degree: PhD PsyD Other

Year degree was awarded: _____

How many years have you been in practice? _____

Primary work location: Rural Urban Suburban

Primary work setting:

Private Practice Community Mental Health Medical

Academic Government/Industry Other _____

Approximate number of psychotherapy appointments per month: _____

Approximate number of psychological assessments per month: _____

Thank you for completing this questionnaire. Please return it in the enclosed envelope. Envelopes and questionnaires will be immediately separated upon receipt. No personally identifying information will be available to the investigators at any time. If you would like a summary of the results or have questions or comments about the study, please contact Jennifer Bearse, M.A., at jebearse@georgefox.edu.

Appendix B
Curriculum Vitae

Jennifer L. Bearse

22695 SW Cowlitz Drive · Tualatin, Oregon 97062
360-303-4802 · jbearse67@gmail.com

Education

Doctor of Psychology, Clinical Psychology

Newberg, Oregon

Anticipated graduation: May 2013

Graduate Department of Clinical Psychology (APA Accredited)

George Fox University

Master of Arts, Clinical Psychology

Newberg, Oregon

2008 – 2010

Graduate Department of Clinical Psychology

George Fox University

Bachelor of Arts, Business

Newberg, Oregon

1985 – 1989

George Fox University

Graduated Magna Cum Laude

Supervised Clinical Experience

Central Washington University

September 2012 – August 2013

Student Medical and Counseling Clinic

- Provide individual therapy using a short-term therapy model emphasizing an integration of psychological, social and physical needs of the client. A multidisciplinary approach is used in collaboration with medical providers.
- Facilitate interpersonal and/or psychoeducational group therapy in addition to structured workshops in such areas as time or anger management.
- Administer and interpret personality and psychodiagnostic assessment batteries, and conduct assessment of ADHD in adults.
- Provide crisis interventions as needed.
- Participate in consultation and outreach to university faculty, residence hall staff, physicians, academic departments, and campus police.
- Participate in ongoing programmatic research and evaluation.
- Provide supervision to Master's level Counseling Psychology and School Psychology students.
- Develop competency and sensitivity in working with clients of varying areas diversity.

Supervisor: Cindy Bruns, Ph.D.

Oregon Health Sciences University

June 2011 – June 2012

Family Medicine at Scappoose – Scappoose, OR

- Provided brief and long term outpatient mental health services for low-income, uninsured and underinsured patients from diverse backgrounds.
- Provided integrated health care, including “warm hand-offs” from primary care providers.
- Provided consultation with an interdisciplinary team including physicians, physicians’ assistants, nurse practitioners, and social workers regarding patient needs.
- Conducted clinical interviews and provide feedback to clients.
- Provided psychodiagnostic evaluations and develop comprehensive psychological reports including intelligence testing, projective personality summaries and neuropsychological screenings.
- Received one hour of group supervision and one hour of individual supervision weekly.

Supervisor: Tami Hoogestraat, Psy.D., MBA

Portland State University

August 2010 – June 2011

Counseling and Psychological Services – Portland, OR

- Provided psychological evaluations for students in a diverse college population to assess for possible learning disabilities and/or ADHD.
- Conducted semi-structured interviews to acquire medical, educational, family, and social history information as well as a self-report of functioning.
- Performed a full battery of tests to assess for cognitive functioning, academic achievement, personality functioning, and neurological functioning.
- Wrote comprehensive reports identifying strengths, weaknesses, and discrepancies.
- Provided a feedback session of results and recommendations.

Supervisor: Michael Chamberlain, Psy.D.

Clark County Juvenile Court – Vancouver, WA

September 2009 – June 2010

- Provided individual psychotherapy to a diverse population in a correctional setting.
- Assessed inmate suicide risk.
- Conducted psychological evaluations consisting of a semi-structured interview, personality testing, cognitive screening, and a diagnostic battery.
- Facilitated process groups covering coping skills, problem solving and mindfulness.
- Provided consultation and feedback within a multidisciplinary team of probation officers, legal representatives, detention staff, and social workers.
- Facilitated Victim Offender Meetings to promote reconciliation and restoration between juvenile offenders and their victims.
- Received weekly supervision and didactic training in a variety of subjects and topics.

Supervisor: Shirley Shen, Ph.D.

**George Fox University, PrePracticum I
Newberg, Oregon**

February 2009 – May 2009

Position: Student Therapist

- Provided simulated psychotherapy to volunteer female and male undergraduate students.
- Services included intake interviews, individual psychotherapy, diagnosis, and treatment planning.
- Responsibilities included report writing, case presentations, and consultation with both supervisor and clinical teams.
- All sessions taped and reviewed by supervisor.
- Received weekly individual and group supervision.

Supervisor: Clark Campbell, Ph.D.

**George Fox University, PrePracticum I
Newberg, Oregon**

September - December 2008

Position: Student Therapist

- Provided simulated psychotherapy to graduate students.
- All sessions taped and reviewed by supervisor.
- Received weekly individual and group supervision, which included training for intake interviews, listening skills and empathic responses.

Supervisor: Meridee Runge, M.A

**Depression Support Group
Newberg, Oregon**

October – December 2008

Position: Group Facilitator

- Facilitated discussion in a small group setting with individuals suffering from depression.
- Received weekly group supervision.

Supervisor: Tammy Rogers, M.D.

Teaching and Supervision Experience

**Clinical Foundations – Teaching Assistant
George Fox University, Newberg, Oregon**

September 2011 – April 2012

- Supervise and teach six pre-practicum students basic client-centered therapy skills.
- Responsible for weekly group and individual supervision of therapeutic skills; provide instruction via role-plays, videotape review, and group discussion.
- Provide formative and summative feedback to students on skill development and personal growth.
- Receive weekly group supervision.

Supervisor: Mary Peterson, Ph.D.

Clinical Oversight of Practicum I Student **September 2011 – April 2012**

George Fox University, Newberg, Oregon

- Supervise one Practicum I student on a weekly basis in areas professional development and clinical training.
- Prepare student for formative and summative evaluation in the areas of case conceptualization, differential diagnosis, multicultural and ethical considerations, and development of therapeutic relationship.

Supervisor: Paul Stolfus, Psy.D.

Advanced Counseling (Undergraduate) – Teaching Assistant

George Fox University, Newberg, Oregon **September 2010 – December 2010**

- Led weekly small groups to assist and guide students to master basic counseling skills.
- Encouraged personal reflection, here and now processing, and self-care and self-awareness.
- Received weekly group supervision.

Supervisor: Kristina Kays, Psy.D.

Other Work Experience

Industry Relations Representative **January 2007 – August 2008**

Keystone Automotive Industries, Inc., Pomona, CA

- Managed relationships and handled conflict resolution with claims personnel from all major insurance companies in the Pacific Northwest.
- Provided training to claims adjusters and appraisers.

Purchasing Manager **October 2001 – December 2006**

Keystone Automotive Industries, Inc., Pomona, CA

- Managed the corporate office purchasing department in the negotiation of pricing and procurement of aftermarket automotive crash parts serving 140 stores nationwide.
- Hired, trained, and supervised a team of 14 employees.
- Managed relationships with international vendors.
- Participated in the development and implementation of a company-wide operating software conversion.

General Manager/Purchasing Manager **March 1998 – September 2001**

Nordan Distributors, Bellingham, WA

- Managed the profitability and day-to-day operations of the branch.
- Hired, trained and supervised a staff of 10 employees.
- Ensured excellence in customer service.

Service and Volunteer Work

Student Council, George Fox University (April 2011 to April 2012)

- Represent the student body by bringing the concerns and views of the students to the student council and faculty.
- Participate in the development of and adherence to the annual student council fiscal budget.

Admissions Interviewer, George Fox University (February 2011, 2012)

- Participated in the interview process of prospective students for the 2011-2012 and 2012-2013 incoming cohorts.

Our Mother's House (October 2010 to March 2011)

- Worked with homeless women providing support, resources, and mentoring.

Grant Junior Generals Girls Basketball Clinic (January 2010 to March 2010)

- Taught basic basketball skills to girls in 1st to 5th grade.

Peer Mentor, George Fox University (August 2009 to 2011)

- Mentored a first-year doctoral student in the Graduate Department of Clinical Psychology.
- Provided guidance and assistance in order to facilitate the transition into graduate school.

Admissions Committee, George Fox University (November 2008 to April 2009)

- Participated in the selection of students for the 2009-2010 incoming cohort.

Volunteer, Haven of Hope, Newberg, Oregon (Fall 2008 to 2009)

- Assisted with care and maintenance of horses used in therapeutic riding with children.

Volunteer, Flood Relief, Boistfort, WA (November 2007)

Volunteer, Disaster Relief, New Orleans, LA (September 2007)

Awards and Honors

Special Commendation (2012) - bestowed by the faculty of the George Fox University Graduate Department of Clinical Psychology for accomplishments and contributions to the program.

Special Commendation (2011) – bestowed by the faculty of the George Fox University Graduate Department of Clinical Psychology for accomplishments and contributions to the program.

Professional Presentations and Publications

- Bearse, J.L.** & McMinn, M.R. (August, 2011). *Barriers to Care: What Stops Psychologists From Seeking Mental Health Services*. A study of the stressors that affect the ability of clinical psychologists to perform therapy and the barriers that deter them from engaging in personal psychotherapy. Poster presentation at the annual meeting of The American Psychological Association, Washington, D.C.
- McMinn, M.R., **Bearse, J.L.**, Heyne, L.K., & Gregg, K. (April, 2011). *Satisfaction with Clinical Training Within the George Fox University Graduate Department of Clinical Psychology*. Presentation to the George Fox University Graduate Department of Clinical Psychology sharing the results of a study to evaluate the level of satisfaction of students, alumni and faculty of the George Fox University GDCP with regard to clinical training.
- Bearse, J.L.** (February, 2011). *Working With LGB Clients: APA Guidelines and Best Practices for Treatment*. Presentation to the George Fox University Graduate Department of Clinical Psychology, Newberg, OR.
- McMinn, M. R., **Bearse, J. L.**, Heyne, L. K., Staley, R. C. (2011). Satisfaction with clinical training in Christian psychology doctoral programs: Survey findings and implications. *Journal of Psychology and Christianity, 30*, 156-162.
- McMinn, M.R. & **Bearse, J.L.** (in press). Religion in the counseling office. Chapter update for *Psychology, Theology, and Spirituality in Christian Counseling* (revised edition). Wheaton, IL: Tyndale House Publishers.
- Judd, T., Jurecska, D., Gathercoal, K., Lee-Zorn, C., Gray, G., Choi, H., & **Bearse, J.** (January, 2011). *Multicultural Contributions to Forensic Psychology*.). A multicultural examination of issues related to the theme of competency to stand trial including the cognitively impaired, non-English speakers, and other characteristics. Symposium presented at the APA National Multicultural Conference and Summit, Seattle, WA.
- McMinn, M. R., **Bearse, J.**, Heyne, L. K., Smithberger, A., & Erb, A. L. (2011). Technology and independent practice: Survey results and implications. *Professional Psychology: Research and Practice, 42*, 176-184.
- McMinn, M. R., **Bearse, J.**, Heyne, L. K., Smithberger, A., & Erb, A. L. (August, 2010). *Technology and Independent Practice: Survey Results and Implications*. Poster presented at the annual meetings of the American Psychological Association. San Diego, CA.

Professional Affiliations and Memberships

American Psychological Association, Student Affiliate, 2008 to Present

Oregon Psychological Association, Student Affiliate, 2008 to 2012

OPA Diversity Committee, 2010 to 2011

GFU Multicultural Committee, 2009 to 2012

Professional Conferences

August 2011 American Psychological Association National Conference
Washington D.C.

January 2011 APA National Multicultural Conference and Summit
Seattle, WA

August 2010 American Psychological Association National Conference
San Diego, CA