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Stressors and Resources of Oregon Psychologists: How Are Helpers Being Helped?

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by

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Abstract

Professional psychology requires the navigation of a complex set of skills including clinical work, research, and consultation while also demanding a level of personal investment, which can tax the psychologists' emotional and physical resources. Bearse, McMinn, Seegobin, & Free (2013) highlighted the deleterious impact of these stressors. The American Psychological Association (APA) has shown an awareness of impactful professional stress and responded by encouraging state psychological associations to create a Colleague Assistance Program (APA, 2006). Although the research and professional guild agree on the existence of professional stress, there is little research regarding the effectiveness of strategies and resources used to manage the stress. The results from a pilot survey administered to Oregon psychologists (May 2012) were consistent with national findings showing that psychologists experienced a variety of biopsychosocial stressors. The current study identifies stressors experienced by Oregon Psychologists and the coping strategies used to manage professional and personal stress.

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Chapter 1

Introduction

Complexity of Professional Psychology

The field of professional psychology contains a history and modern day presentation that is both scientific and personal. Since the days of Freud and Wundt, psychology has expanded into a complex professional field, demanding competence across a wide range of skills, from traditional therapy to inter-professional healthcare collaboration. This complexity presents a multitude of stressors and unique challenges as psychologists not only manage their clinical practice but also remain current in the ever-changing market.

Piotrowski (2012) studied the research trends that reflect the current emphasis and professional demands in an increasingly complex field. He found increasing emphases on evidence-based treatments, multicultural and ethical issues, military and veteran affairs and natural disaster response. Other areas of emphasis remained constant over several decades such as health and child psychology, forensic, interpersonal violence and suicide, chronic pain, and rural practice. As interest expands, professional expectations press psychologists to maintain knowledge and proficiency in a broad scope of practice yet uphold advanced skill sets in complex interventions, in a wide range of pathologies, and in approaches specific to various populations.

Managing professional psychology career requirements of a client or system centered work requires a broad scope of professional awareness as well as refined skills of intervention.

As an example, Linnerooth, Mrdjenovich, and Moore (2011) described the stressors and risks experienced by military psychologists who are expected to provide intensive clinical services while working within a complex matrix of over-lapping systems. Compassion fatigue, a lack of proper training, family related stress, and a lack of professional support were found as consistent stressors experienced by psychologists who serve military populations. Further, vicarious trauma and secondary trauma were found to be a common result from helping traumatized military service individuals. In addition to understanding each client's need and developing an appropriate intervention strategy, professional psychology requires the ability to navigate unique ethical pathways and client confidentiality (Helbok, 2003). Understanding the business side of practicing as well as understanding the laws and court procedures further broadens the psychologist's job description and the risk of layered stress (Varela & Conroy, 2012). Managing multiple systems, populations, and pathologies increases both the intrapersonal and interpersonal stress found in a single-service environment.

Professional psychology is unique in that it not only requires technical competence in the complex set of skills described above; it also requires a significant amount of personal investment, which is inherent to a relationship-focused vocation. Psychologists' personal investment in their clinical work may represent the most significant risk factor, as it may gradually tax the emotional and physical resources of the clinician. Recent research has noted the parallel process that can occur as psychologists face their own set of stressors, which may be similar to their clients, while also experiencing the stress that is unique to being a caregiver (Wise, Hersh, & Gibson, 2012). In addition to the challenges related to specific clinical work, psychologists frequently practice in settings where systemic pressures such as limited resources

and/or excessive administrative demands create a multi-faceted stress that may be difficult to identify, let alone manage (Rupert & Morgan, 2005).

Not only are psychologists expected to be personally invested in their clinical work, they are seen as self-motivated and responsive to community needs (Jenaro, Flores, & Arias, 2007). Reinforcing the commitment to society, the American Psychological Association (APA) encourages psychologists to offer supportive community care outside of their work environment (Newman, 2005). Overall, the field of psychology poses a unique set of professional expectations including technical expertise in multiple domains, personal investment in clinical work and a contribution to the larger community. Given these expectations, it is not surprising that psychologists are becoming increasingly aware of the negative impact their profession has on their quality of life.

Biopsychosocial Impact

The sources of professional stress demand attention and reaction especially when mismanaged stress decreases the psychologist's quality of life. The social impact of professional stress can include increased family stress and conflict, cultural stress, financial concerns, and isolation. Stevanovic and Rupert (2009) elaborate on the relationship between family and work as just one potential stressor for the practicing psychologist. They found that the presence of family stressors correlated with a psychologist experiencing less family support and less life satisfaction. Psychologists working in rural settings or in unique settings that don't offer collegial support often leads to isolation that negatively affects the quality and/or perceived stability of life. Learning ways to adaptively manage the sources of stress may not only improve a psychologist's quality of life but also increase their professional effectiveness.

Professional psychologists experience similar stressors as those not practicing. Anxiety, depression, grief processing, trauma, and performance fears are many of the common stressors that challenge the practitioners' ability to work (Bearse et al., 2013). Additionally, suicide prevalence is a realistic concern among psychologists. The APA's Advisory committee on Colleague Assistance, along with other committees, investigated the incidence of suicide for psychologists as well as the risk and protective factors. (Kleepsies et al., 2011). Meta-analysis of the literature showed an increase in suicide attempts by practicing psychologists in the last two decades. Risk factors for psychologists tend to be similar to non-psychologists, including access to lethal sources, depressive and anxiety disorders, social isolation, and family stress and others like impulsivity and hopelessness. There was a correlation between the length of time as a therapist and compassion fatigue with psychologists reporting increased compassion fatigue and negative psychological changes as their length of time in practice increased. (Linley & Joseph, 2007). Stress' impact on various domains of life compels individuals and organizations to respond to the growing need of psychologists.

Responding to Need: Coping Strategies and Resources

As previously noted, the impact of the stressors experienced by professional psychologists has caught the attention of the professional associations, including the APA and the State Psychological Associations (SPA). The professional organizations have expressed concern about the impact of professional and personal stress on their members' well-being and a corresponding interest in effective coping strategies to mitigate professional stress. Specifically, APA initiated the Colleague Assistance Program (CAP) in the hope of directly influencing the health of professional psychologists across the country (Barnett & Hillard, 2011). Although the

national and state interest in the problem is an important first step, we need to move toward identifying solutions including viable resources and strategies that can mitigate the impact of professional stress.

Stressors within any discipline or field may elicit discipline-congruent coping strategies that attempt to manage the challenges inherent in the profession. In the field of psychology, the use of personal therapy is the most commonly recommended coping strategy. Oteiza (2010) found that therapists perceived personal therapy as

> [relevant] for personal and professional development, from learning about one's emotional blind spots and hypersensitivities, to extending one's awareness of the personal impact one tends to have on other people, as well as increasing the ability to recognize, accept, and work to correct one's inevitable human weaknesses and limitations (p. 227).

Further, another study surveyed 4,000 psychologists across six countries finding that 87% of the sample had experienced personal therapy at least once (Orlinsky, Schofield, Schroder, & Kazantzis, 2011). In exploring the reasons why a psychologist *wouldn't* pursue therapy, Bearse et al. (2013) found that limited access and time were the primary obstacles. Most psychologists view personal therapy as form of self-care and personal development along with an opportunity to experience more of the client's role (Daw & Joseph, 2007). Another study found that psychologists who experienced therapy found both long-term personal benefit and ongoing professional impact (Rake & Paley, 2009). Although personal therapy continues to be seen as a valuable option to manage inevitable stressors of being a psychologist, further coping strategies are needed to manage the increasing pressure.

Other coping strategies come from a multitude of sources ranging from pharmaceuticals and self-help books to pets and exercise. For example, Kuyken, Peters, Power, and Lavender (1998) found that "approval or acceptance from a 'generalized other' is predictive of self-esteem" (p. 248). In other words, having an external source of emotional stability, whether clinical supervisors or significant others, contributes to self-esteem which may increase the psychologists' ability to manage the challenges of the profession. In addition to therapy and coping strategies to specific stressors, general self-care measures were helpful in implementing health coping strategies.

Spiritual practices such as attending religious services or praying/meditating were frequently used coping strategies for religious samples (Case & McMinn, 2001). These coping strategies were reported to be useful in both typical and extremely stressful professional situations. Malinowski (2013) found that "self-enhancing" humor contributed to a sense of personal accomplishment and guarded against a therapist's likelihood of burnout. Finding adaptive modes of coping may require time and effort, which some may feel are two resources that are in short supply for the typical psychologist.

Organizational Responses

The APA and state associations share a common goal to help their members manage the demands of the profession while maintaining a satisfying quality of life. In 2006, APA initiated the CAP to address the unique needs of the professional community. Their goal was twofold, to understand the problem and to identify resources. "The intention … is to provide an understanding of the nature and extent of psychologists' competence problems within a

developmental, context and to provide models and strategies that can address prevention and intervention" (APA, 2006).

Despite the effort to increase the awareness of the potential negative impact of professional stress, only two peer-reviewed articles have addressed Colleague Assistance Program/Committees in the function and care of psychological professionals. One article summarized the concerns expressed by a random sample of psychologists (Floyd, Myszka, & Orr, 1998). The other article surveyed SPAs to identify resources available to help psychologists manage professional stress (Barnett & Hillard, 2001). This limited research suggests an equally limited awareness of the CAPs across the country and/or the resources they provide. Despite APA's effort and the clear need for resources, some state organizations have found it difficult to initiate similar programs for their members. For example, Floyd et al. (1998) found that Tennessee psychologists' perspectives of CAPs were centered on job performance and ethics rather than its primary purpose of psychologists' care. State organizations encounter a unique challenge if they try to create a service for their members who may not perceive a need for such service.

During the late 1990s, nearly 70% SPAs reported having a CAP at one point in time (Barnett & Hillard, 2009). However, by 2008, only 18 states or provinces reported having an active program. The primary reason for program discontinuation of CAPs was lack of use (70%). Additionally, 61% of SPAs reported no plans to reinstate a program in the near future, most of whom did not perceive the need great enough. An APA Colleague Assistance survey showed that the most frequently reported barriers to the use of CAPs were lack of time (61%), minimization or denial of issues (43%), privacy or confidentiality concerns (43%), shame, guilt,

or embarrassment (40%), lack of knowledge of available resources (31%), fear of loss of professional status (29%), and inadequate social support (27%; APA, 2010). Thus, a tentative explanation for the limited use of CAPs at the SPA level may be explained by the above research that identified the multiple barriers that prevent psychologist from pursuing an SPA sponsored program regardless of current stressors.

The Current Study

The literature highlights the stress inherent in the work of the professional psychologist and the potential negative impact on the quality of life. Despite national and state efforts to increase awareness of professional stress there is a lack of research exploring how psychologists effectively manage the demands of the profession. As such, there is a need to better identify the relationships between stressors, coping methods, and the aid provided by state or provincial associations. The purpose of the study was to explore the current stressors experienced by Oregon psychologists, as well as the types and effectiveness of resources used to minimize the impact of these stressors on their quality of life.

Chapter 2

Methods

Participants

Members of the Oregon Psychological Association (OPA) who participated in the present study were contacted via a community announcement during the 2013 OPA Annual Conference and through the OPA listserv. Five categorical age ranges grouped the respondents: 34 or younger, 35 – 44, 45 – 54, 55 – 64, and 65 or older. Participants also self-identified if they were part of a marginalized population. Approximate household income and licensure data further contributed to demographic data. Due to the nature of the information requested, participants were not required to submit certain specific demographic information that may compromise their anonymity.

Instruments

The survey provided a list of current stressors psychologists previously reported experiencing as well as potential coping strategies used to manage the stressors. The previous survey (given at the 2012 conference), peer-reviewed literature, and information from Colleague Assistance Programs and Committees guided the creation of the survey items. The present survey gathered responses using a 5-point Likert-type rating scale and open-ended questions (Appendix A). The paper and digital surveys contained an introductory paragraph explaining the survey. Further, each section of the survey document contained a question or prompt in description of listed material.

Procedures

Participants at the conference received a paper survey to complete during the conference; a statewide email was sent to the OPA psychologist email listserv with a link to the digital version of the survey. All participants provided informed consent following their review of the purpose of the study, approximate length of the survey (10-15 minutes), confidentiality, de-identification of data, and option of voluntary participation. Additionally, the description of the study included a statement of support from the Colleague Assistance Committee (CAC). Each participant was thanked for their time and provided with contact information if they had any follow-up questions or concerns.

Data Analysis

Descriptive information for participants and items were collected. In addition correlational relationships between stressors, coping strategies and participant groups were analyzed using SPSS 20.

Chapter 3

Results

Participant Demographics

A total 108 members including 39 male identified and 64 female identified individuals completed the survey (Table 1). The majority of the surveys (*n* = 82) were completed during the 2013 Oregon Psychological Association (OPA) Annual Conference with the remaining surveys (*n* = 26) completed via an online, digital survey. Respondents were grouped into five categorical age ranges: 34 or younger (n = 21), 35 – 44 (*n* = 20), 45 – 54 (*n* = 22), 55 – 64 (*n* = 31), and 65 or older (*n* = 10) (non-responded, *n* = 4) (Table 2). Participants were also asked whether or not they identified as part of a marginalized population (Yes, *n* = 26; No, n = 77; non-responded, *n* = 5) (Table 3). Approximate Household Income (Table 4) and Licensure data (Table 5) were also collected, finding that nearly 75% of respondents reported income of at least $75,000 annually and that over 86% reported being licensed psychologists.

Table 1

Gender

	n	Total Percentage
Male identified	39	37.9%
Female identified	64	62.1%
Total	103	100%

Table 2

Age Ranges

	n	Total Percentage
34 or younger	21	20.2%
35 – 44	20	19.2%
45 – 54	22	21.2%
55 – 64	31	29.8%
65 or older	10	9.6%
Total	104	100.0%

Table 3

Identify as Part of Marginalized Population

	n	Total Percentage
Yes	26	25.2%
No	77	74.8%
Total	103	100%

Table 4

Approximate Household Income

	n	Total Percentage
$24k or less	11	10.8%
$25k-$49k	4	3.9%
$50k-$74k	12	11.8%
$75k-$99k	23	22.5%
$100k or more	52	51.0%
Total	102	100.0%

Table 5

Licensure

	n	Total Percentage
Licensed Psychologist	88	86.3%
Non-licensed Psychologist	1	1.0%
Other Mental Health Provider	13	12.7%
Total	102	100.0%

Additional descriptive data showed other resource utilization and general information (Tables 6 through 8). The primary perceived barrier to utilizing the coping strategies were Time (n = 22) and Finances (n = 14). The majority of respondents indicated they were aware of the CAC and their support services, however, only 14.3% (n = 11) reported they had ever utilized the resources offered by the Oregon CAC.

Table 6

Perceived Barriers to Resource Utilization

	n
Time	22
Finances	14
Confidentiality Concerns	4
Shame	3

Table 7

Additional Information

	n	Yes
Were aware OPA has Colleague Assistance Committee?	74	74.3%
Were aware CAC's offers Confidential Consultation?	75	66.7%
Were aware CAC's offers a Panel of Providers?	76	64.5%
Were aware CAC's offers a Mentor Program?	76	55.3%
Ever utilized the resources offered by CAC?	77	14.3%
Have weekly activities of self-care?	77	92.2%
Are supervisors and/or colleagues supportive of experience of stressors?	67	92.5%
Ever undertaken personal psychotherapy?	70	84.3%
Personal psychotherapy while practicing professionally?	78	70.5%
Personal psychotherapy within last 5 years?	76	42.1%

Table 8

Average Hours Discussing Traumatic Material with Clients

n	84
M	7.77
SD	6.625
Range	0-25

Stressors

Analyses focused on relational data between professional life stressors and coping strategies. Surveys were collected from OPA 2013 Annual Conference (82 respondents, paper surveys) and through statewide list-serve email system (26 respondents, digital survey). All surveys were submitted and analyzed according to the research guidelines of the APA.

Stressors were rated on a 5-point Likert scale describing how frequently the stressors interfered with their professional life, from *Almost Never* to *Almost Always*. In an effort to

identify the stressors most frequently impacting psychologists, stressors rated as *Moderately, Frequently* and *Almost Always* were grouped together. Thus the following stressors Professional Stress (37.2%), Time Management (30.5%), Sleep Issues (26.6%), Financial Stress (22.4%), and Immediate Family Stress (21.6%) most frequently affected psychologists. (Table 9).

Table 9

Number of Respondents Endorsing Factors (Stressors) that Moderately to Frequently affect Professional Life

Stressors	*n*	Moderately to Frequently Affected
Professional Stress	105	37.2%
Time Management	105	30.5%
Sleep Issues	106	26.4%
Financial Stress	107	22.4%
Immediate Family Stress	102	21.6%
Medical Issues	107	18.7%
Anxiety	105	18.1%
Lifestyle or Health Issues	102	16.6%
Romantic Partner Stress	103	15.6%
Inter-generational Family	106	13.2%
Grief or Loss	106	13.2%
Depression	105	8.6%
Vicarious Trauma	107	8.4%
Cultural Stress	104	5.7%
Cognitive and Memory Issues	103	4.9%
Trauma	106	2.7%
Substance Use	102	2.0%

Coping Strategies

The most frequently used strategies to manage stress included, Colleagues, Friends, Exercise, Social Activities, Mindfulness Activity, Vacation, Hobbies, Family, and Published

Sources and Literature (Table 10). The coping strategies reported as Somewhat Effective, Quite Effective, and Highly Effective demonstrate a general effectiveness of a coping strategy. Most of the coping strategies or resources received reports of effectiveness except for use of Alcohol/Tobacco/Other Substances (n = 52, 23.2%). The reported stressors and coping strategies that were a part of the respondents professional life in the past year provided insight into the behavior of Oregon psychologists.

Table 10

Number of Respondents Endorsing Coping Strategies or Resources Used in the Past Year

	n	*n* (Used past Year)	Somewhat to Highly Effective
Colleagues	107	104	96.10%
Friends	106	104	94.20%
Exercise	108	106	92.70%
Social Activities	108	107	91.60%
Mindfulness Activity	106	86	89.60%
Personal Therapy	104	36	89.00%
Other	18	9	89.00%
Vacation	107	99	88.60%
Prescribed Medication	105	51	82.30%
Hobbies	107	101	82.00%
Family	106	105	80.90%
Spirituality or Religion	105	77	80.50%
Medical Professionals	104	72	76.50%
Pets	107	79	73.40%
Supervisors	104	40	72.60%
CAC's Confidential Consultation	104	7	71.60%
Published Sources/Literature	105	80	66.10%
CAC's Panel of Providers	102	5	61.20%
Alcohol/Tobacco/Other Substances	104	52	23.20%

Note. Somewhat to Highly Effective percentages are of respondents who used the coping strategy in the past year.

Relational Statistics

The relational analyses showed the statistically significant relationships between stressors and coping strategies; additionally, the results provide information relevant to the most frequently endorsed cause of stress, Professional Stress (n = 105, 37.2%) (Tables 11 and 12). Overall, there was a high prevalence of statistically significant relationships between all reported stressors. Factors (stressors) showing the largest correlations were of moderate strength (> .500) include the following: Medical Issues with Lifestyle/Health Issues (.502), Sleep Issues with Immediate Family Stress (.512) and Professional Stress (.515), Intergenerational Stress with Grief or Loss (.525), Professional Stress with Anxiety (.554), Financial Stress with Anxiety (.513), Anxiety with Depression (.580), and Depression with Trauma (.529). Professional Stress alone found significant correlations ($p \leq .005$) with all other factors except for Substance Use.

Similar to Professional Life Stressors, there was a high rate of statistically significant relationships between all Coping Strategy factors at the .01 and .05 levels (Tables 13 and 14). Factors showing significant correlations of moderate strength (> .500) include the following: Medical Professionals with Prescription Medication (.618), Prescription Medication with Other (.518), Friends with Social Activities (.541), CAC Confidential Consultation with CAC Panel of Providers (.662), Vacation with Social Activities (.502), Published Sources/Literature with Other (.508), and Mindfulness Activities with Other (.573).Table 13

When correlational analyses were conducted between stressor and coping strategy, the majority of results indicated that when the frequency of the stressors increased, the effectiveness of coping strategy decreased (Tables 15 through 18). For example, when Professional Stress increased, the effectiveness of many of the coping strategies tended to decrease, specifically the

perceived effectiveness of Supervision and Social Activities were significantly and negatively correlated (-.286 [p = 0.01] and -.245 [p = 0.05] respectively).

Table 11

Correlation between Professional Life Stressors

	1	2	3	4	5	6	7	8
1. Medical Issues	--							
2. Sleep Issues	.422**	--						
3. Cognitive/Memory Issues	.354**	.267**	--					
4. Lifestyle/Health Issues	.502*	.444**	.191	--				
5. Substance Use	.333**	.095	.257**	.343**	--			
6. Immediate Family Stress	.294**	.512**	.163	.369**	.156	--		
7. Intergenerational Stress	.251**	.372**	.311**	.271**	.135	.408**	--	
8. Romantic Partner Stress	.209*	.362**	.114	.378**	.193	.460**	.278**	--
9. Professional Stress	.346**	.515**	.321**	.351**	.055	.332**	.298**	.247*
10. Cultural Stress	.293**	.271**	.248*	.260**	.234*	.090	.090	.044
11. Financial Stress	.065	.341**	.317**	.320**	.086	.203*	.308**	.234*
12. Anxiety	.301**	.430**	.161	.368**	.121	.347**	.364**	.236*
13. Depression	.393**	.405**	.293**	.293**	.267**	.369**	.310**	.203
14. Grief or Loss	.329**	.330**	.164	.296**	.118	.305**	.525**	.233*
15. Trauma	.351**	.364**	.153	.409**	.230*	.259**	.343**	.297**
16. Vicarious Trauma	.264**	.324**	.227*	.218*	.154	.293**	.198*	.111
17. Time Management	.209*	.421**	.167	.050	.050	.249*	.149	.170

Note. ** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the .05 level (2-tailed).

Table 12

Correlation between Professional Life Stressors (continued)

	9	10	11	12	13	14	15	16
1. Medical Issues								
2. Sleep Issues								
3. Cognitive/Memory Issues								
4. Lifestyle/Health Issues								
5. Substance Use								
6. Immediate Family Stress								
7. Intergenerational Stress								
8. Romantic Partner Stress								
9. Professional Stress	--							
10. Cultural Stress	.397**	--						
11. Financial Stress	.471**	.314**	--					
12. Anxiety	.554**	.187	.513**	--				
13. Depression	.496**	.247*	.212*	.580**	--			
14. Grief or Loss	.268**	.062	.167	.437**	.429**	--		
15. Trauma	.355**	.315**	.138	.378**	.529**	.383**	--	
16. Vicarious Trauma	.371**	.310**	.249**	.314**	.286**	.359**	.189	--
17. Time Management	.422**	.357**	.382**	.313**	.145	.126	.177	.303**

Note. ** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the .05 level (2-tailed).

Table 13

Correlation between Coping Strategies

	1	2	3	4	5	6	7	8	9
1. Medical Professionals	--								
2. Prescription Medication	.618**	--							
3. Alc./Tob./Other Subst.	.290**	.276**	--						
4. Exercise	.179	.192*	.254**	--					
5. Colleague	.222*	.176	.040	.214	--				
6. Supervision	.009	.078	.065	.023	.047	--			
7. Friends	.000	.112	.035	.287**	.211*	.015	--		
8. CAC Confid. Consult.	.208*	.196*	.192	.009	-.018	.210*	-.123	--	
9. CAC Panel of Providers	.090	.101	.077	-.066	-.085	.167	-.215*	.662**	--
10. Pets	.099	.159	.151	.244*	.026	-.051	.287**	.033	.008
11. Hobbies	.247*	.194*	.095	.288**	.272**	.251*	.234*	.007	.016
12. Vacation	.087	.146	.062	.237*	.291**	-.059	.330**	-.122	-.111
13. Social Activities	.080	.171	.114	.346**	.259**	.127	.541**	-.101	-.108
14. Personal Therapy	.316**	.176	.225*	.202*	.000	.154	-.036	.412**	.367**
15. Pub. Sources/Lit.	.055	.141	.196*	.177	.052	.199*	.271**	.007	-.007
16. Family	.139	.036	.208*	.167	.045	.134	.279**	-.178	-.086
17. Spirituality/Religion	.115	.252**	.144	-.063	.106	-.048	-.031	-.007	.071
18. Mindfulness Act.	.223*	.185	.117	.096	.156	.190	.138	-.079	.088
19. Other	.491*	.518*	.350	.076	.086	-.048	-.252	.127	--

Note. ** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the .05 level (2-tailed).

Table 14

Correlations between Coping Strategies (continued)

	10	11	12	13	14	15	16	17	18
1. Medical Professionals									
2. Prescription Medication									
3. Alc./Tob./Other Subst.									
4. Exercise									
5. Colleague									
6. Supervision									
7. Friends									
8. CAC Confid. Consult.									
9. CAC Panel of Providers									
10. Pets	--								
11. Hobbies	.143	--							
12. Vacation	.007	.345**	--						
13. Social Activities	.194*	.367**	.502**	--					
14. Personal Therapy	-.096	.062	.038	.017	--				
15. Published Sources/Lit.	.200*	.224*	.164	.253**	.072	--			
16. Family	.201*	.181	.075	.299**	.095	.239*	--		
17. Spirituality/Religion	.067	-.002	.170	.025	.092	.197*	.138	--	
18. Mindfulness Activities	.240*	.271**	.180	.155	.143	.399**	.247*	.216*	--
19. Other	.095	.484*	.228	-.075	.184	.508*	-.062	.207	.573*

Note. ** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the .05 level (2-tailed).

Table 15

Correlations between Coping Strategies and Professional Life Stressors

	Stressors				
Coping Strategies	Medical Issues	Sleep Issues	Cognitive Memory Issues	Lifestyle Health Issues	Substance Use
Medical Professionals	-.336**	-.147	-.197	-.281**	-.133
Prescription Medication	-.263**	-.078	-.172	-.160	-.202*
Alc./Tob./ Other Subst.	-.101	-.069	-.115	-.105	-.216*
Exercise	-.114	-.136	-.115	-.006	.050
Colleague	-.162	-.075	-.054	.028	-.097
Supervision	-.052	-.201*	-.060	-.086	.031
Friends	-.250	-.001	-.158	-.152	-.207*
CAC Confid. Consult.	-.060	-.041	.046	-.152	-.152
CAC Panel of Providers	-.045	-.060	-.100	-.168	-.055
Pets	-.040	-.122	.072	.056	-.108
Hobbies	-.097	-.289**	-.122	-.125	-.039
Vacation	-.141	-.203*	-.005	-.070	-.099
Social Activities	-.290*	-.248*	-.172	-.358**	-.180
Personal Therapy	-.141	-.213*	-.152	-.268**	-.011
Pub. Sources/Lit.	-.129	-.161	-.010	-.107	-.141
Family	-.191	-.187	-.197*	-.238*	-.113
Spirituality/Religion	-.040	-.036	-.034	-.018	-.028
Mindfulness Activities	-.073	-.129	.028	-.026	-.061
Other	.027	-.080	.050	.207	.240

Note. ** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the .05 level (2-tailed).

Table 16

Correlations between Coping Strategies and Professional Life Stressors (continued)

	Stressors				
Coping Strategies	Immediate Family Stress	Inter-Gen. Family Stress	Romantic Partner Stress	Professional Stress	Cultural Stress
Medical Professionals	-.137	-.245*	-.116	-.047	-.071
Prescription Medication	-.062	-.212*	-.023	.023	.069
Alc./Tob./ Other Subst.	.049	-.107	.044	.091	-.058
Exercise	.035	-.036	-.079	.078	-.132
Colleague	-.047	-.036	.030	-.074	-.030
Supervision	-.121	-.083	-.116	-.286**	-.020
Friends	-.079	-.063	-.128	-.148	-.145
CAC Confid. Consult.	-.042	-.025	.018	.037	-.126
CAC Panel of Providers	-.029	-.342**	.011	-.158	-.117
Pets	.006	-.334**	-.013	.120	.041
Hobbies	-.275**	-.035	-.151	-.172	.070
Vacation	-.242*	-.002	-.159	-.018	.079
Social Activities	-.196*	-.086	-.182	-.245*	-.060
Personal Therapy	.009	-.234*	-.117	-.084	-.151
Pub. Sources/Lit.	-.198*	-.016	-.068	-.009	.021
Family	.020	-.061	-.236*	-.121	.003
Spirituality/Religion	.057	-.015	.086	.057	.234*
Mindfulness Activities	-.013	-.032	.008	-.045	.116
Other	-.005	-.134	.214	-.031	.100

Note. ** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the .05 level (2-tailed).

Table 17

Correlations between Coping Strategies and Professional Life Stressors (continued)

	Stressors				
Coping Strategies	Financial Stress	Anxiety	Depression	Grief or Loss	Trauma
Medical Professionals	-.030	-.146	-.238*	-.080	-.166
Prescription Medication	-.006	-.130	-.230*	-.152	-.190
Alc./Tob./ Other Subst.	-.010	-.053	-.074	-.017	-.088
Exercise	-.081	-.041	-.041	-.011	-.150
Colleague	-.155	-.182	-.157	-.128	.039
Supervision	-.200*	-.127	-.162	.014	-.078
Friends	.002	-.147	-.200*	-.128	-.082
CAC Confid. Consult.	-.019	-.108	-.191	-.251*	-.458**
CAC Panel of Prov.	-.140	-.103	-.209*	-.264**	-.444**
Pets	.234*	.105	.099	.003	.059
Hobbies	.055	.001	-.242*	-.090	-.211*
Vacation	.016	-.103	-.097	-.130	-.101
Social Activities	-.172	-.205*	-.234*	-.184	-.136
Personal Therapy	-.184	-.340**	-.265**	-.309**	-.443**
Pub. Sources/Lit.	.048	.003	-.133	-.217*	-.190
Family	-.230*	-.082	-.049	-.089	-.004
Spirituality/Religion	-.015	-.177	-.089	-.054	.023
Mindfulness Activities	-.026	-.101	-.161	-.121	.043
Other	-.124	.215	-.254	-.134	-.110

Note. ** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the .05 level (2-tailed).

Table 18

Correlations between Coping Strategies and Professional Life Stressors (continued)

	Stressors	
Coping Strategies	Vicarious Trauma	Time Management
Medical Prof.	-.128	.097
Prescription Medica.	-.146	.168
Alc./Tob./ Other Subst.	.083	.222*
Exercise	.025	.011
Colleague	.033	.076
Supervision	.132	-.010
Friends	-.168	-.107
CAC Confid. Consult.	.074	.202*
CAC Panel of Providers	.013	.079
Pets	-.061	.212*
Hobbies	-.042	-.022
Vacation	-.017	-.037
Social Activities	-.150	-.109
Personal Therapy	-.039	-.028
Pub. Sources/Lit.	-.111	-.037
Family	-.030	-.083
Spirituality/Religion	-.013	.295*
Mindfulness Activities	-.138	.054
Other	-.186	.065

Note. ** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the .05 level (2-tailed).

Component Analysis revealed clusters of stressors and coping strategies as well as percentages of explained variance. Factors that contribute to stress clustered together in categories of emotional health, resource barriers, and biological barriers. Emotional health issues contribute 35.8% of the total stress that impacts professional life as a professional psychologist. Barriers to resource utilization and barriers rooted in biological issues contributed an additional 10.1% and 7.9%, respectively. In coping strategy component analysis, individually-based coping strategies explained 38.5% of the ways professional psychologists manage professional life

stress. Professional resources and external resources contributed an additional 12.6% and 11.3%, respectively.

Multiple regression analyses assume a larger sample size than was available for this study; therefore, the reported results (Tables 19 and 20) are exploratory rather than a definitive predictive relationship between variables. The regression equation sought to identify factors predicting Professional Stress. Results showed the following predictive factors in order of significance: Depression, Financial Stress, Cultural Stress, and Sleep Issues. Using a step-wise regression, Depression accounted for 31.6% of the variance in Professional Stress. When Financial Stress, Cultural Stress and Sleep Issues were included, the percent of explained variance increased nearly two-fold (52.6%, 58.2%, and 60.9%, respectively).

Table 19

Stressor Component Analysis Matrix

	Components				
Stressors	Emotional Health	Resource Barriers	Biological Barriers	Unspecified	Unspecified
Medical Issues	.606	-.197	.223	.402	.227
Sleep Issues	**.741**	.079	-.006	-.198	.065
Cognitive/Memory Issues	.446	.239	**.407**	.354	-.460
Lifestyle/Health Issue	.631	-.025	**.346**	-.072	.442
Substance Use	.288	-.260	**.670**	.248	.168
Immediate Family Stress	.636	-.182	.104	-.414	.085
Intergenerational Stress	.587	-.344	.168	-.136	-.481
Romantic Partner Stress	.473	-.110	.232	-.576	.067
Professional Stress	**.767**	.307	-.205	.048	-.160
Cultural Stress	.341	**.636**	.157	.301	-.017
Financial Stress	.540	**.452**	.104	-.312	-.373
Anxiety	**.745**	-.096	-.267	-.009	.068
Depression	**.737**	-.259	-.298	.293	-.016
Grief/Loss	**.673**	-.334	-.275	.031	-.136
Trauma	**.688**	-.299	-.236	.155	-.001
Vicarious Trauma	.536	.281	-.294	.211	.233
Time Management	.458	**.567**	-.060	-.186	.321

Note: Extraction method is principal component analysis.

Table 20

Total Variance Explained

	Total Eigenvalues	% of Variance	Cumulative %
Emotional Health	6.086	35.800	35.800
Resource Barriers	1.714	10.082	45.882
Biological Barriers	1.337	7.866	53.748
Unspecified	1.294	7.613	61.361
Unspecified	1.080	6.354	67.715

Note: Extraction method is principal component analysis.

Table 21

Coping Strategy Component Analysis Matrix

	Components			
Coping Strategies	Individually-Based	Professional	External	Unspecified
Exercise	**.572**	.317	-.312	-.126
Colleagues	.232	**.528**	.222	.588
Friends	**.731**	**.477**	.004	-.198
Pets	**.725**	-.110	-.518	.072
Hobbies	**.628**	-.142	-.232	.505
Vacation	.539	-.220	**.502**	.289
Social Activities	**.755**	.248	.249	.019
Published Sources/Literature	**.766**	-.129	-.332	-.140
Family	.561	.250	**.434**	-.487
Spirituality/Religion	.490	-.527	**.404**	.001
Mindfulness Activity	**.629**	-.533	-.001	-.127

Note: Extraction method is principal component analysis.

Table 22

Total Variance Explained

	Total Eigenvalues	% of Variance	Cumulative %
Individually-Based	4.235	38.498	38.498
Professional	1.391	12.643	51.140
External	1.243	11.303	62.443
Unspecified	1.018	9.255	71.698

Note: Extraction method is principal component analysis.

Table 23

Summary of Regression Analysis for Professional Stress

Predictor Models	*B*	*SE B*	β	R Square	Adjusted R Square
Model 1	1.367	.194		.324	.316
Depression	.789	.119	.569		
Model 2	.568	.204		.537	.526
Depression	.680	.101	.491		
Financial Stress	.507	.079	.468		
Model 3	.219	.215		.595	.582
Depression	.652	.095	.471		
Financial Stress	.425	.077	.393		
Cultural Stress	.416	.116	.255		
Model 4	.090	.213		.626	.609
Depression	.551	.099	.397		
Financial Stress	.369	.078	.341		
Cultural Stress	.374	.113	.230		
Sleep Issues	.221	.082	.205		

Table 24

Regression Summary of ANOVA for Professional Stress

Predictors	Sum of Squares	F	Sig.	MS
Depression	34.082	43.581	.000	34.082
Depression and Financial Stress	56.478	52.113	.000	28.239
Depression, Financial Stress, and Cultural Stress	62.647	43.627	.000	20.882
Depression, Financial Stress, Cultural Stress, and Sleep Issues	65.897	36.841	.000	16.474

Chapter 4

Discussion

The review of the literature highlighted the range of professional and personal challenges that contribute to the complex and stressful work environment of a professional psychologist. Many of the prominent stressors and coping strategies identified by this survey were consistent with previous literature (Bearse et al., 2013; Oteiza, 2010). Specifically, Oregon psychologists report that factors contributing to overall professional life stress include stress within the profession (of psychology), time management and financial stress as well as sleep and family stress. Using correlational analysis, multiple weak to moderately strong relationships were found between most of the variables. Further, moderately strong correlations between several variables highlight the potential synergy that may happen as multiple stressors occur simultaneously and may collectively affect psychologists' professional life.

The results of this research are consistent with the emerging awareness that professional psychology is an increasingly complex and stressful field (Piotrowski, 2012; Rupert & Morgan 2005). Further, the stereotype that "professional healers" should also be responsible for self-healing seems unrealistic given the multitude of professional life stressors.

Results diverged from the literature in the severity of influence of traumatic material upon professional life burnout. Previous research and organizations have suggested that professional "burnout" may be driven, in part, by "compassion fatigue" which usually posits that

working with difficult clients contributes significantly to stress. However, Oregon psychologists reported that client trauma and vicarious trauma had less influence on their professional life than other stressors. Kleepsies et al. (2011) and Linley and Joseph (2007) highlight the risk of burnout among professional psychologists. For Oregon psychologists the primary stressors appeared to be more specific, including time and finance management as well as family and sleep issues. Thus, the factors of professional stress for Oregon psychologists suggest that, rather than a global construct of burnout or primarily compassion fatigue, the factors comprising burnout may be rooted in stressors present across multiple domains.

Oregon psychologists reported that the stressors influencing their professional life are similar to the stressors that often face other professionals (Helbok, 2003; Varela & Conroy, 2012). The results fit with research on the influence of family, depression, and anxiety, among others, that influence professional life and limit performance abilities. Research shows the relationship between personal stressors and their potential negative influence on work quality (Bearse et al., 2013; Stevanovic & Rupert, 2009). This relationship reinforces the importance of psychologists pursuing and receiving support in order to maintain performance expectations as a professional.

Psychologists' reported use and effectiveness of coping strategies highlighted a range of ways that psychologists manage a complex, stressful professional life. Consistent with previous literature, the majority of those surveyed reported using relationship groups, personally enjoyable activities and self-help resources as useful strategies to cope with stress. Contrary to expectations, several coping strategies previously identified in the research including personal

therapy and supervisors were not among the most frequently used strategies reported by the survey respondents.

While the recommended sample size and statistical assumptions for regression analysis were not met, exploratory analyses revealed interesting patterns that deserve attention. Results showed depression, financial stress, cultural stress, and sleep issues potentially accounting for 60.1% of professional stress. While the research reinforced the influence of depression, finances, and sleep; cultural stress was an unexpected and interesting variable that correlated with professional stress. One possible contributor to cultural stress may be found in the demographic results that showed that 25.2% of the survey participants identified as a marginalized population. The prevalence of those identifying as part of a marginalized community may suggest the importance of increasing resources to diverse individuals who may be vulnerable to unique cultural stress.

Many of the correlated coping strategies appeared in groups that component analysis process identified. These results confirmed that psychologists continue to experience significant stress in the context of their professional practice. Nearly 36% of the variance of professional life stress is explained by the emotional well-being of the psychologist. Explaining an additional 18% are the barriers to utilizing resources as well as biological barriers, such as memory issues. For effective coping strategies, over 38% of the variance is accounted by individually based coping strategies, such as friends or published resources. Professional, like colleagues, explains an additional 13% and external resources, like vacation, explain another 11%. The general stress experienced by professional psychologists seems most impacted by emotional health and the

effective use of coping strategies. These results validate the effort placed on promoting self-care practices for professional psychologists.

The present study contained limitations in multiple areas, primarily in the survey and surveyed population. The survey utilized in 2013 was an expansion from the 2012 survey. The revision of the survey was a significant alteration both in concept and content. While the surveyed stressors and coping strategies were much more expansive than the factors of the first survey, limitations were found in the subjective wording of many of the factors. The language of the stressor and coping strategy questions influenced the theoretical and statistical interpretation of the data. An additional limitation is the relatively small population. Approximately ten percent of the registered psychologists in Oregon attended the conference, most of who came from relatively nearby cities. Location of residence and of practice can be considerable barriers to access and utilization of resources.

Summary

The overall findings of the present study point to the impact of stressors on the lives of professional psychologists and the coping strategies used to manage a broad range of stressors. However, the perspective that psychologists are naturally able to manage their stress does not seem consistent with current article's findings suggesting a more variable view of effective coping. Specifically, professional stress was reported as the most frequently influential stressor effecting psychologists yet there was a stark absence in significantly correlated effective coping strategies. These results reveal the imperative need for informed support of professional psychologists as well as preventative trainings or programs for graduate students and early career psychologists.

Further, the results showed a surprising lack of relationship between professional stress and coping strategies. There may be considerable benefit in deciphering the difference patterns of coping style and coping behaviors. Results suggest that an increase in the utilization of any coping strategy may not be effective or as useful as reinforcing the use of behaviors that work for an individual. Coping strategy workability and effectiveness seems most rooted within an individual's unique style of managing stress. The complicated nature of stress management may be better understood when psychologists identify their own style or pattern of navigating professional life stress and continue investing in the strategies that work.

Further research may benefit professional awareness of stress and stress management across time and across population groups. Cross-sectional and longitudinal research that explores the management of stressors by professional psychologists could yield information regarding the developmental progression of stress and coping, the relative effectiveness of different strategies as well as the barriers that arise when seeking to activate coping strategies. While there exists themes of stressors across various professions, more analysis could discover the management of stress across various age ranges. Factors that may be influenced by age and experience could be vicarious trauma, managing multiple relationships, or financial and time concerns.

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Appendix A

Administered Survey

Oregon Psychological Association: Colleague Assistance Committee
Survey of Stressors and Coping Strategies for Oregon Psychologists

Previous literature has identified unique stressors for professional psychologists. In an effort to support Oregon psychologists, the OPA created the Colleague Assistance Committee (CAC). This survey is a follow-up to the brief survey administered at the OPA Conference in 2012. We're interested in building on those data to learn more about the typical stressors and coping strategies used by psychologists. We would appreciate your anonymous responses to the following questions:

In the past year, how much have the following stressors affected your professional life?

	Almost Never	Somewhat	Moderately	Frequently	Almost Always
Medical Issues					
Sleep Issues					
Cognitive and Memory Issues					
Lifestyle or Health Issues					
Substance Use					
Immediate Family Stress					
Inter-generational Family Stress					
Romantic Partner Stress					
Professional Stress					
Cultural Stress					
Financial Stress					
Anxiety					
Depression					
Grief or Loss					
Trauma					
Vicarious Trauma					
Time Management					

ı has shown that some psychologists use the following coping strategies or resources. If you have used any of the following in the past ye ıte their effectiveness.

	Not at all Effective	Slightly Effective	Somewhat Effective	Quite Effective	Highly Effective	N/A
Medical Professionals						
Prescribed Medication						
Alcohol/Tobacco/Other Substances						
Exercise						
Colleagues						
Supervisors						
Friends						
CAC's Confidential Consultation						
CAC's Panel of Providers						
Pets						
Hobbies						
Vacation						
Social Activities						
Personal Therapy						
Published Sources/Literature						
Family						
Spirituality or Religion						
Mindfulness Activity						
Other:						

nswer these additional questions.

ou have not utilized any of the above __Shame __Finances __Confidentiality Concerns __Time urces, why not?
se specify other reasons:

	YES	NO
r to today were you aware that the OPA has a Colleague Assistance Committee?		
e you aware that the Colleague Assistance Committee (CAC) offers a Colleague stance Program that includes:		
Confidential Consultation?		
a Panel of Providers?		
a Mentor Program?		
e you ever utilized the resources offered by the Colleague Assistance Committee?		
ou have weekly activities of self-care?		
your supervisors and/or colleagues supportive of your experience of the stressors identified above?		
e you ever undertaken personal psychotherapy?		
While practicing professionally?		
Within the last 5 years?		
ur average clinical week, how many hours are you discussing traumatic material with your clients?		

Gender: __Male identified__Female identified

Age: __ 34 or younger __35 - 44 __45 - 54 __55 - 64 __65 or older

Diversity: Do you identify yourself as part of a marginalized population? __Yes __No

Approximate Household Income:

__$24k or less __$25k-$49k __$50k-$74k __$75k-$99k __$100k or more

Licensure:

__Licensed Psychologist __Non-licensed Psychologist __Other Mental Health Provider

Thank you for providing information concerning typical stressors and coping strategies that you experience. Your collaboration is highly valued. As always, your Colleague Assistance Committee is available for support. Our contact information can be found at www.opa.org.

-The Colleague Assistance Committee

Appendix B

Curriculum Vitae

Nathan William Engle
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EDUCATION

Doctorate of Psychology, Clinical Psychology *Expected* May 2016
Emphasis: Health Psychology
George Fox University, *Newberg, OR*
Doctoral Dissertation: Defended June 2014
Graduate Department of Clinical Psychology: APA accredited

Master of Arts, Clinical Psychology May 2013
George Fox University, *Newberg, OR*
Graduate Department of Clinical Psychology: APA accredited

Bachelor of Arts, Psychology April 2011
Indiana Wesleyan University, *Marion, IN*

Associate of Arts, Applied Vocal Music April 2011
Indiana Wesleyan University, *Marion, IN*

CLINICAL EXPERIENCE

Oregon Health and Science University: June 2013 –
Family Medicine at Richmond Present
Primary Care Behavioral Health Consultant
Setting: primary care, consultation, assessment, systems, interprofessional
Populations: elderly, adults, adolescents, racial minorities, socioeconomic classes, sexual minorities, physical disabilities
Treatments: population health, mood and anxiety, substance use, personality disorders, cognitive and developmental disorders, behavior planning, pain management, trauma-informed treatment, crisis response, individual and group interventions.

- Provide behavioral health consultation, including evidenced-based practice interventions for patients experiencing multiple co-occurring disorders across a broad diagnostic range.
- Utilize Cognitive-Behavioral and Person-Centered strategies as well as psychoeducational tools to address broad diagnostic range

- Administer psychodiagnostic assessments and write integrated reports for cognitive, personality, and behavior functioning
- Integrate treatment planning and interventions with on-site primary healthcare providers to provide collaborative patient care management
- Assist primary care health system to move from co-located psychological care to fully integrated behavioral health consultation
- Create curriculum and conduct treatment groups for smoking cessation
- Respond to patient crisis, escalation, and immediate behavioral issues

Supervisor: Marie-Christine Goodworth, PhD; Darren Janzen, PhD; Tami Hoogstraat, PsyD

Behavioral Health Consultation & Liaison May 2013 –
Providence Newberg Medical Center Present
Willamette Valley Medical Center

Behavioral Health Crisis Consultant, QMHP

Setting: medical consultation, interprofessional, crisis management, systems
Populations: elderly, adults, adolescents
Treatment: crisis assessment and medical consultation

- Conduct risk assessments, cognitive evaluations, and other assessments of patients of varying age, gender, sexual orientation, ethnicity, and socioeconomic status for the Emergency Department, Intensive Care Unit, and Medical/Surgical Unit at local hospitals
- Collaborated with physicians and multi-disciplinary team to provider recommendations regarding patient risk and discharge plan, document evaluations in electronic medical charts, and coordinate resources with county mental health employees

Supervisor: Mary Peterson, PhD, Joel Gregor, PsyD, William Buhrow, PsyD

School Based Behavioral Health August 2012 –
Graduate Student Behaviorist Intern May 2013

Setting: individual, group, systems, consultation, assessment
Populations: children, adolescents, young adults, religious, racial minorities, SES diversity
Treatment: mood, anxiety, adjustment difficulties, family systems, ADHD, panic, crisis, learning disability, Asperger's, adoption

- Provided evidence-based short-term psychotherapeutic interventions, primarily Cognitive-Behavioral, Rogerian, and Interpersonal psychotherapy, for at-risk students and learning disabled students
- Administered psychodiagnostic assessments and wrote comprehensive reports concerning cognitive, achievement, and personality factors as part of a multi-systemic Individual Educational Plan team
- Established and managed working relationships with administrators, staff, parents, and other healthcare providers

- Led evidence-based college preparation and relational skill formation classes and individual intervention
- Conducted a program evaluation using Healthy Lifestyle Choices curriculum
- Managed case conceptualizations and individualized treatment plans

Supervisors: Elizabeth Hamilton, PhD, Kristen Miller, MA

George Fox University Graduate Department of Clinical Psychology January 2012 – April 2012
Pre-Practicum Student Therapist
Setting: individual
Population: young adults
Treatment: adjustment difficulties, family systems, psychoeducation

- Conducted intake interviews, treatment plans, and diagnoses
- Presented written reports, case presentations, and consultations with supervisors and clinical team members
- Provided individual outpatient psychotherapy services for two undergraduate student volunteers
- All sessions taped and reviewed with supervisors and clinical team members

Supervisors: Mary Peterson, PhD, and Laura Heyne, PsyD

George Fox University September 2011 – December 2011
Pre-Practicum Student Therapist
Setting: individual
Population: adults
Treatment: family systems, adjustment difficulties

- Performed intake interviews and treatment planning
- Learned Rogerian therapy skills with clinical team members
- All sessions taped and reviewed with supervisors

Supervisors: Mary Peterson, PhD, and Laura Heyne, PsyD

Providence Health System September 2011 – December 2011
Celebrate Depression Recovery Group Leader
Setting: community mental health
Population: adolescents, adults, family
Treatment: psychoeducation, behavior planning, group,

- Initiated and guided group discussion on symptom reduction
- Assisted program management and client group dynamics
- Provided leadership for psychoeducational process group

Supervisors: Tami Rogers, MD, Mary Peterson, PhD, Joel Simons, MA

RESEARCH EXPERIENCE & PRESENTATIONS

Primary Care and Population Health Program Evaluation 08/14 – Present
Smoking cessation in primary care: Group treatment using PAM and ACT

- Create smoking cessation program targeting short-term, group treatment
- Utilize multiple program and patient tracking tools for pre-test and post-test measurements
- Base treatment protocol on Acceptance and Commitment Therapy principles

Supervisor: Joan Fleishman, PsyD

Research Vertical Team 03/12 – Present

Emphasis: Health Psychology

- Meet twice monthly to discuss, collaborate on and evaluation the design, methodology, and progress of research projects

Supervisor: Mary Peterson, PhD

Doctorate Dissertation Research 11/12 – 10/14

Stressors and resources for Oregon psychologists: how are helpers being helped?

- Created original survey for data collection from state-wide professional psychologists
- Collaborated with Oregon Psychological Association Colleague Assistance Committee
- **Defended June 2014, Full Pass**
- Currently in review for publication by peer-reviewed professional journal

Supervisor: Mary Peterson, PhD

Psychoeducational Intervention Program Evaluation 02/13 – 05/14

Program evaluation of healthy lifestyle choices curriculum using behavior assessment system for children, second edition (BASC-2)

- Evaluated weekly psychoeducational group interventions based upon Healthy Lifestyle Choices curriculum to 7th and 8th grade students
- Implemented BASC-2 assessments as pre- and post-measures
- **Recipient of grant from Richter Scholar Program**
- Currently in final writing stages

Supervisor: Elizabeth Hamilton, PhD

Peer-Reviewed Poster Presentations

Barr, B., Sanders, E., **Engle, N. W.** (2015, August). *Impact of a Cognitive Behavioral Pain Management Group on Depression, Anxiety, Pain Severity, and Opioid Use in an Inpatient Population*. Accepted for poster presentation at annual meeting of the American Psychological Association, Toronto, ON.

Engle, N. W., Galuza, T. (2015, May). *Organizational psychology and medical clinic hiring strategies.* Submitted for poster presentation at annual meeting of the Oregon Psychological Association, Eugene, OR.

Engle, N. W., Malone, M. (2015, May). *Smoking cessation in primary care: A pilot short-term, treatment group.* Submitted for poster presentation at annual meeting of the Oregon Psychological Association, Eugene, OR.

Engle, N. W. (2014, August). *Stressors and coping strategies for Oregon psychologists: How are helpers being helped? P*oster presented at annual meeting of the American Psychological Association, Washington, D.C.

Engle, N. W. (2014, May). *Stressors and coping strategies for Oregon psychologists: How are helpers being helped?* Poster presented at annual meeting of the Oregon Psychological Association, Portland, OR.

Engle, N. W., Barr, B., Galuza, T. (2014, May). *Organizational psychology for medical clinic culture.* Poster presented at annual meeting of the Oregon Psychological Association, Portland, OR

Ellis, C., Cooper, T., **Engle, N. W.** (2013, August). *What leads to service member engagement in group therapy: Factors affecting patient working capacity.* Poster presented at annual meeting of the American Psychological Association, Honolulu, HI.

Ambroson, H., **Engle, N.**, & Peterson, M. (2013, April). *Supervisors' engagement in the integration of religion and psychology may influence their perception of students' competence in this area of diversity.* Poster presented at annual meeting of the Christian Association for Psychological Sciences, Portland, OR.

RELEVANT EXPERIENCE

Clinical Foundations Teaching Assistant August 2014 –
George Fox University Graduate Department of Clinical Psychology Present

- Teach first year doctoral students in Rogerian therapy skills
- Evaluate therapy training videos and session charting
- Guide individual and group developmental process and feedback

Organizational Analyst and Consultant October 2013 –
REFLEX Medical Clinic Present

- Conduct research-based diagnostics of workplace and performance issues
- Recommend system changes to employee review and hiring processes
- Collaborate with clinic director and staff to implement recommendations

OHSU: Primary Care Behavioral Health Forum Presenter October 2014
Oregon Health and Science University: Family Medicine
- Presented on TBI and Integrative Medicine

General Psychology Guest Lecturer March 2014
George Fox University, General Psychology
- Taught concepts of human memory and learning heuristics

OHSU: Primary Care Behavioral Health Forum Presenter October 2013
Oregon Health and Science University: Family Medicine
- Presented on background, prevalence, and application of mindfulness-based interventions

Interpersonal Neurobiology and Pharmacology Teaching Assistant December 2012
George Fox University Graduate School of Counseling
- Assisted in conceptualization and evaluation of essays and presentations

Peer-reviewed Published Essays

Original Article, First Author March 2015
Oregon Psychological Association Quarterly Newsletter
Seeking to Understand; Seeking to Help

Original Article, First Author January 2013
Oregon Psychological Association Quarterly Newsletter
Ethical Webs: Multiple Relationships and Practicum Training Sites

Newberg Psychology Examiner November 2011 – August 2012
Examiner.com
- Published 19 articles on locally-relevant psychological topics
- Received over one thousand page views and multiple subscribers
- Earned several credentialed promotions

UNIVERSITY INVOLVEMENT

Co-Founder of the Clinical Health Psychology Network September 2014 – Present
George Fox University Graduate Department of Clinical Psychology
- Create centralized student network that advances the exchange of professional resources and clinical tools while providing peer-to-peer encouragement and professional camaraderie

Co-Founder of the Gender and Sexuality Consultation Committee September 2013 – Present
George Fox University Graduate Department of Clinical Psychology
- Establish community of clinical research, discussion, and professional consultation targeting gender and sexuality diversity issues

Member of Multicultural Committee August 2011 – Present
George Fox University Graduate Department of Clinical Psychology
- Training and Awareness Subcommittee Chair
- Annual scholarship recipient for diversity-related involvement in community

Member of Community Worship Committee May 2012 – May 2014
George Fox University Graduate Department of Clinical Psychology
- Assisted the facilitation of monthly community spiritual activities

Member of Graduate Chapter of Christian Association of Psychological Studies Dec. 2011 – May 2014
George Fox University Graduate Department of Clinical Psychology
- Participated in religion and spirituality trainings and consultation

MEMBERSHIP & HONORS

Memberships
- American Board of Professional Psychology Early Entry Program
- American Psychology Association, Student Affiliate
    - Member of APA Graduate Students
- Division 19, Society for Military Psychology, Student Affiliate
- Division 38, Health Psychology, Student Affiliate
- Division 44, Society for the Psychological Study of LGBT Issues
- Association of Contextual Behavioral Sciences, Student Member
- Oregon Psychological Association, Student Affiliate
    - Member of OPA Student Committee
- Western Psychological Association, Graduate Student Member
- Christian Association for Psychological Studies, Student Affiliate

Honors
- Psi Chi International Honor Society of Psychology
- Cum Laude, Indiana Wesleyan University
- Deans List, Indiana Wesleyan University
- Who's Who Among Students, Indiana Wesleyan University
- Academic Honor Role, Indiana Wesleyan University

PROFESSIONAL TRAININGS & EDUCATION

Intervention Training:

ACT II – Intermediate and Advanced Skills Training — September 2014
Steven Hayes, PhD

Acceptance and Commitment Therapy Boot Camp — March 2013
Steven Hayes, PhD; Robyn Walser, PhD; Jason Luoma, PhD

An Introduction to Motivational Interviewing — February 2013
Michael Fulop, PsyD, MINT

Motivational Interviewing — March 2011
Michael Fulop, PsyD, MINT

Military Populations Trainings:

The Role of Integrative Medicine in the Treatment of TBI — October 2014
David Drake, MD; Margaret MacDonald, MD; Jean-Louis Belard, MD, PhD, MAc

Caring for the Military Family: — October 2014
What We All Should Know About Military Culture and the Stress Deployment
American Psychological Association

Identifying and Treating Concussion/mTBI in Service Members and Veterans — September 2014
Defense and Veterans Brain Injury Center

Evidenced Based Treatments for PTSD in Veteran Populations: — March 2014
Clinical and Integrative Perspectives
David Beil-Adaskin, PsyD

PVAMC Suicide Prevention Program — September 2013
Monireh Moghadam, LCSW; Aimee Johnson, LCSW

Minority Populations Trainings:

African American History, Culture, and Addictions and Mental Health Treatment — November 2013
Danette Haynes, LCSW, Marcus Sharpe, PsyD

Sexual Identity — November 2012
Erica Tan, PsyD

Treating Gender Variant Clients: Christian Integration — October 2012
Erica Tan, PsyD

Cross-Cultural Psychological Assessment — November 2011
Tedd Judd, PhD

Assessment Training:

The Collaborative Assessment and Management of Suicidality (CAMS) — September 2014
David Jobes, PhD, ABPP

Using Tests of Effort in a Psychological Assessment — May 2013
Paul Green, PhD

Assessing Mild Cognitive Impairment and Dementia — May 2013
Mark Bondi, PhD, ABPP/CN

Assessment and Treatmnet of Anger, Aggression and Bullying in Children and Adults — June 2012
Ray DiGuiseppe, PhD

The Mini-Mental State Examination, 2nd Edition — June 2012
Ray DiGuiseppe, PhD, Joel Gregor, PsyD

Systems and Program Evaluation Training:

2014 Client Summit on Health Activation — May 2014
Insignia Health Inc.

Primary Care Behavioral Health — September 2013
Brian Sandoval, PsyD, Juliette Cutts, PsyD

ASSESSMENT & POPULATION SCREENERS

16 Personality Factors Questionnaire (16PF)
Adaptive Behavior Assessment System, Second Edition (ABAS-II)
Adult ADHD Self-Report Scale (ASRS)
ASEBA Adult Self-Report and Adult Behavior Checklist (ASR, ABCL)
Behavior Assessment System for Children, Second Edition (BASC-II)
Conners 3rd Edition (Conners 3)
Denver, Second Edition (Denver II)
Family Adaptability and Cohesion Evaluation Scales, IV (FACES IV)
Fagerstrom Test for Nicotine Dependence
Generalized Anxiety Disorder, Seventh Addition (GAD-7)
Gilliam Asperger's Disorder Scale (GADS)
Gray Oral Reading Test, Fourth Edition (GORT-IV)
Insomnia Screening Questionnaire

Keirsey Temperament Sorter (KTS-II)
Millon Clinical Multiaxial Inventory-III (MCMI-III)
Mini-Mental State Examination, 2nd Edition (MMSE-II)
Minnesota Multiphasic Personality Inventory-II (MMPI-II)
Minnesota Multiphasic Personality Inventory-II, Restructured Format (MMPI-II-RF)
Montreal Cognitive Assessment (MoCA)
Outcome Rating Scale (ORS)
Patient Activation Measure (PAM)
Patient Health Questionnaire (PHQ-9)
Peabody Picture Vocabulary Test, Fourth Edition (PPVT-IV)
Personality Assessment Inventory (PAI)
Primary Care PTSD Screen (PC-PTSD)
Session Rating Scale (SRS)
Vanderbilt Rating Scales (VRS)
Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV)
Wechsler Individual Achievement Test, Third Edition (WIAT-III)
Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV)
Wide Range Assessment of Memory and Learning, Second Edition (WRAML-II)
Wide Range Achievement Test, Fourth Edition (WRAT-IV)
Wide Range Intelligence Test (WRIT)
Woodcock-Johnson Tests of Cognitive Ability, Third Edition (WJ-III)