

5-2022

Vicarious Trauma and Doctoral-Level Trainees: Self-Care Practices

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Vicarious Trauma and Doctoral-Level Trainees: Self-Care Practices

by

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Presented to the Faculty of the
Graduate School of Clinical Psychology
George Fox University
in partial fulfillment
of the requirements for the degree of
Doctor of Psychology
in Clinical Psychology

Newberg, Oregon

May 25, 2022

Vicarious Trauma and Doctoral level Trainees: Clinical Readiness
and Self-Care Practices

by

Elisabeth B. Gibson

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at the

Graduate School of Clinical Psychology

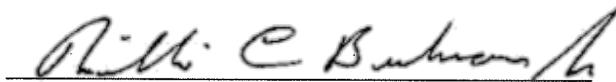
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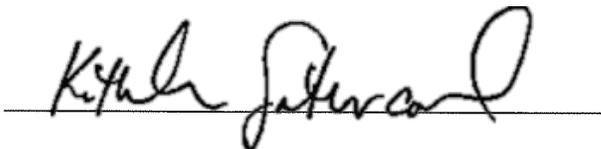
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Vicarious Trauma and Doctoral-Level Trainees: Self-Care Practices

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Abstract

Research reflects correlations between trauma history and motivation to pursue a career in clinical psychology and mental health professions. Professional longevity is a concern for clinicians in general, especially for clinicians with a trauma history who work with people suffering with trauma conditions. Trauma histories measured by adverse childhood experiences (ACEs), are likely to be present within students of doctor of psychology training programs, and may influence doctoral trainee readiness and ability to engage clients in clinical work. Self-care is thought to not only support overall well-being, but to also mitigate the negative consequences of stress associated with clinical work. A survey to evaluate the prevalence of vicarious trauma within doctoral trainees, self-care practices, and program curriculum was distributed via electronic survey to graduate students in three Doctor of Psychology programs in the United States. Results were analyzed using descriptive statistics, comparison of means, analysis of variance (ANOVA), and hierarchical linear regression. Overall results indicated that doctoral trainees experience vicarious trauma in the course of their clinical training, and trainees with trauma histories may be more likely to experience vicarious trauma in the course of their training.

Keywords: vicarious trauma, adverse childhood experiences, ACEs, self-care, doctoral trainee, curriculum

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Chapter 1

Introduction

The adverse effects of workplace and job-related stress have harmful consequences for organizations and on the physical and mental well-being of workers (Maulik, 2017; Sohn et al., 2018). The emotional labor, interpersonal strain, perceived lack of support, and physiological stress is directly related to work-related factors (i.e., environment, duties, structure, support, experiences, etc.). Furthermore, the long-term effects of stress are related to dysfunction in mental health, including depression and anxiety, as well as with physical health conditions (Lanza, Roysircar, & Rodgers, 2018; Ogunbamila et al., 2014; Suran & Sheridan, 1985). Professions involving high job stress and emotional labor, such as health and social service careers (i.e., first responders, hospital workers, mental health clinicians, etc.), are particularly susceptible to the aforementioned conditions. The field of clinical psychology is no exception, with research reflecting a vulnerability to types of distress and burnout (Bercier, 2013; Bettney, 2017). Additionally, the nature of clinical psychology further exposes clinicians to the potential for burnout, compassion fatigue, secondary traumatic stress, and vicarious trauma due to continuous requirements to manage their internal needs for the sake of the organization and their clients (Bercier, 2013; Korn, 2013; Sohn, Park, Park, Hwang, Choi, Lee, & Jung, 2018; Yoon & Kim, 2018).

There is significant research regarding the effects of trauma within clinical mental health treatment that reflects the impact of trauma on the client, including ongoing psychological and

physiological effects (Kanno, 2010; Korn, 2013). Trauma, defined as “a deeply distressing or disturbing event” (Trauma, 2020), has broad meaning when applied to individual experiences. According to Briere and Scott (2015), most adults in the United States have experienced at least one major trauma. While many describe trauma as involving significant isolated events, trauma may also include systemic, ongoing exposures to experiences that may be too difficult for individuals to process. Barbash (2017) asserted the idea that the impact of trauma can be classified into two categories: *large T* and *little t* trauma. Events considered to be *little t* traumas are described as non-life-threatening events that result in a threat to one’s ego and surpasses the individual’s ability to cope, causing impaired emotional functioning. These *little t* events could include experiences such as infidelity, financial distress, and interpersonal conflict and are often not considered traumatic by the individual due to rationalization of the experience (Barbash, 2017). An aspect of *little t* trauma is the psychological impairment that often results from the accumulation of multiple small events. In contrast, *large T* trauma is defined by an intense sense of helplessness associated with a significant event that far exceeds the degree of helplessness felt from a *little t* trauma.

With regard to job-related stress concerns, exposure to degrees of trauma is a contributing factor to multiple areas of dysfunction within an employee, including emotional, social, neurological, and socio-environmental (i.e., an individual’s supports, sense of safety, security) (Korn, 2013; Lanza et al., 2018; Lerias & Byrne, 2003). Research affirms a high possibility for clinicians to not only encounter trauma from working with clients but also to have suffered personal traumas as well. The impact of this trauma is related to multiple variables, including cognitive perceptions, personal experiences, workplace, and environmental factors, personal care, and density of trauma exposure (Gonzalez et al., 2019; Lerias & Bryne, 2003; Newell &

MacNeil, 2010; Sansbury et al., 2015). Employees entering occupations as clinical providers who plan to work with clients with traumatic experiences are vulnerable to multiple areas of dysfunction related to trauma exposure, including vicarious trauma. To address vicarious trauma within clinical providers, the distinction between other responses to trauma exposure is necessary.

Trauma Response Definitions

Vicarious Trauma

Vicarious trauma (VT) occurs when the clinician experiences a cognitive change involving their intrinsic beliefs and perceptions of the world involving areas of trust, safety, and control, as a direct result of chronic or direct practice with trauma populations (Newell & MacNeil, 2010; Pearlman & MacJan, 1995; Sabin-Farrell, R. & Turpin, G., 2003). This may present within the clinician as engaging cognitive errors such as over-generalization, catastrophizing, all or nothing thinking, etc., and applying these errors to themselves and their environment (i.e., the world is not safe). VT differs from secondary traumatic stress in that the change is rooted deeper into the functioning of the clinician, adjusting their beliefs and perception of the world, particularly about themselves (Dunkley & Whelan, 2006; Lanza et al., 2018). The risk factors for traumatic stress overlap with other conditions associated with trauma work (i.e., compassion fatigue, secondary traumatic stress) such as the clinician's mental health and personal trauma histories (Newell & MacNeil, 2010; Sabin-Farrell, R. & Turpin, G., 2003). The experience of VT can be conceptualized as a "transformation experienced by the counselor as a result of empathic engagement with the trauma client" (Dunkley & Whelan, 2006). This concept mirrors descriptions in the literature of secondary traumatic stress, compassion fatigue, and the emotional exhaustion associated with burnout. In many ways, VT may be a natural

occurrence when working with trauma populations (Dunkley & Whelan, 2006). Given the prevalence of trauma in society and the nature of emotional labor required of care providers, there is a growing need for supporting mental health providers in methods to address trauma exposure.

Secondary Traumatic Stress

The research literature recognizes differences between vicarious trauma and secondary traumatic stress (STS); however, the overlap of symptoms creates confusion. Gaining knowledge of traumatic events in combination with empathetic engagement with the traumatized client may result in “consequential behaviors” and stress. Stress associated with this experience mirrors the symptoms of posttraumatic stress disorder, including re-experiencing through memories and intrusive thoughts, difficulty concentrating, fatigue, hypervigilance, and avoidance. The combination of secondary trauma exposure and the emotional vulnerability of the clinician within the therapeutic relationship impacts the experience of STS. (Baird & Jenkins, 2003; Figley, 1995 as cited by Newell & MacNeil, 2010). The symptoms of STS mirror VT in their visible manifestation and level of psychological distress; however, a distinct difference is STS has a greater emphasis on the visible behavioral symptoms and the emotions associated with a desire to help the traumatized clients. On the other hand, VT involves an intrinsic cognitive change within the clinician (Dunkley & Whelan, 2006; Figley, 1995 as cited by Newell & MacNeil, 2010).

Burnout

Burnout is a specific type of work-related stress within an employee that is the result of an organization or system placing high demands on the employee with low levels of support (Sansbury et al., 2015). Research into the concept and experience of burnout identifies three

domains: emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment (Newell & MacNeil, 2010; Richardson, 2013) These domains are warning signs that a clinician (i.e., care provider, therapist, or clinician) may experience psychological distress as a consequence of their work (Lipsky, 2009). Working with traumatized clients holds many risks, including psychological strain associated with serving high-needs populations resulting in a progressive state of fatigue and eventual apathy, as well as stress associated with the organization and population served (Bettney, 2017; Dunkley & Whelan, 2006; Lipsky, 2009; Newell & MacNeil, 2010). Emotional labor is the effort and work to manage one's own emotions in relation to their work and rules of their environment. The concept of emotional labor is highly associated with the helping professions and is interrelated with burnout (Sohn et al., 2018). The risk of burnout is high in professions demanding emotional labor and is increased when working with trauma populations (Bettney, 2017; Newell & MacNeil, 2010; Sohn et al., 2018; Yoon & Kim, 2018).

Compassion Fatigue

Unlike VT, compassion fatigue (CF) does not require contact with clients (Sansbury et al., 2015). CF is described as the clinical provider's reaction or response to the knowledge of another's traumatic experience and is related to the clinical provider's desire to help or support the client (Gonzalez et al., 2019). Often used interchangeably with vicarious trauma and secondary traumatic stress, compassion fatigue is the "overall experience of emotional and physical fatigue" associated with chronic or ongoing empathetic engagement with client experiences of suffering (Dunkley & Whelan, 2006; Lipsky, 2009; Newell & MacNeil, 2010).

Self-Care and Trauma Stewardship

Self-Care is “the practice of taking action to preserve or improve one’s own health” (Self-Care, 2020) and may include a variety of activities, including lifestyle practices, social support, and faith practices (Wicks 2008 as cited by Bettney 2017). O’Halloran and Linton (2000) found that when “creative endeavors, rest, and physical and social activities” (as cited by Pearlman & MacIan, 1995, p. 356) are engaged in as a regular part of one’s lifestyle, or as proactive wellness or prevention, the behavior supported the maintenance of clinician psychological and physical well-being. Preventative measures are considered essential components of professional well-being (O’Halloran & Linton, 2000, p. 356, line 14; Sansbury et al., 2015). Clinicians model and promote self-care practices to their clients, and in many cases, the importance of self-care is introduced during their training (Zahniser et al., 2017). In one study, the perceived importance of self-care was found to be a positive predictor of quality of life and utilization of self-care (Goncher et al., 2013).

When implementing behaviors to maintain individual wellness, there are several areas of self-care practices including emotional, physical, intellectual, spiritual, relational, social well-being, safety, and security. These are regarded as “buffers” to the effects of trauma exposure on the clinician (Brady et al., 1999; Huan-Tang et al., 2017; Lanza et al., 2018; Lipsky 2009; Newell & MacNeil, 2010). Research has shown that it is more challenging to address trauma responses reactively, further endorsing the need for preventative self-care approaches with clinicians. This has been modeled in social work programs and within doctoral level training. However, there is still a gap in the research addressing the relationship of self-care practices and vicarious traumatization in doctoral level trainees in clinical psychology educational programs.

The struggle to balance the demands of academics, clinical training, research, and performance anxiety leaves trainees susceptible to burnout (Bettney, 2017).

There is value in addressing the concept of VT in doctoral level trainees as they are exposed to client trauma. In addition to preparing the students to clinically address trauma, graduate programs also play a vital role in promoting self-care as a professional practice within the trainee not only for longevity in the field but also to mitigate inherent stressors within their professional roles (Bettney, 2017; Goncher et al., 2013; Newell & MacNeil, 2010; Sansbury et al., 2015; Zahniser et al., 2017). When working with clients, all clinicians encounter distressing information that challenges their ability to manage their personal experiences while supporting the client. While it may be helpful to merely model and state the importance of self-care in clinical practice, systematic instruction in self-care may provide more effective encouragement and conceptualization of how to employ self-care (Zahniser et al., 2017). Guiding the client in a practice of making meaning within their trauma experiences, while avoiding clinician internalization of client struggles or enacting their own experiences requires intentional effort on the part of the clinician. This effort and practice ideally will create a scenario where the clinician can hold what the client presents in tandem with their own experiences without being overwhelmed by either (Lipsky, 2009). This practice is referred to *stewardship*, where the idea incorporates the concept of self-care, while acknowledging the potential for burnout and CF (Lipsky, 2009).

It is essential for organizations, including academic institutions, to model a support network and healthy behaviors, as well as formal instruction, in congruence with information distributed to clients (Bettney, 2017; Sansbury et al., 2015; Zahniser et al., 2017). Given the knowledge that VT may occur through any relationship with clients; the loading factors for

clinicians to experience VT, the benefits of stewarding behaviors and the exploration of self-care practices in direct relationship to the occurrence of VT may support an understanding of how to promote personal well-being and professional longevity.

Doctoral Level Training

Motivational factors for pursuing a career in counseling reside within three categories: To reciprocate and mirror help received, to provide what they wish they received, and to help others through gained knowledge or insight (Day, 1994). In a recent study, masters-level and doctoral level graduate students in helping professionals were found to have significantly more adverse childhood experiences (ACEs) than previously believed (Harris, 2019). In a study examining social work students, a third of clinical trainees reported a history of personal trauma (Butler et al., 2017). Clinical training and trauma-exposure related stress in social work students was correlated with extreme degrees of traumatization in the trainees as well as increased risk for burnout (Butler et al., 2017). With this in mind, the likelihood of a clinical trainee presenting with preexisting trauma within a practicum setting is high, and newer therapists with trauma histories were prone to burnout, which continues to be a significant area of concern affecting organizational sustainability and access to mental health services for the community (Pearlman & MacIan, 1995, Suran & Sheridan, 1985).

As stated earlier, self-care is a factor in supporting the health and longevity of clinicians. Research studies within the field of social work and counseling address the concern of provider ability to treat trauma through recommendations to support readiness at a curricular level (Butler et al., 2017; Newell & MacNeil, 2010), as well as relevant supports and recommendations (Newell & MacNeil, 2010; Pearlman & MacIan, 1995; Sansbury et al., 2015).

Avoiding clinician burnout and traumatization during professional activities has been an ongoing concern for professional well-being and longevity. This concern challenges programs and clinicians to consider self-care as an ethical issue to address as part of clinical training programs at all degree levels (Kanno, 2010; Suran & Sheridan, 1983;). Evidence of the inherent stress involved in clinical mental health work suggests clinical providers entering the field with vulnerabilities toward stress (i.e., prior trauma) are more likely to experience STS, VT, and burnout (Jenkins et al., 2011). Self-care practices have the greatest benefit when applied preventatively, when it is adequately modeled within a training community, and when curriculum provides education and training on the ethical importance of the practice.

Purpose of the Study

Trauma is a common experience among clients engaging in services within mental health settings. There is a gap in the literature to address the experiences of doctoral level students with trauma exposure in clinical settings and the effect of self-care in those experiences. Literature supports the importance of self-care practices to mitigate the effects of trauma exposure as well as concern for the effects of stress on clinical trainees (Pakenham & Stafford-Brown, 2012); however, there is little evidence to describe how self-care is being taught or modeled to emerging professionals. The purpose of this study is to examine trauma-exposure and experiences of doctoral level students in clinical training, as well as attitudes and habits associated with self-care practices.

Hypotheses

H1: Doctoral level students experience VT within practicum experiences.

H2: Doctoral level students with a history of trauma experience vicarious trauma within their practicum experiences at higher rates than doctoral level trainees without trauma histories.

H3: Vicarious trauma symptoms are negatively associated with the presence of self-care practices within doctoral level trainees.

H4: Doctoral level trainees' year in clinical training is related to the experience of vicarious trauma.

H5: Doctoral level students with high ACEs scores who engage in personal therapy experience lower vicarious trauma rates than doctoral level students with high ACES scores disengaged from personal therapy.

Chapter 2

Methods

Participants

In this study, participants were surveyed from three APA accredited Doctor of Psychology programs along the West Coast region of the United States. Participants were included based on current enrollment within a Doctor of Psychology program. The researcher gathered responses from 59 doctoral level trainees, with 55 viable to be included in data analysis. Table 1 displays the demographic characteristics of the sample. Within the sample, 69.1% identified as cis-female and 30.9% as cis-male. Participants endorsed ethnic identities consistent with the U.S. Census categories that included 85.5% White, 5.5% Black, 1.8% American Indian, and 7.3% Asian. Participant age data was collected within seven age-band categories with the majority of participants between the ages of 25-30 ($N = 55$, 41.8%); 34.5% identified as 20-24, 14.5% were 31-35, 5.5% were 36-40, 1.8% were 41-45, and 1.8% were 51 or older. Marital status was also reported with 43.6% endorsing a marital status of single, 16.4% as partnered, and 40% as married. Year in program among respondents was represented in the following areas: 27.3% in First Year, 16.4% in Second Year, 20% in Third Year, 30.9% in Fourth Year, 1.8% in Fifth Year, and 3.6% in Seventh Year in the program.

Measures

Trauma Attachment Belief Scale (TABS; Pearlman, 2003)

To measure vicarious trauma, the TABS is an 84-item scale utilizing a 6-point Likert scale (*Strongly Disagree* to *Strongly Agree*), which measures traumatic event experiences and

evaluates beliefs/cognitive schema (with higher scores indicating an increased presence of schematic beliefs) in five areas that may be affected by traumatic experiences: Safety, Trust, Esteem, Intimacy, and Control. The measure yields a total score and subscale total scores within ten categories that include Self-Safety, Other-Safety, Self-Trust, Other-Trust, Self-Esteem, Other-Esteem, Self-Intimacy, Other-Intimacy, Self-Control, and Other-Control. The TABS has been normed for adults aged 17 and older and adolescents ages 9-18. Reported internal consistency for the overall TABS score is significantly high (Cronbach's alpha = .96) with internal consistency of the subscales reflected as moderately high (Cronbach's alpha = .79). Construct validity between overall TABS score and subscales is highly intercorrelated, with lower internal consistency when comparing specific subscales.

Adverse Childhood Experiences Questionnaire (Felitti et al, 1998)

To assess previous experience frequencies of trauma in doctoral students, the ACE Questionnaire is a 10-item yes/no questionnaire, assessing 10 types of childhood adversity within three domains of abuse: emotional and physical abuse, physical neglect, and dysfunctional environment exposure. Total scores range from 0-10, with higher scores indicating adverse experiences and often associated with increased physical and psychological health risks. Reported internal consistency is moderately high (Cronbach's alpha of .88).

Qualitative questions were administered within the electronic survey to collect basic demographic information and clinical training perceptions. Perceptions pertained to the categories of program and curriculum satisfaction (e.g., professor support and modeling of self-care, clinical readiness, etc.), practicum trauma experiences (e.g., difficulty managing practicum stress, supervisory support of self-care, experiencing trauma-related activation) and self-care

practices. The response options were presented using Likert-type scales with five variables (i.e., *Strongly Disagree* to *Strongly Agree*). See Appendix A.

Procedure

Participants were invited to participate in an online survey via a link furnished by their program's Director of Clinical Training (DCT). The researcher provided an email featuring a description of the research, informed consent, and a hyperlink to participate in the survey. Participants accessed the survey through the Qualtrics platform. Participation was voluntary, as indicated within the informed consent and before initiating the survey (Appendix B). The survey was designed to gather data while maintaining participant anonymity, meaning no IP addresses or otherwise identifying information was collected. Completion of the survey took an average of 15-25 minutes.

Data Analysis

Data was analyzed through SPSS 27.0.1. Descriptive statistics were computed to identify the demographic information of the population sample to include age, ethnicity, gender, marital status, and year in program among doctoral level trainees. Data from the ACE questionnaire, TABS measure, and qualitative data regarding participant perceptions in various categories was also analyzed.

Chapter 3

Results

Descriptive statistics were calculated for participant demographic information (Table 1) reflecting age, gender, marital status, year in program, and ethnicity. Descriptive statistics were computed for Total ACE score ($M = 2.53$, $SD = 2.63$). For the purpose of this study, a cut score of four or more was used because research indicates increased correlation for psychological and health issues in adulthood for respondents endorsing four or more ACEs. Therefore, mean and standard deviation were computed for ACE score $4 \geq$ ($M = 6.1$, $SD = 1.74$). The TABS total score ($M = 254.24$, $SD = 26.48$) and the 10 subscales were also computed means and standard deviation (Table 2). TABS total score and subscale scores for the sample were compared with standardized sample of trauma therapists (Table 3). The gender representation is consistent with the percentages of female and male psychologists. After reviewing the data, 55 participants completed all measures.

Hypothesis 1

This hypothesis explored whether doctoral level trainees experience VT during their practicum training. One sample t -tests were calculated for the TABS total and subscale scores comparing the trainees with a standardized sample for trauma therapists (see Table 3). The results indicate significant differences between the two groups, with the doctoral trainees reporting higher levels of VT than the standardized sample of trauma therapists. Specifically, the total TABS score was significantly higher for the trainees ($M = 63.65$, $SD = 5.51$) than for the

Table 1*Descriptive Statistics for Demographics Charts*

Variable	Percentage
Age	
20-24	34.5
25-30	41.8
31-35	14.5
36-40	5.5
41-45	1.8
51+	1.8
Gender	
Male	30.9
Female	69.1
Ethnicity	
White	85.5
Black/AfAm	5.5
American Indian	1.8
Asian	1.2

trauma therapists ($M = 44.00$, $SD = 9.00$), $t(df = 54) = 28.54$, $p < .001$, $d_{prime} = 3.85$. As a result, it can be concluded that doctoral-level trainees do experience VT in their practicum training because their level of VT exceeds that of trauma therapists.

Hypothesis 2

This hypothesis proposed a relationship between trauma history (indicated through ACE scores) and the experience of VT (indicated through TABS measure). The question explored whether trainees endorsing a trauma history experience VT more than trainees without history of trauma. Pearson correlations between ACE Total score, practicum trauma experience, and TABS

Table 2*Descriptive Statistics of ACE and TABS Measures*

Variable	Mean	SD
ACE total score	2.53	2.63
ACE 4 \geq	6.1	1.74
TABS total score	254.25	26.48
Self-Safety subscale	42.91	3.62
Other-Safety subscale	19.82	3.80
Self-Trust subscale	29.07	2.54
Other-Trust subscale	23.55	3.27
Self-Esteem subscale	27.62	3.24
Other-Esteem subscale	26.20	2.48
Self-Intimacy subscale	21.96	3.43
Other-Intimacy subscale	23.96	5.58
Self-Control subscale	24.45	5.84
Other-Control subscale	14.96	3.87

Total score were calculated and are displayed in Table 4. TABS score and practicum trauma experience were positively correlated ($r = .31, p = .02$), reflecting when TABS scores increase practicum trauma experience also increase. A positive correlation between ACE score and TABS Total score ($r = .27, p = .05$) indicates as trauma history scores increase VT endorsement also increases. A positive correlation between ACE score and practicum trauma experience was also observed ($r = .42, p = .001$) indicating that those reporting higher levels of

Table 3*Sample and Standardized Sample Comparison*

Variable	Sample <i>M</i>	Sample <i>SD</i>	Standardized Sample <i>M</i>	Standardized Sample <i>SD</i>	<i>t</i> value	P value (one sided)	Point estimate (Cohen's <i>D</i>)
TABS Total T- Score	63.65	5.11	44.0	9.0	28.54	<.001	3.85
Self-Safety	66.41	3.28	45.4	8.4	47.51	<.001	6.41
Other- Safety	58.53	8.32	45.6	9.1	12.2	<.001	1.64
Self-Trust	73.53	3.13	46.1	8.4	65.1	<.001	8.77
Other- Trust	53.96	6.7	44.9	8.3	10.1	<.001	1.36
Self- Esteem	64.71	3.66	46.4	8.9	37.1	<.001	5.0
Other- Esteem	65.93	4.61	45.2	9.4	33.34	<.001	4.5
Self- Intimacy	60.33	6.39	43.1	7.6	20.0	<.001	2.7
Other- Intimacy	60.45	7.47	47.7	9.2	12.67	<.001	1.71
Self- Control	55.67	9.99	45.8	9.2	7.33	<.001	.99
Other- Control	45.0	8.65	45.8	9.0	-.69	.25	-.09

trauma history report higher levels of practicum trauma experiences. Binomial tests demonstrate that none of these correlations differ significantly from the others. Specifically, the correlation of TABS Total score with ACE Total score does not differ from the correlation of TABS Total score with Practicum trauma experience, $z = -.51, p = .05$; the correlation of TABS Total score

with ACE Total score does not differ from the correlation of ACE Total score with Practicum trauma experience, $z = -1.79, p = .05$; and the correlation of TABS Total score * Practicum trauma score does not differ from the correlation of ACE Total score * Practicum trauma experience, $z = -1.28, p = .05$.

Table 4

Pearson's Correlation for TABS Total Score, ACE Total Score, and Practicum Trauma Experience

Variables	Pearson's r	P value (two tailed)
TABS Total score * ACE Total score	.27	.05
TABS Total score * Prac trauma exp	.31	.02
ACE Total score * Prac trauma exp	.42	.001

Hypothesis 3

This hypothesis examined whether VT symptoms were negatively associated with the presence of self-care practices in doctoral level trainees. Pearson Correlations were calculated to explore relationships between TABS Total score and self-care practices. A negative correlation between VT and self-care practices ($r = -.36, p = .006$) was observed, reflecting that the higher the VT endorsement the lower the practice of self-care.

Hypothesis 4

This hypothesis addressed whether the year in program is related to the experience of VT in doctoral level trainees. Spearman's rank correlation was computed to assess the relationship between the year in program and the scores for TABS total score, program and curriculum satisfaction, practicum trauma experience, and self-care practices (see Table 5). Negative

correlations were found between year in program and program/curriculum satisfaction, TABS total score and program/curriculum satisfaction, TABS total score and self-care practices, and program/curriculum satisfaction and practicum trauma experience. There were positive correlations between TABS total score and practicum trauma experience, and between program/curriculum satisfaction and self-care practices.

Table 5

Spearman's Rank Correlation for Current Year in Program, TABS Total Score, Program/Curriculum Satisfaction, Practicum Trauma Experience, and Self-Care Practices

Variables	<i>Spearman's r</i>	<i>P value</i>
Current year in program * program/curriculum satisfaction	-.30	.03
TABS total score * program/curriculum satisfaction	-.30	.03
TABS total score * practicum trauma experience	.35	.01
TABS total score * self-care practices	-.35	.01
Program/curriculum satisfaction * practicum trauma experience	-.40	.003
Program/curriculum satisfaction * self-care practices	.33	.01

Note. All of these correlations were moderate in effect size.

Hypothesis 5

This hypothesis posited that doctoral level trainees with high ACE scores who engage in personal therapy experience lower VT rates than doctoral level trainees with high ACE scores who do not engage in personal therapy. To evaluate predictors for TABS total score, variables were analyzed with TABS total score through hierarchical and stepwise regression. TABS total score and demographic variables (i.e., age, gender, ethnicity, current year in program, marital

status) were entered in Step 1, with self-care practices questions were entered in Step 2. ACE 4 \geq was entered in Step 3 to evaluate the predictive power of trauma history. Results showed that R^2 for TABS total score and demographics was .115; $\Delta R^2 = -.008$ after entering Step 2, i.e., accounting for less than 1% of the variance in VT. When ACE 4 \geq was entered in the third step, R^2 was .44 with $\Delta R^2 = .202$ (Table 6), indicating that high ACE scores predicted 20% of the variance in VT.

Table 6

Hierarchical and Stepwise Regression with TABS Total Score and Demographic Variables, Self-Care Practice Questions, and ACE 4_≥ as Predictors

	Variable	R	R ²	ΔR ²	Beta	<i>t</i>	Sig.
Model 1	TABS Total score	.340	.115	.025		14.96	<.001
	Current year in program				-.092	-.497	.622
	Gender				.079	.544	.589
	Age				-.168	-.873	.387
	Ethnicity				-.121	-.837	.407
	Marital Status				-.120	-.738	.464
	Model 2	TABS Total score	.522	.272	-.008		
Current year in program					-.195	-.992	.327
Gender					-.045	-.256	.799
Age					.067	.283	.779
Ethnicity					-.059	-.362	.719
Marital Status					-.168	-.892	.378
Engage/d in personal psychotherapy					.067	.269	.790
Model 3	TABS Total score	.662	.439	.202			
	Current year in program				-.109	-.617	.541
	Gender				-.091	-.583	.564
	Age				-.203	-.899	.374
	Ethnicity				-.006	-.039	.969
	Marital Status				-.078	-.459	.649
	Engage/d in personal psychotherapy				.083	.378	.707
	ACE 4 _≥				.473	3.357	.002

Chapter 4

Discussion

As trauma awareness and trauma reports increase within society, and access to mental health services continues to grow, clinicians encounter more trauma in their clinical work. (Dunkley & Whelan, 2006). Previous studies (Butler et al., 2017; Goncher et al. 2013; Zahniser, et al., 2017) illustrate the importance of self-care in the professional development of doctoral students and the potential for trauma-related psychological stressors from clinical work on professionals, including students. As a result, mental health clinicians have a growing need for personal and professional support to address the trauma exposure they experience in their professional work.

This study explored the occurrence of vicarious trauma and self-care attitudes and practices within doctoral level trainees in Doctor of Psychology programs (PsyD) and used the TABS to measure VT. The purpose of this research was to identify whether VT occurred within clinical training, and if trauma history and self-care practices influenced the development of VT.

The first research question sought to ascertain whether doctoral level trainees experience VT within practicum settings. It was found that trainees did experience VT. Exposure to clinical work during practicum training resulted in shifts in cognitive schema similar to what is observed in VT presentations. This indicates trainees are at risk of enduring traumatization during their training experience negatively impacting their personal and professional well-being at the

beginning of their careers. Traumatic experiences in early-career may lead to reduce professional longevity and increased health issues.

The second hypothesis in the study explored in trainees with a trauma history experience VT in practicum settings more than trainees without a trauma history. The results suggested that VT and trauma history are related to practicum-related trauma. A stronger relationship was present between practicum trauma experience and ACE score compared to practicum trauma experience and TABS scores, although this was not a significant difference. One consideration for the relationship are the beliefs a trainee has about their trauma experiences. As nature and circumstances surrounding prior trauma experiences are thought to inform future interactions, it is plausible that trainee perception of support or lack of support to engage in self-care by their supervisors as a factor. Additionally, variables involved in historic trauma experiences likely bear influence on potential triggers or activation points within a practicum setting. On a general level, practicum experiences during a doctoral program may be a trainee's first exposure to clinical work, fostering additional stress as they navigate the demands of both graduate education and being a clinical provider. Practicum training itself can be strenuous, which may further contribute to perceptions of practicum as trauma-inducing. Upon entering graduate training, trainee ability to manage stress is supported by previously learned coping strategies. Trainees may struggle with stress management during practicum training due to various factors such as ineffective coping strategies, adjustment difficulties to training, overall severity of trauma history, and/or poor interpersonal support from supervisors (Jenkins et al, 2011).

The third hypothesis considered the relationship between VT and self-care practices. The data analysis showed that higher VT in training is related to lower self-care practices. Research demonstrates the importance of self-care in professional well-being and longevity (Bettney 2017,

Butler et al. 2017, Zahniser et al, 2017). Additionally, self-care is an important foundation in clinical training (Goncher et al., 2013). The results indicated trainees with poor self-care practices may be more likely to experience VT. While this seems like an obvious connection, it must be noted that academic pressures, adjustment stress to graduate training (i.e., relocating for school, starting school), and other life changes coinciding with graduate training may also hinder the implementation of self-care. Culture, in general, encourages the worker to “press on” and “persevere” when they encounter struggles. This mindset to push beyond our limits, often at the sacrifice of sleep, exercise, social engagement, diet, etc., has direct consequences for the human capacity to manage health and stress. The learned behaviors associated with this mindset and its reinforcement through academic marks and societal expectations foster barriers for the trainee to abandon this mindset as they enter the intensity of doctoral training. One suggestion to address the negative consequence of trainee stress is to provide formal instruction on self-care relevance and implementation strategies as part of the curriculum within clinical training. By presenting self-care as part of the clinical training material, it emphasizes self-care as an essential aspect of a clinical training (Zahniser et al, 2017).

The fourth hypothesis found that trainee graduate year within the program did not influence VT; however, program satisfaction and self-care practices were related. Results suggested year in program had a bearing on program and curriculum satisfaction, with those early in their training holding higher satisfaction than those farther along. As trainees progress in their clinical training, observed or perceived training gaps are brought to light as trainees gain clinical experience, likely influencing program satisfaction. Likewise, trauma-inducing or activating experiences would impact on trainee satisfaction with clinical preparation.

Furthermore, VT endorsement was related to lower self-care practices. Program and curriculum satisfaction was also negatively related to practicum trauma experience.

Additional analysis regarding the effects of year in program on self-care practices indicated year in clinical training may be related to self-care attitudes. First year trainees and fourth year trainees appeared to endorse higher self-care attitudes than second and third year students. This may be explained by the rhythm of clinical training. The first year of graduate training is most similar to earlier college experiences with the primary focus on coursework. In contrast, fourth year trainees are more familiar with the demands of managing coursework and practicum. Additionally, some programs structure the fourth year of training as a lighter year for academic coursework and many students have completed their dissertation requirements by this time. 4th year trainees have more accomplished than those in earlier years of training and they have the most familiarity with the demands of the program. It is possible that self-care practices may be more readily implemented by 4th year trainees to manage the incurred stress of the program and support the new transitional stressors of the clinical internship and interview process and remaining finalization of their dissertations.

Second year trainees reported the lowest self-care practices. This year of clinical training introduces the need to balance practicum experiences with academic requirements as well as beginning dissertation requirements. In some programs, second year is also the onset of benchmark exams, requiring additional preparation. The third year of training offers some familiarity as the demands introduced during the second year are maintained. During this half way point in clinical training, there is an increase in self-care practice endorsement within the results, possibly indicating increased awareness after the difficulties of second year. The second and third year of graduate training are the most demanding of the five-year process, with the

multiple demands accounting for the reduced self-care practices compared to 1st and 4th year trainees.

In the fifth hypothesis regarding VT, trainees with trauma histories who engaged in therapy endorsed the same level of VT as those with trauma histories who did not engage in therapy. However, when controlling for demographic factors, the results found that higher ACE scores of four or higher, predicted higher VT. Essentially this means that those who come into clinical training with a trauma history are more likely to experience trauma in their clinical work. These findings align with prior research finding that ACE scores of four or higher are associated with an increased risk of physical and mental health issues (Felitti et al., 1998). Another finding was that age of trainee was related to the VT reported. Younger trainees (between ages 20-30) had higher endorsements of VT than older trainees (between ages 31-51+). It may be that individuals with more life experiences have more coping strategies or have a meaning making process that allows them to adjust or contend with stress more effectively than younger trainees.

Clinical Implications

This study found evidence that there is VT within doctoral level trainees that exceeds the VT experienced by trauma therapists in clinical practice. Given the cognitive restructuring that occurs due to VT (i.e., a shift in their perceptions and beliefs of safety, trust, and control) this means that experiencing VT is more common than we realize among doctoral-level trainees. When trainees are forming their clinical skills and intellectual abilities, and adjusting their ideas of trust, safety, and control within their clinical work, this may explain some of the concerns found in the literature about impaired longevity in the field, clinical burnout, and mental/physical health problems in therapists. When considering self-care practices, attitudes, and VT in doctoral level trainees we know the long-term consequences of stress contribute to psychological and

physiological health issues. For many clinical trainees to experience this in their training raises some concerns as to how they are developing a mindset of balance and self-care.

Limitations and Future Research

There are some challenges within the study that merit further research to confirm and clarify certain results. The small sample size was a factor when considering effect size and generalizability of the results. Despite results reflecting that self-care practices are lower with higher endorsement of VT; self-care practices were not found to be a mitigating factor. Some reasons the beneficial effects of self-care were not reflected within this data analysis includes the small sample size and the subjective measures utilized. Lack of ethnic diversity within the sample is also a concern with generalizability of the information. Surveying more institutions across the United States would provide increase relatability of the results to this population.

In addition to the sample size, it is important to consider the timeframe within which the data was gathered. Responses were collected during the COVID-19 pandemic, a period of time characterized by extreme changes within numerous areas of living, including academic institutions. Amid global changes, trainees experienced shifts in their clinical training and academic engagement as well as managing the stress of various adjustments (i.e., socialization practices, financial instability, workplace changes, health anxiety, etc.). Given the increased stress burden, it is reasonable to consider how this impacted responses on vicarious trauma and qualitative measures. It is difficult to accept the vicarious trauma and qualitative scores at face value since responses cannot control for the influence on non-clinical training related stress.

As trainees responded to the surveys, it is important to highlight that these questions are self-report and elicit opinion-based responses. Subjective responses provide useful experiential

information; however, utilization of objective measures of trauma characteristics may prove more beneficial in identifying stress points within doctoral level training.

Concern for the role of the curriculum in trainee readiness was considered in this study. At issue is whether the results reflect a curricular issue or a matter of perception. Trauma can affect perception. Thus; a trainee may determine they were not trained to respond to client trauma despite the presence of curriculum or faculty discussion to address that very topic. It is also possible that the trainee assessed their training accurately and the curriculum is lacking. This lack of perceived readiness may delay entrance into clinical practice as trainees seek additional, potentially unnecessary, training, or worse, they could jeopardize their treatment with clients through the felt anxieties of professional inadequacy and incompetence. Ultimately, this may impact clinical care and professional development/health. Further research to evaluate curriculum and clinical readiness to engage in trauma work may be merited.

The TABS uses attachment beliefs as a key factor in evaluating VT. However, there may be cultural differences in attachment formation for these two age groups described above. Trainees aged 20-30 would have more exposure to “helicopter” and “snow-plow parenting,” where they may have experienced fewer opportunities to manage stressful situations independently. This lack of experience with distressing circumstances may directly relate to poor distress tolerance, inadequate coping approaches, and a poor sense of agency to enact change or action at all. There are also more post-modern cultural influences about personal truth and individual experiences are considered fact with younger generations, rendering the processing of a distressing event with clinical objectiveness more challenging. Additional research into generational factors in trainees regarding VT have to best address the cultural and historical

challenges the next generation of trainees possess. This could help mitigate the amount of VT they could develop.

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APPENDIX A**Survey Demographic Questions**

Please respond to the following statements using the provided agreement scale

Strongly Disagree, Disagree, Neutral, Agree, Strongly Agree

Questions referencing “self-care” will utilize the following definition, “the practice of taking action to preserve or improve one’s health.

Using the provided scale, please answer the following questions about your program and its curriculum (i.e., the courses and classes offered as part of your PsyD requirements)

1. Our curriculum addresses the importance of self-care in clinical providers.
2. My program and its representatives (i.e., Faculty, staff) within the program visibly practice self-care.
3. My program and its representatives (i.e., Faculty, staff) profess a positive attitude toward self-care.
4. My program and its representatives (i.e., Faculty, staff) encourages self-care in its students.
5. My program supports and encourages me to engage in self-care practice.
6. As a result of training in my program, my awareness of the prevalence of trauma increased.
7. My program’s curriculum clearly described or communicated the emotional and psychological risks with working with clients.

Although not all clients struggle with trauma, when I encounter those that do:

8. My program is preparing/has prepared me to respond to my client’s traumas.
9. My program is preparing/has prepared me to manage my emotional responses to my client’s trauma.
10. Professional mentorship, including program representatives or practicum professionals, supported my ability to clinically address client trauma.
11. Professional mentorship, including program representatives or practicum professionals, supported my ability to manage my reactions to client trauma.

Using the provided scale, please answer the following questions about your current and past practicum settings within your program

1. I feel supported by my supervisors and practicum to engage in self-care practices.
2. My current practicum setting activates or triggers prior traumatic experiences.
3. My practicum setting is stressful.
4. It is difficult to manage my stress within my practicum setting.

5. I experience trauma from the work at my current or past practicum setting.

Using the provided scale, please answer the following questions about self-care

1. I engage in outdoor recreational activities (i.e., hiking, climbing, trail running or biking, etc.).
2. I engage or have engaged in spiritual practices (i.e., prayer, church/mass/gathering, meditation, etc.).
3. My faith is very important to me.
4. I engage or have engaged in personal psychotherapy.
5. I engage in creative activities (i.e., sewing, crafting, musical arts, theater, painting, etc.).
6. I engage in physical activity (i.e., gym, exercise, swimming, etc.).
7. I engage in leisure activities alone or with others (i.e., reading, playing games, watching movies).
8. My forms of self-care are effective in supporting my mental, physical, spiritual, and emotional well-being.
9. I make a point of eating a balanced diet with respect to my dietary needs.
10. I engage in the minimum sleep recommendations for my age group.
11. I limit the amount of technology I use before sleeping.

Descriptive Demographic Questions

1. Are you enrolled in a doctoral level clinical program [Yes, No]
2. Current year in academic program [drop down menu: 1-7+]
3. Gender identity [drop down menu: cis-male, cis-female, transgender, non-conforming, other, do not disclose]
4. Age
5. Ethnic Identity [drop down menu: White (European Heritage, Middle Eastern, North African), Black or African-American, American Indian or Alaskan Native (North, South, and Central American), Asian (Far East, Southeast Asia, Indian), Native Hawaiian or Other Pacific Islander (Hawaii, Guam, Samoa, Pacific Islands)]

*Qualitative short response opportunities were provided to gather additional details on select questions.

APPENDIX B

Informed Consent

Title of Research: Vicarious Trauma and Doctoral level Trainees: Clinical Readiness and Self-Care

Principle Investigator, Affiliation and Contact Information: Elisabeth Gibson, MA, MS

Additional Investigators and Affiliations: Kenneth Logan, PsyD

Institutional Contact:

1. Purpose of the Study
 - a. The purpose of this study is to determine if past traumatic experiences within a student are activated or worsened as a result of their clinical training experiences. The study will also examine student perspectives on how graduate programs prepared them to work with trauma populations, how the program promotes/d self-care practices in their staff and students, as well as asking for student beliefs and habits related to self-care.
2. Description of the Research
 - a. You will be asked to complete an electronic survey with questions about your clinical training, self-care habits and beliefs, and about your program. Your participation will involve a single attempt taking approximately 15-30 minutes depending on your chosen pace.
3. Subject Participation
 - a. Participation requires reading questions in an electronic format and manipulating a computer mouse or touchpad to select a response. Some questions include an optional area to provide a written response feature where a participant would select the short answer space and type a response.
4. Potential Risks and Discomforts
 - a. Some of the questions will ask participants about the presence of prior traumatic experiences. Questions will not request details related to those experiences, it is possible that some individuals may feel uncomfortable by some of the questions or memories prompted by certain questions. If a participant feels uncomfortable to the point where they are unable to continue, they are reminded this is a voluntary activity and they can discontinue at any time. If they feel emotionally activated, they are encouraged to engage any of the following options:
 - i. Contact your Program Director or Training Director for mental health resources accessible to your program
 - ii. National Alliance on Mental Illness (NAMI) Helpline

1. Monday-Friday 10am-6pm, (800) 950-NAMI (6294)
 2. Email: info@nami.org
 - iii. Suicide Prevention Lifeline – (800) 273-TALK (8255)
 - iv. RAINN: National Sexual Assault Hotline (24/7 support)
 1. Online Chat: online.rainn.org
 2. (800) 656-4673
 - v. 1in6: National Helpline for Male Survivors
 1. 1in6.org/helpline/
 - vi. Sexual Assault Resource Center (Oregon) – (503) 626-9100
5. Potential Benefits
- a. Individuals who participate in this study will contribute to data meant to inform curricular design within clinical training in higher education, with results furnished to their respective graduate programs.
6. Confidentiality
- a. All responses are completely anonymous. No personal identifying information or IP addresses will be collected. Data will be aggregated via the Qualtrics reporting function. Data analysis will be reviewed by the Dissertation committee, and may be available upon request from the Director of Clinical Training in the participating programs, with no distribution of raw aggregate data. Any data requested will be furnished in a deidentified format.
 - b. **By signing this form, you agree to voluntarily complete the survey questions related to this study.**
7. Compensation
- a. Participants will not be compensated for participation in this study.
8. Voluntary Participation and Authorization
- a. Your decision to participate in this study is completely voluntary. If you decide not to participate, it will not affect the care, services, or benefits you currently experience within your program.
9. Withdrawal from the Study
- a. If you decide to participate in this study, you may withdraw or discontinue your participation at any time without penalty.
10. Cost
- a. There is no cost participating in this study.

I voluntarily agree to participate in this research study.

Yes

No

Appendix C

Curriculum Vitae

Education

Doctorate in Clinical Psychology **Expected: April 2022**

APA Accredited Program

George Fox University, Newberg, OR

Dissertation topic: Vicarious Trauma and Doctoral-Level Trainees: Self-Care Practices

Final Defense Passed: April 2022

Preliminary Defense Passed: June 2020

Committee: Kenneth Logan, PsyD, William Buhrow, PsyD, Kathleen Gathercoal, PhD

Masters of Arts in Clinical Psychology

May 2019

George Fox University, Newberg, OR

Master of Science, College Counseling and Student Development

May 2014

Azusa Pacific University, Azusa, CA

Bachelor of Arts, Sociology – Work and Society: Emphasis in Counseling and Guidance

May 2012

California State University Northridge, Northridge, CA

Certifications

STAR Behavioral Health Provider (SBHP), Center for Deployment Psychology (CDP)

- Tier 3 Certification: Cognitive Processing Therapy (CPT)

Sept. 2020

- Tier 2 Certification

April 2020

- Tier 1 Certification

April 2019

Certified Movement Coach

Aug. 2019

Primal Fitness, London, United Kingdom

Certification in Nutritional Therapy

June 2017

Nutritional Therapy Association, Olympia, WA

Certificate in Strengths Approaches in Higher Education

April 2014

Noel Academy for Strengths, Azusa Pacific University, Azusa, CA

Clinical Experience

Internship Experience: Veterans Administration North Texas Health Care System– Dallas (VANTHCS)

Trauma Clinic – Women Stress Disorders/Military Sexual Trauma

Feb. 2022 – July 2022

Part-time Rotation

Individual Supervision: Sarah Sadler, PhD

- Outpatient Mental Health Clinic treating trauma-stressor related disorders and co-occurring conditions
- Patient demographics include adult patients aged 22-61 with diverse ethnicities, socioeconomic statuses, sexual orientations, spiritual beliefs, and history of comorbid diagnoses to include PTSD, substance use disorders, mood disorders, and dissociative conditions
- Co-facilitate a closed psychoeducation group addressing sexual trauma using CBT, affective regulation, and DBT principles
- Complete clinical intakes to determine treatment needs and level of acuity
- Provide emotion regulation skills therapy and Evidence Based Practices (EBP) including Cognitive Processing Therapy, Prolonged Exposure Therapy, and CBT based interventions
- Collaborate on patient treatment plans and care within interdisciplinary meetings
- Conduct psychological assessment to provide diagnostic clarification and support treatment planning

Fort Worth Mental Health Outpatient Clinic

Feb. 2022 – July 2022

Part-time Rotation

Individual Supervision: Justin Litvin, PhD

- Community Based Outpatient Clinic
- Patient demographics include adult patients age 34-60 with diverse ethnicities, sexual orientations, and gender identities
- Co-facilitate group therapy utilizing Cognitive Behavioral Therapy for Depression (CBT-D)
- Provide 1:1 therapy in-person and via telehealth using evidence-based practices such as Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), CBT-D, CBT-I, and ACT techniques
- Engage in collaborative treatment planning with patients to meet individual treatment goals

Domiciliary Care for Homeless Veterans

Nov. 2021 – Feb. 2022

Individual Supervision: Jonathan Fluck, PhD

Full-time Rotation

- Residential Treatment Program for veterans experiencing housing insecurity
- Patient demographics included adult patients age 29-66 with diverse ethnicities, sexual orientation, and history of comorbid diagnoses to include PTSD, substance use disorders, and personality disorders.
- Provide therapeutic and rehabilitative services through 1:1 psychotherapy using ACT and DBT approaches and co-facilitation of group therapy to address DBT skills, Motivational skills for Substance Recovery, and Sleep Health
- Collaborate with interdisciplinary team of mental health, social work, and medical staff to coordinate care and treatment plan needs in response to outcomes and treatment recommendations
- Committees: Disruptive Behavior Committee, DBT Consultation

Diamond Clinic Rotation

July 2021-Oct. 2021

Individual Supervision: Angela Beard, PhD

- Outpatient Mental Health clinic within Veteran's Medical Center
- Patient demographics included adult patients age 28-66 with diverse ethnicities, SES, and sexual orientation
- Provided 1:1 therapy in-person and via telemental health, developed treatment plans using CBT approaches
- Engaged as part of a BHIP team to ensure quality care and treatment continuity
- Committees: Disruptive Behavior Committee

Practicum Experiences

Assessment Clinician, Pre-Internship, Oregon Health and Science University (OHSU)

July 2020 – May 2021

Part-time Rotation (10 month, 20 hours per week)

Individual Supervision: Glenna Andrews, PhD, Group Supervision: Kenneth Logan, PsyD

- Family Medicine clinic in urban University Hospital setting
- Patient demographics included adolescent to older adult patients of diverse ethnicities, SES, ability, religious, and sexual identities
- Administer neuropsychological assessment batteries in response to referrals regarding cognitive functioning, memory and learning difficulties, ADHD, learning disabilities, motor impairment, and trauma for diagnostic clarification and evaluation of psychological functionality
- Work with interdisciplinary team of mental health clinicians and primary care physicians to coordinate care in response to outcomes and treatment recommendations

Behavioral Health Consultant, Practicum 2

Aug. 2019 – June 2020

Physician's Medical Center, McMinnville, OR

Part-time Rotation (10 month, 20 hours per week)

Individual and Group Supervision: Kristie Schmidlkofer, PsyD

- Rural primary care clinic serving Internal Medicine, Pediatrics, and Family Medicine serving patients age 5-81 with diverse ethnicities (Latino, Native American, African American, Asian/Pacific Islander, and European Heritage), SES, religious, indigenous heritage, and sexual orientation
- Provided therapy to patients 1:1 and developed treatment plans using CBT/ACT techniques, FACT (Focused ACT), and solutions-focused approaches
- Collaborated within interdisciplinary medical team and external organizations to ensure continuity of care
- Conducted crisis and risk assessment for at-risk patients using Columbia Risk Assessment to evaluate appropriate level of care and inform treatment plan
- Administered neuropsychological assessments, diagnostic screeners, and Achenbach questionnaires to provide diagnostic clarification and inform treatment

University Counseling, Practicum 1, Concordia University

Aug. 2018 – April 2019

Part-time Rotation (9 month, 16 hours per week)

Individual Supervision: Gregory Peterson, MA LPC, Kristina Kays, PsyD

- Suburban University Counseling and Health Center serving students age 17-33, with diverse ethnicities (African American, Latino, European Heritage, Filipino, Pacific Islander, Biracial), SES, and sexual identities
- Counseled, developed treatment plans, and conducted risk assessments for diverse population of clients in 1:1 setting using Rogerian and CBT techniques
- Administered comprehensive psychological assessments for diagnostic clarification and evaluation of psychological functionality

Supplemental Practicum Experiences

Intake Evaluator and Assessment Examiner

Oct. 2020 – Feb. 2021

Part-time Rotation (4 month, 2-8 hours per week)

Friendsview Retirement Community, Newberg, OR

- Residential and Assisted Living Community serving residents age 50-end of life, ethnicities representing primarily European heritage
- Conduct intake interviews, neurological exams, and MoCA assessments for prospective community members, including individual and couple evaluations

Assessment Clinician, Supplemental Practicum

July 2019 – Aug. 2020

Assessment Clinic-Behavioral Health Center, Newberg, OR

Part-time Rotation (11 months, varied hours)

Individual Supervision: Christina Weiss, PsyD, Glenna Andrews, PhD

- Community Health Clinic serving patients across the life span representing diverse ethnic, SES, ability, and sexual identities
- Administered neuropsychological assessment batteries in response to referrals regarding, cognitive ability and academic aptitude for the purpose of diagnostic clarification and evaluating psychological functionality

Behavioral Health Crisis Consultant Team, Supplemental Practicum

Jan. 2019 – July 2020

George Fox University, Newberg, OR

Part-time Position (19 months, 20-30 hours per month)

Individual and Group Supervision: Luann Foster, PsyD, William Buhrow, PsyD, Mary Peterson, PhD

- Rural Public and Private Hospitals serving patients across the life span representing diverse ethnic, sexual, SES, ability, religious, and indigenous backgrounds
- Provided on-call crisis and risk assessment to patients using the CAMS and Columbia Risk Assessment measures
- Collaborated within an interdisciplinary team of medical staff, psychologists, social workers, and law enforcement and coordinated care for acute, subacute, and outpatient services available throughout the state of Oregon
- Implemented brief interventions utilizing Motivation Interviewing strategies and Mindfulness to facilitate patient stabilization, risk assessment, and safety planning

Intake Specialist and Clinician, Supplemental Practicum

Oct. 2018 – Aug. 2019

Therapy Clinic-Behavioral Health Center, Newberg, OR

Part-time Rotation (10 months, varied hours)

Individual Supervision: Joel Gregor, PsyD

- Community Health Clinic serving patients across the life span representing diverse ethnic, SES, ability, and sexual identities
- Conducted clinical interviews for clients recently discharged from the Emergency Department (ED) with presenting concerns including suicidal ideation and potential risk of harm to self or others
- Provided 1:1 individual therapy using Acceptance Commitment Therapy (ACT) and Solutions-focused therapy to support client treatment goals

Counseling Experience

Career Counselor – IDEA Center

Oct. 2014 – Aug. 2017

George Fox University, Newberg, OR

- Counseled students on career pathways and job selection, and supported preparation for interview and employment opportunities
- Developed programming through interdepartmental and community collaboration that supported university and state employment initiatives
- Trained staff and faculty on career coaching practices and industry standards to support soft and hard skills development, meeting department and university objectives for job-readiness

Event Coordinator to Career Counselor Graduate Assistant – Career Services

Feb. 2013 – May 2014

Azusa Pacific University, Azusa, CA

- Counseled and advised students in their career planning process and academic trajectory to support realistic employment goals and professional growth in transitioning professionals
- Co-designed and facilitated workshops for undeclared freshmen and sophomore students, and underserved populations major selection and understanding their Strengths themes

Program Director & Prevention Education Specialist – Project DATE **June 2012 – May 2013**

California State University Northridge, Northridge, CA

- Counseled undergraduate and graduate students in positive coping strategies to prepare for engagement with course content, content comprehension, and peer-to-peer interaction
- Supported a diverse community of learners through interpersonal rapport building and increasing cultural awareness to meet participant needs
- Provided emotional accountability for trauma survivors to prevent negative arousal due to content through weekly check-ins and collaboration with therapy providers

Research Experience

- Qu, L., Gibson, E., & Andrews, G. (2021, August). Effects of gender and birth cohort on single children's ACEs in China. Poster presentation at 2021 American Psychological Association Annual Conference, Virtual Presentation.
- Crowl, J., Naber, K., Gibson, E., Ewing, D., & Buhrow, W. (2020, May). Suicidal Ideation in a Transgender/Gender Non-Conforming Population. Poster presentation at 2020 Oregon Psychological Association Annual Conference, Virtual Presentation.

- Rich-Wimmer, N., Napier, L., Shattuck, M., Gibson, E., Spromberg, C., & Andrews, G. (2019, July). Physiological responses to masculinity and shame: a case study on cultural norms. Poster presentation at 2019 SBPn INS, Rio, Brazil.
- Qualitative analysis for George Fox University, Office of the Provost – evaluate faculty satisfaction and identifying themes to support program development and policy change. (Fall 2018)
- Gibson, E. & Zago, G. (2013, January). Impact of pre-workshop support for networking. Research contracted for university staff, not yet published. Azusa Pacific University, Azusa, CA
- Gibson, E. (2012, February). Vicarious trauma and motivation in sexual assault advocates. Poster presentation presented at the College Counseling and Student Development Alumni Reception, Azusa Pacific University, Azusa, CA.

Professional Trainings/Didactics & Certificate Courses

Trainings

- Jackson, J. *Psychology Supervision Seminar*. VANTHCS, Dallas, TX. 8 hrs. **Oct. 2021**
- Thoman, L. *Prolonged Exposure Therapy*. VANTHCS, Dallas, TX. 12 hrs. **Aug. 2021**
- Carver, K., Litvin, J. *Integrated Couples Behavioral Therapy*. VANTHCS, Dallas, TX. 8 hrs. **Aug. 2021**
- Miesse, C. *Interpersonal Processing Therapy*. VANTHCS, Dallas, TX. 4 hrs. **Aug. 2021**
- St. John, C., Bennett, J., Emmett, G. *Acceptance and Commitment Therapy*. VANTHCS, Dallas, TX. 8hrs **Aug. 2021**
- Carver, K., Litvin, J. *Cognitive Behavioral Conjoint Therapy*. VANTHCS, Dallas, TX. 4 hrs. **Aug. 2021**
- Spain, S. *CBT-Depression*. VANTHCS, Dallas, TX. 8 hrs. **July 2021**
- Saxon, L. *CBT-Insomnia and CBT-Chronic Pain*. VANTHCS, Dallas, TX. 8 hrs. **July 2021**
- Koehler, H., Wright, B. *Cognitive Processing Therapy*. VANTHCS, Dallas, TX. 8 hrs. **July 2021**
- Santanello, A. *Tier 3: Cognitive Processing Therapy*. STAR Behavioral Health Providers, CDP **Sept. 2020**
- Riggs, D., Domenici, P., Parins, L., Shillinglaw, P., Belleau, E., French, L., Cook, J., Holloway, K., Rodgers, T., Landoll, R., Tison, L., Chrestman, K., Thompson, A., Thompson, M. *The Center for Deployment Psychology Summer Institute*. Uniformed Services University of the Health Sciences, CDP **June 2020**
- Santanello, A. & Mann, J. *Tier 2: Alcohol, PTSD Assessment and Treatment, Sleep Disorders, TBI, Addressing Suicide in Military-Connected Patients, Ethical Considerations with Military Populations, and Military Family Resilience*. STAR Behavioral Health Providers, CDP **April 2020**
- *Tier 1: Training on Military Culture and Deployment*. STAR Behavioral Health Providers, CDP **April 2019**
- Dunn, D. *Leadership Training Workshop*. George Fox University, GSCP, Newberg, OR. 8 hours. **Sept. 2017**

Didactics

- Shivakumar, G. & Ugoh, M. *DSM-5 eating Disorder Prevalence in US Military Veterans*. VANTHCS, Mental Health Journal Club, Dallas, TX. **Jan. 2022**
- Shivakumar, G., Johnson, A., & Chen, P. *Antipsychotic Use and Risk of Breast Cancer in Women with Schizophrenia*. VANTHCS, Grand Rounds, Dallas, TX. **Oct. 2021**
- Okere, J., Marino, E., & Chapman, L. *Substance Use and Treatment During the COVID-19 Pandemic*. VANTHCS, Grand Rounds, Dallas, TX. **Oct. 2021**
- Siddique, R. & Kazzaz, S. *Antipsychotics and Weight Gain*. VANTHCS, Grand Rounds, Dallas, TX. **Oct. 2021**
- Lang, A. *Meditative Approaches for the Treatment of PTSD*. MIRECC, VANTHCS, Grand Rounds, Dallas, TX. **Oct. 2021**
- Russo, R., Dela Cruz, A., Thomas, L. *Optimizing your Leadership Style*. VANTHCS, Grand Rounds, Dallas, TX. **Sept. 2021**
- Boninger, M.L. *The Hype and Hope of Assistive Technology*. UTSW Medical Center, Grand Rounds, Dallas, TX. **Sept. 2021**
- Wotzel, H.S. *Therapeutic Risk Management of the Suicidal Patient*. University of Colorado School of Medicine, Grand Rounds, Dallas, TX. **Sept. 2021**
- Guthrie, T.M. *Racism in Academic Psychiatry: Hiding beneath the cloak of our benevolence*. VANTHCS, Grand Rounds, Dallas, TX. **Sept. 2021**
- Shivakumar, G., Jackson, J. *Mental Health Treatment and the Role of Tele-Mental Health at the Veterans Health Administration During the COVID-19 Pandemic*. VANTHCS, Grand Rounds, Dallas, TX. **Aug. 2021**
- Pendergrass, C. *Performance Validity in Teleneuropsychology*. VANTHCS, Neuropsychology Grand Rounds, Dallas, TX. **Aug. 2021**
- Lee, J. *Pediatric Oncology and Neuropsychology*. GSCP, George Fox University, Fall Grand Rounds, Newberg, OR. **Oct. 2020**
- Stoeber, A. *Child Adverse Events to Adults with Substance Use Problems*. George Fox University, GSCP, Spring Grand Rounds, Newberg, OR. **Feb. 2020**
- Forster, C. *Intercultural Communication*. George Fox University, GSCP, Fall Colloquia, Newberg OR. **Oct. 2019**
- Worthington, E. *Promoting Forgiveness*. George Fox University, GSCP, Fall Colloquia, Newberg, OR. **Sept. 2019**
- Marlow, D. *Foundations of Relationships Therapy – The Gottman Model*. George Fox University, GSCP, Spring Grand Rounds, Newberg, OR. **March 2019**
- Milkey, A., Safi, D. *Opportunities in Forensic Psychology*. George Fox University, GSCP, Spring Colloquia, Newberg, OR. **Feb. 2019**
- Pengally, S. *Old Pain in New Brains*. George Fox University, GSCP, Fall Grand Rounds, Newberg, OR. **Oct. 2018**
- McMinn, L., McMinn, M. *Spiritual Formation and the Life of a Psychologist: Looking Closer at Soul-Care*. George Fox University, GSCP, Fall Colloquia, Newberg, OR. **Sept. 2018**
- Vogel, M. *Integration and Ecclesia*. George Fox University, GSCP, Spring Colloquia, Newberg, OR. **March 2018**
- Teloyo, C. *Interpersonal Therapy*. George Fox University, GSCP, Spring Grand Rounds, Newberg, OR. **Feb. 2018**

- Sordahl, J. *Tele-health*. George Fox University, GSCP, Fall Colloquia, Newberg, OR. **Nov. 2017**
- Gil-Kasiwabara, E. *Using community based participatory research to promote mental health in American Indian/Alaskan Native children, youth, and families*. George Fox University, GSCP, Fall Grand Rounds, Newberg, OR. **Oct. 2017**

Certificate Courses

- *PSYD 585 Neuroanatomy*, GSCP, George Fox University **Aug. 2020**
Survey of neuroanatomical structures, observed symptomology and psychopathology associated with neurological and neuropsychological conditions, and critical application through case studies
- *Trauma Treatment and Assessment*, GSCP, George Fox University **April 2020**
Address of trauma prevalence in clinical treatment, EBP and limitations to treatment, and assessment tools for trauma intervention. This course included assignments and deidentified case studies to support comprehension and competence.
- *Gender and Sexuality*, GSCP, George Fox University **Nov. 2018**
A survey course with group discussions related to gender and sexual identity, and sexual attitudes. This course included critical application through case studies.

Teaching Experience

Adjunct Faculty, PSYC 220A: Biological Psychology (3 credits) **Aug. 2020 – Dec. 2020**
Department of Psychology, George Fox University, Newberg, OR

- Taught 38 undergraduate students Behavioral Neuroscience covering the following topics: Cells and Structures, Neurophysiology, Brain Chemistry, Sensorimotor System, Senses, Hormones and Sex, Homeostasis and Sleep, Emotions and Aggression, Psychopathology, Memory and Learning, Attention and Higher Cognition, and Language and Lateralization
- Creating modified and condensed lessons based on learning objectives and COVID-19 restrictions
- Revised syllabus to meet accreditation standards and department goals
- Provide in-person and virtual lecture with break-out groups to communicate course learning objectives
- Monitor student growth and concerns through university health system, using interdepartmental collaboration to support students in crisis events
- Monitor and manage student grades within a Moodle based system, with assessment through brief essays, quizzes, exams, and critical analysis papers

Teaching Assistant, PSYD 527: Neuropsychological Assessment **Aug 2020 – April 2021**
Graduate School of Clinical Psychology, George Fox University, Newberg, OR

- Provide live assessment demonstrations to adult and child/adolescent track students
- Coordinated grading and competency labs within a team of 3 teaching assistants
- Meet with individual and student groups to review assessments and course concepts

Teaching Assistant, PSYD 574: Spiritual and Religious Diversity **Aug 2020 – Dec. 2020**
Graduate School of Clinical Psychology, George Fox University, Newberg, OR

- Facilitate class discussions exploring various religion in relation to promote increased knowledge and understanding, as well as student clinician's ability to recognize held biases

- Grade assignments to support greater understanding of religious diversity within client populations

Teaching Assistant, PSYD503: Learning, Emotion, and Cognition

May 2020

Graduate School of Clinical Psychology, George Fox University, Newberg, OR

- Supported two sections totaling 36 students, covering topics related to cognitive science, emotion, learning, and neurophysiological aspects of behaviorism
- Facilitated class discussions in professor's absence related to consciousness and affect recognition
- Developed quizzes and graded papers to support student learning and timely feedback
- Led student study groups to support assignment and exam preparation
- Created assignment examples to provide clarity of expectations

Teaching Assistant to Lead Teaching Assistant, PSYD 502: Psychopathology

Aug. 2019 – Dec. 2020

Graduate School of Clinical Psychology, George Fox University, Newberg, OR

- Grade student conceptualizations to support learning outcomes and competency
- Provide 1:1 coaching and consultation related to diagnostic considerations and client conceptualization
- Facilitate student learning and development through 1:1 and group Q&A sessions
- Coordinated grading and office hours within a team of 4 teaching assistants
- Updated PowerPoint slides and course material to reflect current research and trends

Teaching Assistant, PSYD 541: Multicultural Therapy

Jan. 2020 – May 2020

Graduate School of Clinical Psychology, George Fox University, Newberg, OR

- Administer pre and posttest surveys to measure student development and comprehension of materials and multicultural competencies
- Facilitate small group discussions around complex and culturally diverse topics to foster comprehension
- Provide student feedback on written assignments through grading

Teaching Assistant, PSYD 552: Cognitive Behavioral Therapy

Aug. 2019 – Dec. 2019

Graduate School of Clinical Psychology, George Fox University, Newberg, OR

- Supported professor in course planning and preparation of materials for class sessions
- Co-facilitated class activities to increase student competence in CBT-based techniques
- Provided student feedback on written assignments through grading and 1:1 competency evaluation

Teaching Assistant, PSYD 504: Advanced Social Psychology

May 2019 – July 2019, April 2020 – June 2020

Graduate School of Clinical Psychology, George Fox University, Newberg, OR

- Supported professor through preparation and organization of materials
- Taught course content related to social cognition and health psychology
- Developed health psychology lesson to meet course learning objectives
- Provided student feedback on assignments through editing and grading

- Facilitated group Q&A session to support learning and comprehension of content

*Group Leader***Sept. 2018 – May 2019**

Nutritional Therapy Association, Olympia WA

- Supported workshop weekends through skills demonstrations and 1:1 mentoring
- Collaborated with peer leaders and lead instructors on strategic implementation of activities and examinations
- Proctored midterm and final exam and graded/evaluated students practice client projects for competency in documentation, health assessment, and health recommendations and treatment planning

*Invited Guest Lecturer***Spring 2018, Fall 2019**

George Fox University, Newberg, OR

- PSYC 150: General Psychology, Undergraduate Psychology Department, College of Behavioral and Health Sciences
- PSYC 383: Culture & Psychology, Undergraduate Psychology Department, College of Behavioral and Health Sciences

*Adjunct Faculty, Office of the Provost***Sept. 2016 – April 2017**

George Fox University, Newberg, OR

- Taught GEED 218: Developing Professional Identity
- Developed 16-week curriculum focusing on personal branding, e-presence, employment strategies, and self-discovery in a professional and personal context

Adjunct Instructor/Prevention Education Specialist & Program Director **June 2012 –May 2013**

California State University Northridge, Northridge, CA

- Taught EPC 499 A-C: Independent Study – Seminar on Peer Education, Sexual Assault Prevention and Education
- Developed 16-week course focused on sexual assault prevention and rape culture, including critical analysis of human sexuality and socio-cultural ideas of sexuality
- Designed curriculum for prevention education course based on program goal assessment to support critical thinking, communication, and leadership skills development with peer educators
- Created an advanced cohort model for students to continue developing as gender-based violence activists and educators by establishing a tiered course structure, advanced lesson plans, and implementing peer mentoring
- Developed and implemented peer educator orientation program to promote program preparation and encourage student investment

Leadership Experience*Co-Chair, Multicultural Community***Dec. 2018 – Nov. 2020**

GSCP, George Fox University, Newberg, OR

- Developed position descriptions and reorganization of committee leadership to create an effective and sustainable structure
- Established application cycle and process to promote equitable access to leadership opportunities with clarity of leadership roles and responsibilities

- Co-Coordinated events with committee leadership to promote clinical growth and community engagement with topics of multiculturalism
- Managed budget and expenditure requests between committee leadership and student council to ensure adequate funding for activities
- Coordinated logistics and communications with guests and GSCP through attention to detail and time management
- Facilitated Strengths training for committee leadership to cultivate insight into their natural talents and provide strategies to leverage abilities within their designated roles and professional endeavors

*Member to President***Fall 2017 – Spring 2020**

Military Psychology SIG (Special Interest Group), GSCP, George Fox University, Newberg, OR

- Facilitated events related to military psychology and first responders to inform approaches to treatment
- Maintained relationships with military branch recruiters and military psychologists to foster student access to professional resources
- Coordinated logistics and communications with military and professional guest speakers
- Supported holiday events for local Army National Guard by providing volunteers to support service members and their families preparing for deployment cycle
- Managed budget and leadership recruitment for interest group
- Selected as Division 19 Campus Representative, American Psychological Association for Fall 2018 to Spring 2020

Conferences/Conference Presentation Experience*Nutritional Therapy Association Conference, “Live Nourished”***March 2018***Nutritional Therapy Association Conference, “It Begins in the Gut”***March 2017***Workshop Presenter – Christian College Leadership Conference (CLCC)***April 2014**

California Baptist University, Riverside, CA

- Co-led #My Calling: Strengths and Leadership workshop addressing how college leadership roles can influence calling discernment and career pathways, and the influence Strengths awareness has in leadership roles

*Workshop Presenter – Christian College Leadership Conference (CCLC)***May 2013**

Azusa Pacific University, Azusa, CA

- Co-led *Strengths and Leadership Style* workshop for student leaders to educate participants on how to recognize and synthesize their strengths within their leadership role

Scholarships, Awards, Honors, and Grants

- Multicultural Scholarship Award, GSCP, George Fox University
2017-2021

Professional Affiliations

APA, Division 19 – Military Psychology Graduate Student Member since 2018

APA (American Psychological Association) Graduate Student Member since 2017

NTA (Nutritional Therapy Association) Member since 2016