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Development and Validation of a Self-care Scale for Clinical and Counseling Doctoral Students

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DEVELOPMENT AND VALIDATION OF A SELF-CARE SCALE FOR CLINICAL AND COUSELING DOCTORAL STUDENTS

by

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ABSTRACT

DEVELOPMENT AND VALIDATION OF A SELF-CARE SCALE FOR CLINICAL AND COUSELING DOCTORAL STUDENTS

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Under the Supervision of Professor Nadya Fouad

Self-care is a critical component and considered a core foundational competency for doctoral students in the field of psychology. It is an ethical imperative to maintain adequate self-care in order to prevent burnout and negative outcomes to those receiving our healthcare services. Self-care is also related to the professional values of psychology, specifically beneficence and nonmaleficence which relates to our duty of exercising good judgment to avoid harm to clients. Despite being identified as such little research has explored the topic. One reason that may contribute to the lack of research is the need for a measure self-care behaviors. In this study, I sought to develop and evaluate a psychometric instrument to assess clinical and counseling doctoral students' practice of self-care.

The sample included a total of 232 current doctoral students in APA-accredited programs across different stages of the developmental trajectory. A pilot study was used for feedback on item content and suggestions for refinement with a sample of 28 clinical and counseling students from two APA-accredited programs. Participants received a $25 gift card as a token of appreciation for their time. In the full study, participants completed an online survey including a

demographics form, the refined self-care measure, Maslach Burnout Inventory (emotional exhaustion, depersonalization, and personal accomplishment), Flourishing, Perception of Competence Scale, and a Distress Inventory. Participants received a $5 gift card as a reward. Internal consistency estimates were measured using Cronbach's alpha for all measures: self-care scale (a = .83), burnout scales (a = .84EE, .79DEP, .87PA), well-being (a = .84), perceived competence (a = .88), and distress (a = .82). Convergent and discriminant validity was examined through the evaluation of self-care with all other instruments used. Exploratory factor analyses revealed a three-factor model with cognitive-emotional/relational, physical, and spiritual components underlying the construct of self-care. Bivariate correlations were conducted to understand relationships between self-care and other constructs in this study. Due to the training context of this study, post-hoc analyses revealed no significant differences between the three developmental stages in mean global scores of self-care. Limitations of the current study and implications for future research and practice are discussed.

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Chapter One: Statement of Problem

As the landscape of duties for a professional psychologist continue to diversify, doctoral training programs hold rigorous standards in education to meet the essential competencies upon entrance into the field. Competency in the profession of psychology serves to protect the "entrustability" of the field (Falender & Shafranske, 2007, p. 234) and requires a commitment to ethical conduct for services provided to the general public. Psychologists-in-training need to learn how to evaluate their own competence and potential for impairment. If a student is unable to self- reflect and self-monitor, engage in self-care and understand the relationship of these behaviors to ethical conduct, they will not be able to be a fully competent psychologist. The Ethical Principles of Psychologists and Code of Conduct (2010) asserts that psychologists maintain competence (2.02) and that they exercise self-awareness, self- monitoring, and self-reflection as a means to maintain adequate self-care and prevent impairment (2.06). Self-care is a key component in a professional's ability to provide adequate services. The empirical and theoretical literature has expanded in the past two decades to better conceptualize the necessary competencies and their operationalization for professional psychology.

The competency movement. The competency-based model is part of a paradigm movement in the health sciences that has filtered into the counseling psychology literature (Fouad & Grus, 2014). The competency-based model has established professional benchmarks that must be met in order for graduate students to develop during the course of formal training. Trainees who are not able to function due to improper self-care may put themselves at risk for remediation and other serious consequences involving client care.

Unfortunately, self-care has been neglected as an important part of training programs (Barnett & Cooper, 2009). Self-care has not widely been incorporated into training program

curricula despite being a part of the benchmarks outlined by the American Psychological Association's competency-based model for training. Despite self-care being integrated into benchmarks for counseling psychology trainees, little research has been done on the topic of self-care. Recent work that has focused efforts on graduate students' self-care focused efforts on clinical psychology programs, it is equally important to address the needs of counseling psychology graduate programs (Bamonti et al., 2014). The developing counseling psychologist juggles and wears multiple roles during the professional developmental process in scientist-practitioner programs. Trainees are faced with managing multiple tasks while learning to provide care for others. Self-care is an ethical imperative obligation (Barnett, Baker, Elman, & Schoener, 2007). Self-care reflects a competency that must be attended to and revisited frequently by counseling psychologists through training and beyond.

To understand the competency movement, it is necessary to understand the established expectations of competent trainees and professionals across the training stages. In the past ten years, the field has undergone major changes to meet the demands for better graduate training to meet the standards for accreditation and practice (Kaslow, 2004; Roberts, Borden, Christiansen, & Lopez, 2005; Rodolfa et al., 2005). The first major cultural shift towards a competence-based training began with the 2002 Competency Conference: Future Directions in Education and Credentialing co-sponsored by The American Psychological Association (APA) and The Association of Psychology Postdoctoral and Internship Centers (APPIC). The central competence-based outcome from this conference was the three-dimensional Cube model to illustrate the foundation and functional competencies based on the training stages continuum (Rodolfa et al., 2005). The foundational skills that represent the basic building blocks of trainee development include key components such as Reflective-Practice/Self-Assessment, Individual-

cultural Diversity, and Legal and Ethical standards. Functional skills on the model include essential skills such as interventions, consultation and supervision. Professional development is captured across three stages: Readiness for Practicum, Readiness for Internship, and Entry to Practice. The stages of development may vary based on a trainee's exposure to different settings, populations, specialties, and theoretical orientation.

As the competency movement progressed, calls from the field to implement the Cube model competencies (Lichtenberg et al., 2007) motivated further publications to assist training programs in their ability to implement and assess professional competence. A seminal Benchmarks article documented the deliberations of a workgroup (Fouad et al., 2009) to delineate behavioral anchors and key stages of trainee development. Additionally, The Competency Assessment Toolkit for Professional Psychology (Kaslow et al., 2009) provided 15 techniques for evaluation of competencies. A need for guiding competence-based education into training programs still existed. In 2012, to address implementation, an APA workgroup created A Practical Guidebook for the Competency Benchmarks document (Campbell et al., 2012). This guidebook clearly explains the ways in which doctoral training programs might implement competency-based education using provided rating forms guided by established benchmarks.

By using the established benchmark competency rating system, clinical supervisors and trainers can identify competence using a shared language. Scholars still argue that the competency-based training remains challenging for implementation (Lichtenberg et al., 2007). The value of these documents is that it provides both clinical supervisors and trainers the ability to identify and intervene when foundational and functional skills are lacking. A training and education challenge still faced by the field of psychology revolves around best practices to intervene when a trainee is demonstrating competency impairment.

Prevalence of impairment. Over the past two decades, there has been a tremendous growth in literature related to trainees with problems of professional competence (TPPCs) or trainees' problems with professional competence (PPCs) as it continues to be a challenging area in training and education (Forrest, Elman, Gizara, & Vacha-Hasse, 1999; Elman & Forrest, 2007). The prevalence rates of TPPCs are alarming from the voice of training programs and trainees. Vacha-Hasse, Davenport, and Kerewsky (1995) observed that over half of studied training programs dismissed at least one trainee per year over a three-year period due to impaired functioning. At the peer-to-peer trainee level Shen-Miller, et al. (2011) found that 44% of participants had awareness of at least one colleague with PPC. More, an exploratory examination of trainee attitudes towards peers' experience problems with professional competency revealed that trainees viewed impairment as a highly sensitive and inadequately addressed issue in their clinical psychology graduate programs (Oliver, Bernstein, Anderson, Blashfield, & Roberts, 2004).

At the professional level, practicing psychologists are not professionally proactive in safeguarding the general public, and are unlikely to intervene with impaired colleagues, despite understanding their own ethical duty to do so (Barnett, 2008). When professionals do not intervene on colleagues practicing with competency issues the individual is left to their own decision-making behaviors. For the emerging psychologist-in-training, this can be extremely problematic due to their developmental stage. Research suggests that trainees are vulnerable to inaccurate self-assessment of competence therefore lacking the skills to strengthen and methods by which to do so (Worthington, Mobley, Franks, & Tan, 2000).

Research has uncovered the following as typical trainee distinctive clinical incompetence: unresolved interpersonal problems, problems in clinical supervision, and

hindering trainee personality characteristics (Forrest, et al., 1999). Self-report research shows that more than 70% of graduate students reported a stressor that interfered with their ability to perform at an optimal level (El-Ghoroury, Galper, Sawaqdeh, & Bufka, 2012). This is a startling number, which could result in poor outcomes in personal health and clinical practice. From these empirical articles, it is clear that trainee impairment is a phenomenon in every training program and within different aspects of training, specifically engagement in supervision and interpersonal functioning highlighted. TCCPs theoretically would have more difficulties in the functional competency area due to the nature of involvement with a faculty, clinical supervisor, peer, and/or client. Research on impairment has created an all-or-nothing idea of competence; a professional psychologist is practicing as competent or as impaired. Scholars challenge the dichotomous view of competency and suggest that impairment happens on a continuum (Falender, et al., 2009; Rodolfa, et al., 2005). Advancements towards extending the area of research via systematic evaluation based off the Cube model may offer a deeper insight into TPPCs. Development of tools to capture the specific domains of PPC could add depth into trainers' and clinical supervisors' conceptualization of their trainees. Self-reflection and self-care are core essentials foundational domains in which a trainee must utilize to understand their ability to serve clients.

Importance of self-care. Self-care is especially important in graduate training due to the academic demands on the trainee. The work of a counselor is unique in that they are trained to work with mental health issues. The caveat is that working with mental health issues in clinical practice can produce great stress and distress in the counselor. Clinical practice is an active part of the trainee's training and is required throughout the process of becoming a psychologist. Becoming a psychologist involves going through an enculturation process into the academic environment. In the environment, there are examples from role models, mentors, advisers,

faculty instructors, and clinical supervisors. Depending on their philosophy, self-care may be promoted, encourage, ignored or something in between. The rigors of training generally include practicum, completing coursework, assistantships, research, internship, and completion of a dissertation in addition to maintaining a personal life (DeAngelis, 2002). Scholars have suggested that a lack of attention to the self increases the amount an individual experiences emotional distress (Skolvholt et al., 2001). Graduate training presents a unique opportunity to develop trainees' ability and ethical obligation to engage in self-care. Research on the consequences of self-care neglect demonstrate a clear need for early proactive promotion of self-care (Baker, 2003; Figley, 2002). The promotion of self-care is directly linked to ethical conduct. A competent professional psychologist must understand and demonstrate the connection of self-care and ethics.

All APA accredited programs require trainees to successfully complete ethics coursework to gain awareness, knowledge, and skills connected with the Code of Conduct. At this time, there is little discussion of how programs promote self-care competency as an ethical imperative. Doctoral psychology graduate students are ethically required to adhere to maintain competence across domains of research, clinical intervention, and cultural diversity in addition to self-care. It has been suggested that building ethical sensitive behavior is best addressed during graduate training (Moffett, Backer, & Patton, 2014). Therefore, it seems most appropriate for self-care competence to be promoted by training programs and clinical supervisors directly or indirectly. It has been recommended that trainees engage in their own personal therapy as part of the training process for self-care (Norcross & Guy, 2007). Recent research shows that students within the health professions made use of mental health therapy more so than other fields as a way of self-care (El-Ghoroury, Galper, Sawaqdeh, & Bufka, 2012). Some of the benefits noted for engaging

in personal therapy are facilitation of intrapersonal conflict, develop the trainee's understanding therapy experiences of clients, and broaden insight for the trainee to self-reflect on self-care. Acknowledgment of the potential benefits of self-care for trainees, a reported 10% of graduate students participate in their own therapy, however 90% of professional psychologists enter psychotherapy after entry to field (Norcross & Guy, 2005). Clearly, more investigation is needed in this area to better understand self-care best practices in training and intervention with this population.

Conceptual training models. Research on how programs assess self-care in the curriculum has not yet explored counseling psychology graduate programs. Specific to counseling psychology, infusing positive psychology strategies have recently been highlighted by scholars as a strategy to increase reflective practice (Georges & Tomlinson-Clarke, 2015). Limited research on clinical psychology graduate programs have been explored and reveal that students received encouragement as the main method of infusing self-care into training (Bamonti et al., 2014). Although encouragement can promote self-care, formal training on this topic across programs ensures that as a field we are going beyond the basics in our training of future psychologists. To foster early ethical behavior, decrease both a lack of ability to self-assess and a lack of focus on self-care, it has been suggested that a communitarian training culture be created.

A communitarian approach to reinforce ethical sensitivity has been echoed by many scholars (Bamonti et al., 2014; Johnson et al., 2014; Johnson, Barnett, Elman, Forrest, & Kaslow, 2012). A communitarian environment creates a space to celebrate each member's special contributions where competencies are grown and strengthened through interconnections within the group. A communitarian environment is a space where the professional can grow and

continue to participate throughout the life span, decreasing the competency degradation. APA Ethical standards place the individual in the position of being all knowing and do not mention the professional community's responsibility to maintain high standards and maximum competency of all its members. The sense of community allows us to spread compassion for colleagues and protection of clients, and provides a safe space to maintain a healthy professional self, which may prevent burnout and increase resiliency amongst other virtues. It still remains unknown how doctoral level counseling psychology trainees are safeguarded against burnout. The communitarian approach has been used to create a constellation of competency growth in a way that promotes engagement in self-care and ethical conduct.

A communitarian environment creates a space to celebrate each member's special contributions where competencies are grown and strengthened through interconnections within the group. Conceptually, the communitarian environment provides a place for professionals to grow and be proactive in their lifelong learning, decreasing the competency degradation. APA Ethical standards place the individual in the position of being all knowing and do not mention the professional community's responsibility to maintain high standards and maximum competency of all its members. The sense of community allows us to spread compassion for colleagues and protection of clients, and provides a safe space to maintain a healthy professional self, which may prevent burnout and increase resiliency. It still remains unknown how doctoral level counseling psychology trainees are safeguarded against burnout. The communitarian approach has been used to create a constellation of competency growth.

As mentioned earlier it has been recommended that instilling ethical sensitivity is part of graduate training. Johnson et al. (2013) proposed the Competence Constellation Model (CCM) where a constellation places the trainee at the center surrounded by those who foster growth,

adaptive functioning, and professional competence. The CCM's influence on an individual depends on the interconnections, diversity, and initiatory behaviors. Another model that has been introduced into the literature is creating a Communitarian Training Community (CTC). The role of the CTC is to combine interdependence and communal strength. The model proposed that individuals in the community respond to one another from a place of compassion and support while upholding ethics to the highest degree. The model seeks to infuse self-care into formal training, and asks that trainers model effective use of their constellations through transparent modeling. The transparent modeling between trainee and trainer involved reciprocal growth, addressing developmental needs, and opportunities for feedback. This model uses a holistic view of the trainee where development takes place across a broad spectrum including personal and career development.

Burnout. Self-care is a constant part of reflective practice and needs constant maintenance. Literature from other parts of the health sciences field has highlighted burnout. The literature on burnout fails to specifically examine the experiences of counseling psychology and instead has explored the experiences of other mental health related professions. The term 'burnout' has been defined in multiple ways and is a core concept to this research proposal. There is no one definition that is used across the literature to define the term. Generally, the term includes stress and exhaustion. Maslach, Schaufeli, and Leiter (2001) has proposed a tridimensional model of burnout that includes three subcategories of emotional exhaustion, depersonalization, and reduced personal accomplishment. The dimension of emotional exhaustion encompasses the individual's experience of feeling fatigued and overstretched. Depersonalization happens when the individual becomes a cynic about their work, viewing events with a negative lens. Reduced personal accomplishment refers to a negative self-

evaluation of the individual's work contributions. Maslach's model has been widely used in the literature to quantitatively gauge burnout by identify the symptomology. This tridimensional model will be used in the proposed project as defining burnout in as a cue for self-care.

Clearly, experiencing burnout can have extremely negative effects on the counselor, client, and work environment. With that being said, self-care is an ongoing effort to maintain the ability to practice at a level where burnout components are not obstructing an individual's counseling practices. Within the training process, self-care needs to be fostered as the trainee faces work overload a concept included in the burnout literature. There is a need to explore the underlying components of self-care and create a measure for individuals to use for maintaining adequate clinical practices. Researchers have called for more attention to be paid on prevention and reduction burnout in the field of mental health professionals serving the general public (Morse, Saylers, Rollins, Monroe-DeVita, & Pfahler, 2012).

Trainee well-being. Another factor in the self-care equation is optimal human virtues, in particular resiliency, another core concept of this proposal. Jackson, Firtko, and Edenborough (2007) define resilience as an individual's ability to maintain balance through the maintenance of supportive relationships, positive outlook, engaging in self-reflection and using insight to maintain overall life balance. This definition will be used in the proposed project as it encompasses a holistic view of the individual and allows room for growth in multiple ways. Each component of this resilience definition is an area for exploration in self-care research.

The importance of this research proposal is that it will open the door to the trainee's engagement in self-care and its relationship with burnout and wellbeing. This proposal is especially unusual in that it is focusing on clinical and counseling psychology doctoral trainees, a population that have not been explored collectively in the literature in regard to self-care.

Project Goal and Objectives

My primary goal is to contribute to the training literature through validation of a psychometric instrument to assess an individual's self-care during the training development process in APA-accredited clinical and counseling psychology doctoral studies. This goal is reflected in the following objectives for this proposal:

1. To establish a valid and reliable measure with identification of the core underlying factors of self-care for clinical and counseling doctoral level trainees.
2. To broaden our understanding of the variety of self-care activities exercised by clinical and counseling psychology doctoral trainees to maintain ability to function adequately.
3. To better understand the relationship of self-care with the following constructs: competence perceived, wellness, burnout, and supervision utilization.

Conceptual Framework

This framework seeks to understand how doctoral level counseling psychology trainees' implementation of resilience to combat burnout. Scholars have called for a community that fosters healthy management of self-care (Bamonti et al., 2014; Barnett & Cooper, 2009). These communitarian approaches are fostered in the APA benchmarks and ethical guidelines as to providing adequate care, essentially, to the general public. Burnout happens after a prolonged exposure to chronic emotional and interpersonal stressors, work overload, and overall exhaustion as captured in Maslach's (1986) tridimensional model. In the helping professions industry, exhaustion is inevitable, yet research has not placed its focus on the trainee level of counseling psychologists. Exhaustion is the core concept of burnout encapsulating the extreme stress causing an individual to distance one's self from their work to psychologically preserve. This

conceptual framework looks at the individuals' community and to better understand the interactions of cultural dimensions, work overload, competency based learning on self-care facilitated by resilience or diminished by burnout.

The conceptual framework shows that around self-care there are a number of factors that can influence or prohibit practices. There clearly is a relationship between burnout and self-care. There is a connection between self-care and supervision utilization. Wellness has a connection to self-care practices. However, there are many other factors that may influence an individual's ability to protect acceptable self-care.

There may be some dimensions of culture or context that play a role in the maintenance of self-care. For example, gender, age, ethnicity, ability status, workplace and religious beliefs could all influence the practice and frequency of self-care.

Conceptual Framework

1. Self-care.

The study under development is to better understand what buffers self-care. The term self-care has been defined in the literature as "the application of a range of activities with the goal being "well-functioning," which is described as "the enduring quality in one's professional functioning over time and in the face of professional and personal stressors" (Coster & Schwebel, 1997, as cited in Barnett & Cooper, 2009). For the purpose of this study the term 'buffer' is defined as a shield or guard that serves to protect an individual's self-care. This research comes from a lack of self-care investigations with counseling psychology doctoral trainees. Not a whole lot is known about this population. This research study seeks to further investigation in this area to add to the knowledgebase in this area. In particular, a qualitative pilot study will allow me to better hear the experiences of this population. This study is working from

an interpretivist paradigm while taking on a strengths-based approach. The conceptual framework will apply a strengths-based approach that is referred to as shifting away from a deficit-approach to building on the strengths that an individual encompasses. Well-being, in particular, flourishing will be investigated for its relationship to self-care.

2. Burnout.

For this framework, 'burnout' as defined by Maslach et al.'s (2001) in a tridimensional model with three sub-concepts included. The sub-concepts are emotional exhaustion, depersonalization, and reduced personal accomplishment. The dimension of emotional exhaustion encompasses the individual's experience of feeling fatigued and overstretched. Depersonalization happens when the individual becomes a cynic about their work, viewing events through a negative lens. Reduced personal accomplishment refers to a negative self-evaluation of the individual's work contributions. The dimension of emotional exhaustion listed above highlights the work overload that is experienced by students as they navigate multiple settings wearing different hats in each. It can be hypothesized that the constant taxation in the emotional work done by counseling psychologists places an increased level of emotional exhaustion on the trainee who is learning how to manage these new encounters.

Limitations of the Study

It is impossible for this researcher to control for all extraneous and unanticipated factors. This research design is exploratory in nature and will utilize qualitative responses for the validation of the self-care measurement. Concerns of psychometric validity for this study will be guided by survey research (Messick, 1994). This researcher is aware that respondents will be familiar with the psychological assessments and research in the field of professional psychology training and education.

Chapter II

LITERATURE REVIEW

Training Professional Competent Counseling Psychologists

Over the past two decades there has been a major shift in the focus of education and training future psychologists. Research trends show that competence is gaining an increasing interest across all health care fields as an outcome of professional preparation to enter the field and practice (Bandiera, Sherbino, & Frank, 2006; Kaslow, 2004; Nelson, 2007). This new approach to training differs from the previous course curriculum focus (Nelson, 2007). A commonly used definition of professional competence, derived from the medical field, describes competence as, "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served" (Epstein & Hundert, 2007, p.227). Professional training must meet the demands of the public need as well as safeguarding the public. Defining competency also allows psychologists to acquire specialty accreditation, which may bring more power and financial reward. Of most importance to competence is the ethical accountability one takes on as a professional psychologist in today's world. Indeed, the APA Ethics Code identifies maintaining competence as a key minimal ethical mandate, as well as understanding when one is affected by personal problems (APA, 2010). Self-care is vital to the work of professional psychologists with the challenge being maintaining a balance between a strong and deep connection with the self for the purpose of providing to others. For the purposes of this research, I will begin by reviewing the competency movement with a review of the proposed categories and skills representative of a competent counseling psychologist.

The competency movement in psychology. In the past decade, psychologists have spent a great deal of effort to define how competence is constructed for evaluation. Professional psychologists have expressed a need for well-defined competency benchmarks in order to maintain the highest standards in training, credentialing, and practice (Kaslow, 2004; Rodolfa et al., 2005). Rodolfa et al. emphasized that, the role of a psychologist has shifted to encompass a greater variety of services provided; hence it is vital to revisit and better understand the necessary competencies. Based on the field's changing landscape, these authors stated: "It is increasingly apparent that the practice of psychology has expanded in recent years to include services that are additional to, and at times different from, those offered by psychologists even a quarter century ago" (p.348). This call for action was echoed by scholars as the competency movement continued to unfold. Fouad et al. (2009) stated "There is a need for a better, competency-based definition, of readiness for entry to practice. For many years, the doctoral degree has been linked with the vaguely defined construct" (S7). The progression of this professional competency movement in psychology has been identified as a major change (Kaslow, Falender, & Grus, 2012) and addressed as a crucial training element in the "cultural shift" of psychology (Forrest & Campbell, 2012).

Fouad et al. (2009) identified the organization of the Competencies Conference: Future Directions in Education and Credentialing in 2002 sponsored by Association of Psychology Postdoctoral and Internship Centers (APPIC) in collaboration with the American Psychology Association (APA) as a key point in the progression of the competency based movement. The competency specific goals of this conference were: (a) identify core competencies, building upon already existing models, (b) formulate developmental and integrated models of competencies for the training of the next generation of professional psychologists, and (c) develop strategies for

the evaluation of competencies and the assessment of competence (Kaslow et al., 2004). Attendees of this conference emphasized "competence implies performance at an acceptable level, and presumes integration of multiple competencies" (Fouad, 2009, p. 227). To capture this multidimensional assessment of the core competencies a three-dimensional "Cube model" was created (Rodolfa et al., 2005).

The Cube model. The Cube model (Rodolfa et al., 2005) provided a theoretical framework for understanding how the 12 core competencies interact as a trainee progresses through education and training. The competencies are defined in domains as either foundational (x-axis) or functional (y-axis). The z-axis represents the stages of development. The cells of the cube define the expected level of competence at each stage as the trainee moves towards completion of formal training and entry to practice. See Figure 1.

The foundational domain refers to the fundamental intrapersonal and interpersonal abilities for the functioning of a professional psychologist. Within this domain the following skills are included: (a) reflective practice and self-assessment, (b) scientific knowledge and methods, (c) relationships, (d) ethical legal standards and policy, (e) individual and cultural diversity, and (f) interdisciplinary systems. These authors suggest that these foundational competencies should be addressed during graduate training and beyond to maintain adequate standards of practice are being met (Rodolfa et al., 2005).

The functional domain requires interaction with the foundational competencies for the ability to identify and find solutions to professional problems. These include (a) assessment (formal assessment/diagnosis/conceptualization), (b) intervention, (c) consultation, (d) research/evaluation, (e) supervision/training, (f) teaching, and (g) management/administration. Unique to the functional competencies is their likelihood of utilized daily in the practice of

psychologists. These competencies were revised by Fouad et al. (2009) to include “advocacy” as an additional key component that is necessary for training and education. In 2012, another addition was made to the competencies as an outcome of the APA workgroup. Campbell and colleagues added “evidence based practice” as a necessary competency to complete functional skills in this domain.

The last dimension of the Cube model represents the professional stages of development (Rodolfa et al., 2005). The stages of assessment for the training trajectory unfold as: entry to graduate training, internship, postdoctoral training, and the continuation of revisiting competency throughout one's professional practice. The authors state that subsections of the stage dimension may exist depending on the individual’s unique training experiences gained from their specific training program, practicum site, or other professional engagement opportunity.

The Cube model (Rodolfa et al., 2005) is designed to serve as a demonstration of intersecting competencies. This model illustrates how the abilities intersect in a way that it is a rare occurrence that only one competency is being exercised at any given time. The model is comprised of building blocks connecting over time as a trainee matures in their training. At the current time, training experts in psychology maintain consensus that this framework is “credible” (Fouad et al., 2009) in addressing the essential areas of competency necessary to preparing psychologists-in-training. This model has bridged the previous training focus to current needs as a result of diversification in the field of psychology. This framework has been mentioned in the literature as a guide for clinical practice supervisors and training programs to use for purposes of competency evaluation (Rubin et al., 2007).

Benchmarks. The APA Workgroup on competence based training used the Cube model (Rodolfa et al., 2005), constructed for application to professional psychology, as a starting point to operationalize each of the core competencies to fit the needs of training competent counseling psychologists. The competency movement progressed with a request from the Council of Chairs of Training Councils (CCTC) to the APA's Board of Educational Affairs (BEA). The outcome was the creation of the first Benchmarks document in 2009 (Fouad et al.) that served to bridge the breadth of training. The Benchmarks document defined a total of 15 essential core competencies by highlighting critical components and behavioral anchors at the three stages of trainee development: readiness for practicum, readiness for internship, and readiness for practice. Different from the interconnectedness of competencies on the Cube model, the Benchmarks tend to be more individualistic to define the foundational and functional domains.

The Benchmarks suggest a pathway a trainee follows from entry to graduate training through entering the field of professional practice. As a trainee progresses through their graduate training program, the Benchmarks show an increase in the individual's ability to function with independence. To illustrate this development and growth across the training years, and connect this research with self-care, I will focus on the core foundational competency of "Reflective Practice/Self-Assessment/Self-Care" which is defined as "practice conducted with personal and professional self-awareness and reflection; with awareness of competencies; with appropriate self-care." Trainees at a beginning level readiness for practicum are expected to demonstrate the behavior anchors of "problem solving skills, critical thinking, organized reasoning and intellectual curiosity and flexibility" (p. S10). At the next stage of training "readiness for internship", the trainee would be expected to "articulate attitudes, values, beliefs towards diverse others, recognizes impact of self on others, self-identifies multiple individual and cultural

identities, described how others experience him/her and identifies roles one might play within a group, responsively utilizes supervision to enhance reflectivity, systematically and effectively reviews own professional performance via videotape or other technology with supervisors, and initial indicators of monitoring and adjusting professional performance in action as a situation requires" (p. S10). At the final scientist-practitioner developmental stage "readiness for entry to practice" behavioral anchors expected include "demonstrates frequent congruence between own and others' assessment and seeks to resolve incongruities, models self-care, monitors and evaluates attitudes, values, and beliefs towards diverse others, systematically and effectively monitors and adjusts professional performance in action as situation requires, and consistently recognizes and addresses own problems, minimizing interference with competent professional functioning." As the competency movement continued, a call for assessment tools to be created for continual competence assessment over the lifespan (Roberts, Borden, Christiansen, & Lopez, 2005).

Competency Assessment Toolkit. At the same time as the competencies were being defined and benchmarks developed, there was a need to determine appropriate ways to assess them. As a response to the call for evaluation tools, Kaslow et al. (2009) provided The Competency Assessment Toolkit to provide systematic evaluation procedures to assess the professional competencies. The "toolkit" was created with specific tailoring to the Benchmarks document. The authors stated the following regarding the purpose of the toolkit,

> First, the toolkit delineates appropriate methods for assessing each of the overall and broad foundational and functional competencies outlined in the Benchmarks document. Second, the toolkit outlines relevant assessment strategies for measuring the essential components of each of the foundational competencies. Third, the toolkit discusses the

> appropriateness of each tool for measuring competency at the three levels of education and training that are the focus of the Benchmarks document, while adding a fourth level of professional development (p. S34).

This assessment toolkit offers a total of 15 strategies for evaluating core competencies derived from the establishment of the Cube model. The following is the list of assessment strategies offered by this document: 360-degree evaluation, annual/rotation performance reviews, case presentation reviews, competency rating forms, client/patient process and outcome data, consumer surveys, live or recorded performance ratings, objective structured clinical examinations, portfolios, record review, simulations/role plays, self-assessment, standardized client/patient interviews, structured oral examinations, and written examinations. This toolkit provides training programs and clinical supervisors with a variety of options for implementation of trainee competency evaluation. The toolkit suggests using the following competence evaluation methods for trainees in the foundational competency of "Reflective Practice/Self-Assessment/Self-Care": 360-degree evaluation, Objective Structured Clinical Examinations (OSCEs), portfolios, self-assessment, and structured oral examinations.

Guidebook for competency benchmarks. In July 2012, APA's website added a Competency workgroup document with suggestions for revisions of the Competency Benchmarks competency documents (Campbell et al., 2012). The focus of the Practical Guidebook for Competency Benchmarks is on the application of competency evaluation and continual development of evaluative tools. This document was constructed by the professional development workgroups to promote competency-based training and evaluation. Provided in this document are the practical rating forms based on the newest benchmark clusters and core competencies with the addition of "Evidence-based Practice".

The Guidebook focuses on 6 competency clusters: Professionalism, Relational, Application, Science, Education, and Systems. Most all of the competencies in the documents are based on the 15 core competencies illustrated in the Cube model across training progression. The documents found in the Guidebook provide training programs guided information to tailor evaluation to be program specific. It includes suggestions for how to evaluate trainee specific issues within a training program. The document can be used as a base to build curriculum and assess learning outcomes.

Summary of professional psychology competency movement. Over the past two decades, there has been a great amount of growth in the field's clarification of essential competencies needed to practice efficiently. These competencies are foundational to specialty credentialing and ethics codes to provide the best services to the general public. The efforts put forward thus far provide training programs and accreditation communities a solid foundation for evaluation by providing behavior-based outcomes within specific domains (Fouad et al., 2009; Kaslow et al., 2009; Campbell et al., 2012). Schaffer, Rodolfa, Hatcher, and Fouad (2013) have continued the competency movement by incorporating feedback from educators and regulators for moving towards a set of competencies shared across all levels of professional psychology. The main concern from both sides is the key components that all professional psychologists need in order to obtain licensure. These authors have suggested the shift towards a clear consensus on core competencies with a clear plan for training implementation and evaluation.

Since 2012, the evolution of competency documents has halted. There is still a great need for evaluative tools for training program and clinical supervisors to remain as gatekeepers to field entry. There is much more work to be done in order to specify which core competencies are needed within the assortment of specialties within the professional psychology field. Scholars

have stated that further examination should focus on specifically on how to proactively address trainee impairment and further investigation of the fidelity of competence assessments (Lichtenberg, et al., 2007). Another area for exploration is through examination of client outcomes as trainee competency develops during the course of training.

The recent shift to benchmark competencies as part of graduate training across health fields has created a need to supplement evaluation criterion with explicit and identifiable behavioral anchors and essential components. A critical facet of a competent psychologist is the ability to engage in reflection, including self-care. In order to demonstrate self-care as a professional competency one must broaden the ability to self-monitor for accurate appraisal of self-care. Self-assessment is crucial to safeguard the psychological services we provided to the general public. This has been identified as one of the key ingredients from the wide variety of the healthcare professional competencies. Scholars have identified self-care as a key factor in the prevention of burnout, however little empirical research has been conducted. As a result of the competencies based movement, there is now a clear need for integration of ethics into education, training, and supervision (Cornish, 2014). Self-care is an important ethical imperative that all counseling psychologists must attend to over the course of their career, starting in graduate training. The following focus of this literature review will be ethical codes enforcing self-care, definitions of self-care, graduate trainee professional stress and impairment, self-care measures, and training models used to foster self-care competency.

Problems with professional competency (PPCs)

The competency movement, which provided definition and conceptualization of competency expectations across the developmental trajectory, sparked conversation about the need to address trainees and professional psychologists who may lack core competencies (Elman

& Forrest, 2007; Donovan & Ponce, 2009). In an advocacy-focused article, Elman and Forrest (2007) discouraged using terms such as "impairment" (p. 505), which may suggest psychological pathology of the trainee, or other terms that do not fully capture the entirety of professional competency issues. The suggestion of these authors is to connect the three concepts together using the following terms: problems, professional, and competence to provide a broader scope issues (p. 510). Specifically, to provide a broad term for trainees, it was decided that *trainee with problems of professional competency* (TPPC) or *problems with professional competency* (PPC) are fitting terminology to capture the varying types of competency deficits that can arise during graduate training.

Historical literature on competence "impairment". The APA Ethics Committee is charged with addressing issues of professional psychologists practicing without adequate ability to provide services to the general public. Pope, Keith-Spiegel, and Tabachnick (1986) reviewed the number of cases involving "impaired" practicing psychologists in the early 1980's and found that it had doubled since the previous decade. This finding initiated more investigation of the conceptualization and measurement of practicing professional experiencing "impairment".

It is important to understand the historical context from which the word "impairment" originates. As previously stated, scholars have advocated for terminology to be broad and focused on professional competency problems (Elman & Forrest, 2007). In the early 1980's, "impairment" was the most commonly used term (Forrest et al., 1999; Collins et al., 2011) adopted from the medical field that uses the term to describe the concept. The APA Board of Professional Affairs (BPA) created an advisory committee to define key areas of professional impairment. They highlighted behaviors for further investigation identified by this committee were: physical handicaps, alcohol dependencies, sexual intimacy with clients or students, mental

illness and suicide (Thoreson, Nathan, Skorina, & Kilburg, 1983). The work done by this advisory committee ignited discussion of how to remediate psychologists experiencing any of the identified areas for investigation. A steering committee created a group called "Psychologists Helping Psychologists", which sought out to help individuals with impairment issues, particularly those struggling with chemical dependency issues. It was argued that using the term "impairment" too often referred to professionals with chemical substance dependency and narrowed the focus of possible issues (Benningfield, 1994). The focus does not extend beyond practicing professionals with acute mental health issues, or dangerous unprofessional/unethical conduct such as engaging in sexual conduct with a client. A response to the APA Task Force (1981) was an article published by Laliotis and Grayson (1985). It was echoed that the impairment definition did not encompass impairments that were not related to mental health or substance dependency. These authors provided a broader definition of impairment in psychology to be: "interference in professional functioning due to chemical dependency, mental illness, or personal conflict" (p. 84). The authors extended recommendations to credentialing associations to provide assistance to impaired psychologists in order to safeguard the general public.

Expansion of PPC definitions. As the impairment literature continued to grow**,** Overholser and Fine (1990) offered an expansion to the definition of impairment that focused on self-reflective practice on competency and interventions from colleagues when competency may be compromised. The definition provided by these authors focused emphasis on the point of incompetence, which occurs when psychologists "continue to provide services when they are not fully capable of performing" (p. 462). These authors defined the following categories for areas of possible professional impairment: general knowledge, general clinical skills, orientation-specific

technical skills, clinical judgment and interpersonal attributes. The broadness in this definition focuses more on the ethical conduct and less on the psychological pathology of an individual. This definition links to the advocacy by Elman and Forrest (2007) to focus on the landscape of descriptive competency terminology.

As this area of literature continued to blossom, the terms "impairment" and "unethical" were not fully distinguished from an individual experiencing some form of illness. Orr (1997) defined impairment as:

> The presence of an illness or illnesses that render or are very likely to render the professional incapable of maintaining acceptable practice standards.

This definition is connected with unethical conduct. Orr argued that in order to accurately describe a PPC psychologist, labels should be assigned to designate the specific type of impairment. It is important to remember competence happens on a continuum and is not dichotomous in nature. Further, scholars argue that PPCs and TPPCs were not detected or addressed due to the "subtle" nature in which these behaviors can occur (Overholser & Fine, 1990; Forrest et al., 1999). A gap in the literature also exists at the stages of development of training. Forrest et al. (1999) argued that the frequency, type, and remediation of impairment leaves educators very little ability to draw conclusions. The literature does not clearly designate the stages of development for TPPCs, which creates even more difficulty to extract best practices for impairment management. Huprich and Rudd (2004) examined trainee impairment at a national level across counseling, clinical, and school psychology and pre-doctoral internships. The results of their study revealed that internships were more equipped to manage TPPCs through site policy documents in comparison to doctoral programs. These authors recommend

that more attention be focused at the application stage, as recommendation letters and interviews may not reveal enough about an individual's ability to be trained.

Summary of PPC Literature

The historical literature in this area started with using "impairment" to describe an inability to function due to the existence of extreme mental illness or chemical dependency usually indicated unprofessional and unethical behavior. It is clear that the field needs to continue to use broad definitions in order to avoid possible pathology when an individual is experiencing distress. For purposes of this literature review the terms "impairment" and PPC will be used interchangeably. As the competency movement progresses, it is important to understand the relationship between the key component of self-reflection and ethical conduct.

Self-Care Ethics Competency

As a result of the competencies based movement, there is now a clear need for integration of ethics into education, training, and supervision (Cornish, 2014). Self-care is an important ethical imperative that all counseling psychologists must attend to over the course of their career, starting in graduate training. The following focus of this literature review will be ethical codes enforcing self-care, definitions of self-care, graduate trainee professional stress and impairment, self-care measures, and training models used to foster self-care competency. Competency around self-care should be a major focus during graduate training due to its potential danger to the services psychologists serves to the general public. Ethical codes exist to ensure competent practice to protect against potential negative outcomes for patient. Research shows that providing psychological services to clients while impaired can negatively affect treatment (Norcross & Guy, 2007).

Professional development codes from the field of medicine and psychology will be reviewed to better understand the importance of adherence to ethics codes in order to safeguard the general public. We will begin the discussion with the American Psychological Association.

American Psychological Association. The Ethical Principles of Psychologists and Code of Conduct (2002) asserts that psychologists exercise self-awareness, self-monitoring, and self-reflection as a means to maintain adequate self-care and prevent impairment. Specifically, Boundaries of Competence, Section 2.01, states:

"(e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm."

Specific to issues of professional impairment, Section 2.06, Personal Problems and Conflicts, states:

"(a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.

(b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties."

Part (a) of this principle requires that psychologists develop the skill of regularly exercising self-awareness at all times as it relates to their work duties. Part (b) requires the skill of being self-aware including self-monitoring of professional competency to provide adequate

psychological services. Self-care is an essential component in maintenance of balance and ability to perform work duties. This guideline suggests involving other professional psychologists to provide consultation and feedback when interacting with a potentially impaired peer. The APA does not provide a clear definition of what providing "adequate" duties involves and it assumes that all psychologists are connected to other competent colleagues for feedback regarding ability to function. Self-care is not promoted in these guidelines as a way to avoid impairment.

Feminist Ethics in Psychotherapy. Unlike the APA guidelines for maintaining self-awareness to avoid practicing under impaired conditions this codes provides a directive involving the initiative of the psychologists to engage in self-care activities. Specifically the code states, "a feminist therapist engages in self-care activities in an ongoing manner outside the work setting. She recognizes her own needs and vulnerabilities as well as the unique stresses inherent in this work. She demonstrates an ability to establish boundaries with the client that are health for both of them. She is also willing to self-nurture in appropriate and self-empowering ways" (Lerman & Porter, 1990). This code involves a collaborative participation of both client and therapist in the process of self-care. It highlights that self-care should take place "outside" of practice in order to enter practice with ability to provide services to clients. Through the therapeutic working alliance, the needs of both client and therapist are addressed through self-awareness of boundaries and ability to provide nurturance to self. This code fails to define "self-care" and involvement of colleagues as potential resources for feedback on potential impairment in prevention of harm to both client and therapist.

American Counseling Association. The issue of counselor impairment is most explicitly stated in the American Counseling Association (ACA) Code of Ethics and Standards of Practice (2005). It states that "counselors are alert to the signs of impairment from their own physical,

mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others" (A.11.b). This standard requires counselors to engage in self-reflective practice and use self-awareness as tools for maintaining ability to provide services. This statement outlines the potential harm to clients as an outcome of impairment.

American Medical Association. The Principles of Medical Ethics (2003) state under Section 2 "A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities." The AMA Principles of Medical Ethics recommends that an "impaired" physician to obtain treatment. The self-care and self-reflection takes place in formal treatment. Unlike the other codes discussed in this chapter, the direct connection to negative consequences is not included. Similarly, to the other codes, the Principle calls for physicians to maintain competence during lifelong practice. The recommendation for physicians to obtain formal treatment assists the impaired professional to self-reflect and increase ability to intervene when competence is jeopardized potentially leading to negative consequences.

Summary of Self-Care Ethics

The presented guidelines, principles, and standards are all related to an individual's ability to use self-reflection as a way to assess ability to provide healthcare services. These statements seem to incorporate the use of colleagues and other governing entities as gatekeepers of the profession to safeguard the general public. A key component to monitoring one’s ability to fulfill work duties is an awareness of self. These ethical codes require an individual to engage in self-reflective practice in order to monitor and assess wellbeing and overall functioning to

provide psychological services. The ethics code is not sufficient to train counseling psychologists. The doctoral training process needs to maintain a focus on reinforcing these professional competencies to safeguard the general public.

Professional Stress, Burnout, and Impairment in Healthcare.

There are numerous ways in which 'burnout' is described, however every definition involves occupational stress that involves consequences to physical, mental, and emotional health. Burnout is a gradual process that occurs over time as a result of inability to meet increasing stressors (Killian, 2007). As burnout increases in an individual, there is a decrease in level of functioning. The term 'burnout' is defined by Jenkins and Baird (2002) as, "a defensive response to prolonged occupational exposure to demanding interpersonal situations that produce psychological strain and inadequate support" (p. 424). It has been stated that anger and frustration are two characteristics of burnout accompanied by fear and anxiety (Maslach & Jackson, 1981). Professionals working in the healthcare field must consistently address a multitude of difficult challenges to help those in need. Those who are unable to manage stress run the risk of becoming impaired due to burnout with potential for engaging in unethical conduct.

Burnout happens in many different areas of healthcare professions. Shanafelt and Dyrbye (2010) argued that burnout for an oncologist starts in training and follows into practice. In the authors' literature review the research suggests between 28-38% of oncologists (depending on the specialty) face burnout due to demands and distress associated with work related duties. The contributors to oncologists' burnout include challenges using the medical model, work overload, threat of malpractice suits, and additional administrative tasks. These authors' state consequences to burnout for this health profession are unprofessional conduct, poor ability to

provide quality care, medical errors, and poor personal overall health. Unfortunately, the review did not specify between oncology specialties nor did it provide specific contextual demographic factors to better understand the application of the literature. Furthermore, Drybye et al. (2010) conducted a study to examine the relationship between professional conduct and burnout in a large sample (N = 2,682) of U.S. medical students. They argued that professional conduct is greatly influenced by the amount of distress encountered by the student. They used the Maslach Burnout Inventory (MBI), 2-item PRIME (depression screening), and MSATU (attitudes towards providing for underserved populations). The results revealed that those higher in burnout (33%) were more likely to be dishonest in academic and clinical work versus those with lower burnout scores. Medical students with lower burnout had more altruism, and those with low scores for mental health did not suggest a higher likelihood for dishonesty or a lack of altruism. This study does not provide any information on protective factors against burnout.

In a study about gender differences in career and burnout with professional psychologists Rupert and Kent (2007) argued that burnout ultimately affects work performance and quality of services delivered to the public. The instrument used in this study was the MBI. They examined differences in professional psychologists working in independent settings versus agency settings. They found that personal achievement combined with fewer sources of stress and higher control at work by those working in independent settings. Both men and women endorsed the following six strategies: maintaining sense of humor, self-monitoring, work/life balance, maintaining professional identity/values, engagement in hobbies, and time spent with family. Results revealed that women experience more emotional exhaustion in agency settings whereas men did not differ in emotional exhaustion. The sample in this study was comprised of 58% women and the average age was 52. The range for years of experience for men was 21 years and women 16

years with a standard deviation of 8 years. The authors suggested that developing a self-awareness and exercising self-monitoring can help protect professional psychologists from burnout. This research study is focused on later career career-sustaining behaviors (CSBs) in their relation to burnout. More research is needed to understand the gender differences in burnout among graduate students and early professional psychologists.

Trainee Stress and Wellness

There has been a very small amount of attention on self-care among psychology graduate students. Self-care is an important topic to be taught to the psychology graduate student as they begin working with clients entering into practicum and through internship. The skills, attitudes, and behaviors shaped during this time, as it relates to self-care, is likely to follow through the rest of the career practice. Research has shown that negative effects caused by stress are prevented through the use of regular self-care (Brucato & Neimeyer, 2009; DeAngelis, 2002). Therefore, acquiring this professional competency is imperative to continue the lifelong process of serving the public in a number of capacities. Despite the critical need for understanding self-care among counseling psychology graduate students, studies lack in measuring the range of specific self-care behaviors and attitudes.

The stresses that accompany the job of a psychologist providing mental health services are inherent. Identified factors for burnout include large client caseloads, insufficient resources, extensive work hours, and providing service to challenging populations (Dane, 2000). Specific to psychology graduate trainees, exploratory research has shown that work overload, finances, anxiety, lack of time, and poor work/life balance as contributors to stress (El-Ghoroury, Galper, Sawaqdeh, & Bufta, 2012). They cited that 70% of graduate students at one time have reported a

stressor that impaired their ability to function. The sources of the impairment came from academic responsibilities, finances, anxiety, and poor work/life balance. Coping strategies reported from graduate students include emotional support from peers, friends, and family, in addition to regular exercise, and engagement in enjoyable activities. The barriers identified to using wellness strategies were a lack of time and finances. PsyD students reported debt or financial strain as a barrier significantly more frequent than PhD students. Results suggest that ethnic/racial minorities are more likely than whites to report discrimination as a stressor and spirituality as a coping strategy. This study does not provide specific information with the frequency or understanding of the triggers for this population to engage in coping strategies.

In another study, Dearing, Maddux, and Tangney (2005) examined the predictors for clinical and counseling psychology graduate students to engage in personal psychotherapy for help. Results revealed that faculty attitudes towards students seeking therapy was related to second year students seeing therapy as a positive way to manage stress. The barriers for students to engage in help seeking include cost, time, and confidentiality. This study provides insight as to how faculty can influence the wellness behaviors of their students. Unfortunately, this study specifically examined doctoral students in years one or two.

In a study exploring the effect of stress on psychology graduate students' functioning, McKinzie et al. (2006) conducted a quantitative study to examine the relationship of mood, self-esteem, and daily habits. The authors hypothesized that daily habits, self-esteem, and mood will significantly correlate with stress. Secondly that daily habits, self-esteem, and mood are significant unique predictors of stress. The sample (n = 65), was comprised majorly of White (88%), female (75%), year 1 and 2 (62%), Clinical/Clinical Health Psychology (62%) graduate students in the New York City metro area. The instruments used were the Student Stress Scale

(1991), Self-Esteem Rosenberg Self-Esteem Scale (1965), and mood assessed using Positive/Negative Affectivity Scale (1988). Single item indicators were used to assess daily habits. The results revealed that participants, who experienced lower stress, had moderate self-esteem, and moderate levels of low/high mood. Sleep, exercise and negative affect significantly correlated with stress. The predictors of stress were negative affect (34%) and sleep patterns (23%). This study used single item indicators to account for daily habits, which may not completely capture the behaviors of this population. This study also has a very small sample size and was not with counseling psychology graduate students. More research is needed to better understand the interaction of health behaviors, mood, and self-esteem with doctoral counseling psychology students.

In a study addressing self-care Myers et al. (2012) explored practices of self-care and perceived stress levels among psychology graduate trainees. They argue that not enough research has been conducted to establish an understanding that stress among psychology graduate students can have negative impacts on academics, overall well-being, and clinical skill acquisition. The authors state that less is known about the factors related to stress management among this population. The sample (N= 488) consisted of psychology graduate students (94%) from APA accredited programs, (87%) White, (84%) female, 17% in a master's or other graduate program, and 60% reported being married or in a serious committed relationship. Instruments used: Sleep Hygiene Index (Mastin, Bryson, Corwyn, 2006); Godin Leisure Time Exercise Questionnaire (GLTEQ; Goldin & Shepard, 1985); Multidimensional Scale of Perceived Social Support (MPSS; (Zimet, Dahlem, Zimet, & Farley, 1988); Emotion Regulation Questionnaire (ERQ; Gross & John, 2003); Philedelphia Mindfulness Scale (PHLMS; Cardaciotto, Herbert et al., 2008); Perceived Stress Scale (PSS-14; Cohen, Kamarck, &

Mermelstein, 1983). Results indicated sleep hygiene, social support, emotional regulation, and acceptance using a mindfulness framework were significantly related to perceived stress. More research is needed specifically on doctoral counseling psychology students in all years of their APA accredited training program to better understand the broad context from which these health behaviors unfold and their emergence during the developmental trajectory.

In a study on the perception of self-care and quality of life with graduate trainees in a clinical psychology program, Goncher et al. (2013) conducted a qualitative study to understand the relationship between self-care and quality of life. This study seeks to build on our understanding of the importance of ongoing self-care as a part of professional practice. The authors had four hypotheses. The first hypothesis is that there would be a clear relationship between students' perceptions of self-care emphasis in their program and quality of life. The second would be higher scores on self-care measures would correlate with high self-care utilization. Third, more self-care utilization would correlate with higher scores on quality of life measure. And last, the introduction of self-care education would mediate the utilization of self-care and the quality of life. The sample (N = 221) consisted of 84% white women. Participants were asked to compare self-care utilization before entering training and now in the program. They found that 37% increased utilization, 32% decreased utilization, and 30% had no change in utilization. The measures used were Perceived Self-Care Emphasis 30-item (PSEQ), Self-Care Utilization Questionnaire 30-item (SCUQ), and Quality of Life Inventory 66-item (QLI). The results from this revealed that self-care utilization was a strong positive predictor of quality of life when controlling for self-care emphasis. Using multiple regression, SCE and SCU together accounted for 50% of variance in quality of life scores.

Recent research on clinical and counseling doctoral trainee health, program satisfaction, and workload has revealed that rates of physical and mental health symptomology are greater than the general population and medical students (Rummell, 2015). This data was gathered via online survey from APA. Approximately 33% of graduate students endorsed thesis, dissertation, or other research as the most stressful aspect of training, followed by work-life balance (15%). The most prevalent physical health symptoms on a biweekly basis reported were fatigue (80%), headache (61%), and back pain (61%). In addition, psychological symptoms reported in the same time frame included mental fatigue (86%), feeling overly stressed (81%), feeling anxious or worried (80%), and irritability (78%). When asked about areas of dissatisfaction with doctoral program, 44% reported lack of emphasis on self-care. This study is more evidence of the stresses and need for self-care during doctoral training. Unfortunately, the highlighted lack of emphasis on self-care is vague and does not specify practices trainees can incorporate to improve well-ness.

Self-Care Interventions and Strategies

At this time, there is very little known about self-care interventions and strategies implemented by psychology trainees. The medical field has implemented self-care interventions to reduce stress and burnout. Essential to mental health counselors, Yager and Tovar-Blank (2007) stated that counselors must work being mindful of their own need for self-care to maintain wellbeing for the course of their professional career to feel capable of serving clients. The research mentioned in this section serves as research-based evidence in their usefulness and effectiveness for professionals providing services to others.

Mindfulness-Based Stress-Reduction Programs (MBSRP). The term ‘mindfulness’ can best be described as “paying attention on purpose, in the present moment, and

nonjudgmentally to the unfolding of experience moment by moment" (Kabat-Zinn, p. 145, 2003). A study of mental health counselors in training in a randomized controlled intervention study revealed those involved in a MBSR showed significantly greater increases in self-compassion in comparison to the control group (Shapiro, Brown, & Biegel, 2007). Another intervention study with a 6-week MBSRP resulted in decrease perceived stress and increased self-compassion in a group of college students entering into nursing, social work, counseling, and teaching (Newsome, Waldo, & Gruszka, 2012). Unfortunately, these studies do not include clinical or counseling trainees at the doctoral level.

Utilization of Clinical Supervision. Community mental health nursing literature demonstrated that using clinical supervision is an effective strategy for buffering burnout and occupational stressors (Bedward & Daniels, 2005; Edwards, Bundard, Coyle, Fothergill, & Hannigan, 2003; Edward & Hercelinskyi, 2007). Supervision is identified as a helpful strategy to support the supervisee across many helping fields (Severinsson, 1994). Cummins, Massey, and Jones (2007) argued that clinical supervision assists in reducing distress prior to a counselor's unethical conduct or development of severe significant impairment of functioning. These authors further stated that work culture such as supportive colleagues and manageable caseloads assist in promotion of engagement in self-care. Supervision is an important aspect of psychology doctoral training, however no or few research has focused on the relationship of self-care and clinical supervision.

Self-Reflection. Self-reflection is a competency in the same domain as self-care and is identified as a key ingredient in the development of the professional self (Urdang, 2010). Specifically, self-reflectiveness is described as a self-care strategy that "builds clinical competence, prevents boundary violations and burnout, and offers protection against client

violence" (Urdang, 2010, p. 523). A strategy to build self-reflectiveness is writing. Research on teaching in medical school suggested that reflective writing is an effective strategy to build self-reflectiveness (Shapiro, Kasman, & Shafer, 2006).

Professional Stress, Self-Compassion, and Resilience

A positive psychology lens has been applied to examine how others working in challenging work environments maintain their resilience. Gilbert (2006) contends that self-compassion is a key element in self-care that needs present in health care professionals. In the psychology literature, research shows that a lack of self-care is directly related to poor patient outcomes (Castonguay, Boswell, Constantino, Goldfried & Hill, 2010). In a qualitative study by Patsiopoulos and Buchanan (2011), the practice of self-compassion for counseling professionals was explored. The three themes that emerged were finding balance through self-care strategies (work/life balance, engagement in enjoyable experience, and management of overall mental and physical health). The second theme that emerged was the workplace relational culture where individuals are being open and honest with others. The third theme that emerged was the counselors' position in session utilizing mindfulness, self-acceptance, and self-care. They reported that self-care and self-compassion share overlapping aspects, however, they are two different constructs. The definition of self-compassion used is *a basic kindness, with a deep awareness of the suffering of oneself and others and the desire to relieve it* (Gilbert, 2006). The instrument they used to capture self-compassion was the Self-Compassion Scale (Neff, 2003). More research needs to be done in order to better understand the differences between self-compassion and self-care.

Scholars have moved towards examining how stress is managed through the lens of positive psychology. In a conceptual article by Vogelgesang and Lester (2006) recommended

strategies to develop resiliency. They argued that resiliency has “state-like properties”, differing from the previous research that suggests that resiliency is a trait that can be built upon for professionals to utilize in the workplace when faced with difficult challenges. Psychological capital (PsyCap) in the form of resilience focuses on a proactive assessment of risks and personal assets that affect employee outcomes. Research has suggested that resilience can bring one back to baseline functioning or increase the ability to get the job done. Convergent and differentiation of resilience in relation to other PsyCap factors are hope, optimism, and confidence. These may act as moderators. Resilience is different in that it has an antecedent and it is reactive in nature. Resilience can "restore" the other virtues. How resilience differs from hope is the willpower to use alternative methods for handing challenges. Optimism is expectancy that one will experience good outcomes in life goal oriented. Finally, confidence can apply effort to complete tasks perceived by the individual to be challenging. The authors proposed three strategies to build an individual’s PsyCap. First, they proposed a risk-focused strategy where a strong organizational culture can and does continual fostering of strengths. Second was a process-focused strategy where those who have higher confidence have higher resiliency. And finally, an asset focused strategy that works to supply the individual with the needed training to increase their ability to do the job, and focus on the positives of their skills/knowledge.

A literature review by Jackson, Firtko, and Edenborough (2007) examined how some nurses are able to thrive and continue to find career satisfaction despite the challenges they face working with patients. The authors argue that developing resiliency can reduce challenges such as vulnerability and workplace adversity. The authors propose strategies to build resilience in the workplace despite adversity that are particularly grounded in interpersonal problems. The first suggestion is engaging in nurturing relationships and networks in the workplace. Secondly,

they emphasized the importance of work/life balance with incorporation of spirituality. Finally, they suggest increasing an individual's ability to self-reflect in order to maintain optimism.

In a mixed methods study by Killian (2008) compassion fatigue, burnout, and self-care for professionals that work with survivors of trauma were explored. Interview data (N = 20) revealed that therapists detect job stress somatically. One of the qualitative themes found highlighted that social support is highly important for self-care, in addition to regular exercise. Quantitative (N = 104) social support, work hours, and internal locus of control account for 41% of variance in compassion satisfaction. Multiple regression analysis showed 54% of variance in compassion fatigue and 74% of variance in burnout. Unfortunately, the sample size is relatively low and generalizations cannot be drawn from qualitative data.

Alkema, Linton and Davies (2008) examined the relationship between satisfaction, compassion fatigue and burnout with professionals working in hospice settings. The identified stressful events experienced by these healthcare providers involved patient death/dying, working with grieving families, experiencing personal grief, exposure to traumatic stories, the observation of extreme physical pain, personal feelings of anger and depression and both emotional and physical exhaustion. The authors state that reasons for burnout include: low salaries, demanding schedules, varying work shifts, low social recognition, lack of financial resources, role ambiguity and dealing with difficult client behavior. Psychology trainees experience many of these reasons for burnout. The authors state that compassion fatigue takes place due to exposure to vicarious trauma, lack of social support in workplace, and poor self-care.

Compassion fatigue is identified to have rapid onset versus burnout's gradual onset. It has been suggested that compassion fatigue can lead to reduced quality of care for patients (Keidel, 2002). The author suggests that self-care promotion may be effective to enhance

compassion satisfaction and decrease both burnout and compassion fatigue. The authors hypothesized that those who engaged in several self-care activities would experience higher levels of compassion satisfaction, lower burnout and compassion fatigue. The instruments used for measurement were the Professional Quality of Life Assessment and the Self-Care Assessment Worksheet. It is important to note that no psychometric properties have been established for the Self-Care Assessment Worksheet used. The findings of this study revealed a negative correlation between compassion satisfaction and burnout (-.61). In addition, a negative correlation was found for the relationship between compassion satisfaction and compassion fatigue (-.30). A strong correlation was found between compassion fatigue and burnout (.76), which suggests that these three constructs are related but different.

Professional Impairment

The engagement in self-care practices can prevent, disrupt, reverse, and minimize burnout and other impairment (Barnett et al., 2005). APA provides a specific Competency Remediation Plan to address the domains where trainees demonstrate professional competency issues. Part of the unknown about impairment is that its foundation is not always clear. Trainee impairment is an ethical and critical issue for gatekeeping the profession and challenging for natural helpers to make serious decisions regarding trainees' the entrance into field of professional psychology.

Impairment literature still remains an area for investigation, especially as it relates to trainees. Schwartz-Mette (2009) examined challenges in addressing impaired trainees in psychology programs and found an alarming 85% of graduate students were able to identify at least one peer with impairment in their program. Graduate students are at high risk for burnout due to factors of work overload, including multiple roles and novice experiences. Research

shows the following factors leading to burnout: personality traits (defined as ability to delay gratification), strong personal ethics, practicing outside range of competence, and developmental stress. Consequences of burnout have been identified as emotional fatigue/distress, inability to distinguish between roles in therapy, loss of positive feelings for clients, absenteeism, exhaustion, substance abuse, and decreased participation in training.

Adding more complexity is the subtle nature of impairment and stigma of asking for assistance from faculty or clinical supervisors. For these reasons, trainees tend to hide impairment for many reasons, mainly desire to persist in their graduate programs. Peers do not want to put faculty "on notice" of a colleague that is demonstrating behaviors that may indicate impairment. Schwartz-Mette argues that student-to-student identification of impairment is not sufficient. The challenges in addressing impairment are complex as many professional psychologists play a role in training. Research has shown that 89% of reported impairment issues are a result of insufficient clinical skills and/or personality/emotional problems. Baker (2003) suggests that self-awareness, self-regulation, and work/life balance be focal points for the development of the emerging professional. Training models will be discussed later in this chapter.

In an exploratory qualitative study, Oliver et al. (2004), examined the attitudes towards peers who may be facing impairment issues in clinical psychology training programs. The authors used a comprehensive definition of impairment: *inability or unwillingness to acquire and integrate professional standards into professional behavior; inability to acquire skills to reach acceptable level of competency; and, inability to control personal stress, psychological dysfunction, and/or excessive emotional reactions that interfere with the ability to professionally functioning*. The data gathered in this study focused on peer perceptions of impairment,

impairment behavior, a number estimation of impaired peers in the program, and issues around reporting an impaired peer to faculty. The implications from this study clearly convey professional standards of practice, review documentation process for evaluating student performance, provide students with resources and create a learning space where communicating needs is welcomed by students. Limited attention has been focused on the perspectives of psychology student trainees on impairment.

Professional Stress Summary

Several themes seem to run through the literature on professional stress with those working or studying in the helping field. For example, self-care utilization can influence the overall quality of life for psychology graduate trainees. Also, there is a need to know more about how to be proactive in protecting self-care in order to safeguard the general public. General obstacles for practicing professionals and graduate students are the lack of time and work overload to engage in self-care regularly. Lastly, organizational or work culture environments tend to promote or hinder one's ability to self-reflect and engage. To draw attention to building the construct of self-care in counseling psychology graduate training programs this paper will now shift focus on several proposed conceptual models in reaction to the call for action.

Conceptual Training Models

A recent call for attention to teaching ethics stems from a conceptual article addressing ethical issues in professional training. Cornish (2014) argued that, as a profession, we tend to be client centered as it relates to ethics when many of the ethical issues are related to the education and training process. The article defines competency as knowledge, skills, attitudes/values, in

foundational and functional activities performed health-service psychologists. The author suggested that a fundamental change in ethics training could be to move towards the utilization of a communitarian training models to extend the learning process throughout the professional career as proposed by Johnson, Barnett, Forrest, and Kaslow, 2013a, 2013b. This call for action is in response to the shift in training and the importance of fostering ethical practitioners. These training models are built upon the notion that self-care is an ethical obligation (Barnett et al., 2007).

In a practical article, Moffett, Becker, and Patton (2014) proposed several ways in which training can be used to foster ethical sensitivity of early professionals. They define ethical sensitivity as the recognition that a professional event poses an issue of ethics that may require action by the clinician. The authors state that failure to understand and development this sensitivity is likely to produce a failure to take appropriate actions. They build from Fouad et al's (2009) statement that virtues of psychologists ought to include integrity, honesty, responsibility, compassion, and courage in order to best serve others. They argue that ethical behavioral is best developed in the context of role induction that continues throughout the professional's life. They state that education or skill building does not necessarily lead to fostering ethical behavior. They proposed the use of Welfel's (2012) teaching modalities incorporating: case examples, emphasis on the role of ethical principles, using films for engaging trainees in education and encouraging self-exploration of morality. The foundational skill of self-reflection may best be addressed more heavily in a more intimate setting, as it requires the trainee to focus and reveal personal experiences along the developmental trajectory, specifically in the clinical work.

Falender and Shafranske (2012) suggest that enhancing self-reflective practice is essential to building the skill of self-assessment and have highlighted that supervision is a place for development of this skill. It has been highlighted that psychology graduate students do not prioritize self-care (Kaslow & Rice, 1985). There does not seem to be a consensus on approaches to follow for training. Norcross (2002) urges career-long approaches need to be taught during graduate training. Research in the implementation of self-care as a competency is still emerging as a focal area for training and education. Recent research has uncovered alarming rates (85%) of students reported they did not get training materials regarding self-care, 63% self-care activities were not sponsored by the program and, 59% stated self-care was not encouraged in training (Barnett & Cooper, 2009). In order to avoid possible impairment research shows that social support, education, and work/life balance are all coping strategies that are used by psychology graduate students (Turner et al., 2005). It is important to address the vicarious trauma exposure due to the nature of the work which creates a higher need for self-care. Spiritual beliefs may be a protective factor for the experience of vicarious trauma. Self-care is an ongoing process, deeply involving self-reflection. The depth of self-exploration may be best guided by one of the gatekeepers in the trainee's constellation of clinical supervisors, faculty, and peers.

Johnson et al. (2014) suggest that a training culture be adapted toward a communitarian approach. They authors' argument is that despite a large body of literature that indicated healthcare providers' inability to self-assess competency accurately, ethical policies are continually viewed as a responsibility of an individual. They argue that a sense of community allows us to spread compassion for colleagues and protection of clients. Further they state that the sense of community allows us to create a safe space where community members can

maintain a healthy professional self. This article touches upon the lifelong process that psychologists must continually engage in maintaining the ability to self-assess and provide adequate care for clients at all times.

The communitarian approach that is outlined in this article is based off the idea that "It Take a Village". The communitarian "village" allows the space where each individual's unique contributions are celebrated and allows the professional the flourish through the use of interconnections and collaborations that can result in increasing each other's competence. This model is especially useful, as the authors state, after licensure, competency undergoes a gradual process of degradation, unless the individual is involved in some type of community that allows collaboration and feedback from field members. Despite counseling psychologists' training to help fellow psychologists, many studies have shown that indeed there is a lack of intervention to assist colleagues. While there are many factors related to intervention with colleagues, the article focuses on several empirical studies that address the reluctance to self-assess competence and/or provide assistance to another professional with competency issues. As it relates to work stressors, the authors cite difficult clients, unsuccessful therapy experience, and emotional depletion lead to depletion of compassion and burnout (Epstein & Hundert, 2002; Norcross & Guy, 2007). Additionally, studies have shown that despite professionals practicing with competency issues are unlikely to intervene, despite understanding their own professional duty to do so (Barnett, 2008; Wilkins, McGuire, Abbott, & Blau, 1990; Wood, Klein, Cross, Lammers, & Elliott, 1985). Finally, they highlight empirical research that indicates psychologists underutilize assistance programs (Barnett, 2008; Wood et al., 1985) and face barriers to seeking their own psychotherapy (Bearse, McMinn, Seegobin, & Free, 2013).

The focus on the professional psychologists' inability to maintain ethical sensitivity highlights a need for training to focus on self-knowledge. They define self-knowledge as one's own pattern of thinking, feeling, and behaving as well as accurate awareness of how others perceive those patterns (Vazire & Carlson, 2011). By developmental virtue, trainees are vulnerable to inaccurate self-assessments of competence and lack the skills to strengthen their competencies and methods to do so. Research has suggested trainees provide perceived socially desirable responses to multicultural competencies when compared to observer ratings (Worthington, Mobley, Franks, & Tan, 2000). As a way to address the issues of self-assessment in training and professional levels, the Competence Constellation Model (CCM) (Johnson et al., 2013) which is defined as a cluster of relationships a professional has with people who take an active interest in and action to advance the individual's well-being and professional competence. The constellation centers the trainee/psychologist at the center surrounded by those who foster growth, adaptive functioning, and professional competence over the lifespan.

The major contributor to overall efficacy of a CCM involves constellation diversity, strength of ties, and initiatory behaviors. A model is presented in this article by the authors to foster trainee development. The model proposed by this article's authors is the Communitarian Training Culture (CTC) that infuses interdependent and communal sense of character that values a high standard of accountability where individuals respond to one another with compassion and support. CTCs promote trainers to model transparency and self-care. The authors suggest that trainer-trainee relationships should focus on mutual growth based on developmental needs through a holistic view of the trainee including broader development in identity, self-efficacy, emotional intelligence, and work-life balance. The recommendations for the implementation for a CTC include infusion of communitarian elements into the competency benchmarks, virtues in

the process of training, a greater emphasis on self-care in training program curriculum, and considerations of assessing efficacy of this training model.

Training Model Summary

Unfortunately, there is no empirical literature to support these conceptual training models. It is important to understand the common themes of training move from independent and limited to communitarian and ongoing. These models present a number of ways for enhancing the ethical responsibility of self-care using all those involved in the training process. It is clear that self-reflective practice is a key component to include in the promotion of ethical behavior, especially as it starts with the self. These conceptual models hold that training stretches beyond the specific training program into clinical work and practice beyond licensure. The following are recommendations from the proposed communitarian models: infuse communitarian elements into Benchmark Competencies, embed communitarian values early in the training process, trainers serve as models of communitarian virtues and behaviors, emphasize the importance of self-care in curriculum, consider assessment modalities of a CTC and find best practices for implementation.

Theory of Self-Care

Orem's (2001) theory, primarily applied in the nursing literature, is posited on internal or external orientations of motivation that one uses to engage in self-care practices. An individual who is internally oriented would practice self-care deliberately as a way to maintain overall wellness. External orientations involve an interaction with others or the environment. Eight fundamental self-care practices in this theory are: maintaining air, water, food, bowel

movements, balancing activity and rest, being alone or interacting with others, preserving human life, performance, welfare, and preservation of optimal human functioning (Orem, 1991). It has been suggested that self-care is a learned behavior and self-care theory presumes that individuals have an intrinsic need to care for themselves (Easton, 1993). Still, individuals need to learn how to plan, engage, and evaluate their own self-care as necessary as possible (Timmerman, 1999). Scholars argue that individuals have the choice and ability to engage in self-care (Orem, 1995). The intrinsic (attitudes, beliefs, and values) and extrinsic (actions performed) components of this theory relate to an individual's engagement and frequency of self-care as it relates to adherence to ethical obligations.

The *Wheel of Wellness (*WoW*)* is a holistic theoretical model for wellness across the lifespan based on psychological theory, inspired by Adler's Individual Psychology, and empirical research on aspects of a healthy individual (Myers, Sweeny, & Witmer, 2000). These authors define wellness as, "a way of life oriented toward optimal health and well-being in which the body, mind, and spirit are integrated by the individual to live more fully within the human and natural community." The theory is that the following twelve tasks of self-direction are conceptualized to successfully meet Adler's major life tasks: sense of worth, sense of control, realistic beliefs, emotional awareness/management, problem solving/creativity, sense of humor, nutrition, exercise, self-care, stress management, gender identity, and cultural identity. At the core of the Wheel is spirituality, the most salient component of health according to this theory. According to this theory, the care of self will assist in maintenance of optimal health.

The authors struggled to statistically verify the relationship of self-care practices to the identified domains of the self in this theory. As a result, Myers et al. (2004) used confirmatory factor analyses (CFA) to examine the underlying factors of wellness and updated the Wellness

Evaluation of Lifestyle inventory. Using a large sample (N=3,993) psychometric properties of the instrument were established. The four underlying factors confirmed are Cognitive-Emotional, Relational, Physical, and Spiritual Wellness. The current version of the inventory is the four-factor Wellness Evaluation of Lifestyle (4F-WEL). The 4F-WEL has 16 subscales. The model accounted for 30% of the variance with eigenvalues at or above 2.25. Previously there were five factors in the Wellness Evaluation Lifestyle inventory (5F-WEL), however through the above CFA “creative self” was eliminated. 4F-WEL Next, the four factors are defined with example inventory items.

Cognitive-Emotional Wellness. This aspect focuses on the cognitive-emotional self-care that is used to maintain balanced mental health. One of the most common strategies in the literature includes the ability to express distress in a healthy manner, monitor thinking, and maintaining a healthy work/life balance (Myers et al., 2004). This domain is predicted to have a higher number of items due to the combination of cognition and emotion. An example of an item in this domain is: "I allow myself to cry when upset", "I use positive self-talk", "I set limits with clients", and "I engage in hobbies outside of work."

Relational Wellness. Items in this aspect will involve interaction with others to access the relational care component. This aspect works to enforce the work/life balance. Examples of items in this domain are: "I talk to my friends for support", "I discuss my work stress with colleagues", and "I receive adequate supervision in my work."

Physical Wellness. This aspect demonstrates the need to maintain physical health in order to function adequately. Example items are: I eat balanced and nutritional meals", "I do physical exercise", and "I sleep restfully at night."

Spiritual Wellness. Spirituality is a central core component of the Myers et al. (2004) that promotes personal growth, seek purpose in life, achieve self-awareness, and moving toward personal growth and responsibility. Example items in this aspect are: "I meditate", "I devote quiet time for myself to be alone", and "I practice yoga or some other form of meditative exercise."

Self-Care Theory Summary

Theory of self-care and identification of the dimensional structure is needed to extend research. Orem's theory is not in the psychological literature and focuses on the underlying construct of motivation for engagement in maintenance of wellness. Myers et al. (1998) has used psychology theory to explain the concept of wellness however does not specifically isolate and measure the construct of self-care. Research needs to focus on self-care as an individual construct. As a relationship between self-care and wellness may exist, they are definitely separate constructs. The 4F-WEL will inform this research study, as it provides 56 behavioral items. Clearly, more psychology theory is needed to direct attention at self-care, its underlying factors, and definition.

Purpose of Study

It is clear that despite the clear connection of ethical guidelines to self-care not enough is being done to foster self-reflective practice in graduate training as a lifelong professional competency. There is very little known about what, how, and when clinical and counseling psychology doctoral students engage in self-care practices. The current literature does not give us a comprehensive definition of self-care for this specific population, which creates a need to understand the various components that make the construct. It is also unknown how balance of

self-care is maintained without overindulgence. There has not been any literature focusing on the construct overlapping of self-indulgence and self-care. Currently, there is not a measure for self-care for clinical or counseling psychology graduate students, an instrument that must include self-reflection. This proposal aims to create a psychometric instrument for use in training and practice with clinical and counseling psychology graduate students.

Chapter 3: Method

Introduction

This chapter provides a description of the study design to address the research questions. Information is presented on the target population and sampling procedures used for recruitment. Instrumentation used in this study is reviewed. Additionally, the data analysis plan and ethical considerations are also discussed. This chapter concludes with a summarization of the methodological elements of this study.

Research Design and Rationale

This study was exploratory and investigative in nature. In the first part of this study, I sought to examine clinical and counseling doctoral students' self-care practices while simultaneously seeking to confirm psychometric properties of a scale representing the construct of self-care. This research study was grant funded by APPIC's Competencies Assessment Project Review Committee. In attempting to explore the construct of self-care, the Self-Care Assessment Work Sheet (SCAW) was tested in a pilot study. The second part of this study sought to further establish construct validity of the SCBS through convergent and discriminant comparisons.

Specifically, the study was designed to develop an instrument, followed by analyses conducted to establish the validity and reliability of the SCBS. Self-report questionnaires were completed by an intentional sample of clinical and counseling doctoral trainees. The relationships of scores between measures were examined to establish convergent and discriminant validity. These relationships make this research design correlational, to allow for analyzing relationships between variables.

This study used a pilot study to gather feedback on items on the SCAW to examine construct relatedness, clarity, and feedback using individuals from the target population. As a self-care instrument does not currently exist for the target population using a pilot study facilitated the information gathering process before the full study was conducted. This pilot study was advantageous as it allowed for survey protocol and instrument testing before the study. As a result, the pilot-testing established which items were pertinent and those in need of revision.

Sampling Procedures

Pilot Study. Doctoral graduate students were recruited from two Ph.D. programs, the University of Wisconsin-Milwaukee (Clinical Psychology) and University of Missouri-Kansas City (Counseling Psychology). Recruitment took place via email sent from respective program training directors to current doctoral students. Training directors received an email explaining the study and requesting them to forward the research invitation to their students. Participants were asked to complete the measures and provide feedback on 60 SCAW items for relatedness to self-care, clarity, and feedback.

Thirty-three students began the online survey. Of the 33, a total of 28 students (84.8%) completed the pilot survey. At the end of the survey, participants were directed to a separate survey and received an Amazon gift card in the amount of $25. A total of 27 students (96.4%) provided their name and email address to receive participation compensation. Feedback from pilot participants was used to refine the SCAW to eliminate or refine items. The pilot sample was comprised of 15 clinical psychology students and 13 counseling psychology students. Participants were predominantly White (81%), female (67.8%), and single (52%). Ages ranged from 21 to 37. Students represented the full range of the training development with clinical experiences reported across all stages of competence benchmarks.

Pilot data. Qualitative pilot data collected was reviewed for item analyses, in addition to wording and interpretation of the items. All feedback on the survey items were considered for scale revisions. Particular attention was paid to items that were unclear to the reader. For instance, the pilot item "Have your own personal psychotherapy" received feedback on the item wording. As a result, this item was revised to "See a therapist" for the final survey administration. A total of 12 items were eliminated. I received feedback from an expert in the area of doctoral training in addition to 5 peers regarding item wording and clarity before moving into the full study. A total of 48 items were retained for administration in this study.

Current study. Upon participation agreement, a brief demographic questionnaire providing personal and career information was completed. The remainder of the survey utilized self-report inventories. The first asked for information related to the frequency of self-care behaviors. The second asked participants to rate their agreement with statements that reflected overall well-being (flourishing). Third, participants were asked to rate their level of distress experienced as a doctoral trainee personally and professionally. The fourth set of questions asked about professional burnout. Lastly, the fifth survey asked about perceived competence. As an assurance that all questions would be answered beyond the demographic section, participants were required to answer all questions before accessing the next part of the survey to prevent missed, skipped, or unanswered items. At the end of the survey, participants were redirected to a separate survey to input their email and name to receive a $5 Amazon gift card as a token of appreciation for participation. All recorded data were kept on the password-protected Qualtrics server, to which only the researcher had access. Data were downloaded into an SPSS file for analysis. Descriptive demographics for the current study is presented in chapter 4.

Participants

An a priori test to compute sample size revealed that a sample total of 111 was needed to establish power of .95. Descriptive statistics were conducted to ensure that data was normally distributed, demonstrated linear relationships, and skewness. The study's sample characteristics were examined (N = 232). The study participants identified as Caucasian (69%), female (73%), single (43%), completed a master's degree (75%), and reported no professional work history in a mental health setting prior to entering doctoral training (69%). The average age was 28 years old. The average number of participants' semesters in doctoral practicum was 3.57 (SD = 2.72). Finally, the most reported practicum setting was University Counseling Centers 33%. It is important to note that gender was coded using data in the rewards survey data. The next chapter will provide more in-depth reporting of descriptive statistics of the study's sample.

Instrumentation

This study used several measures to collect information on the self-care practices used by professionals working in the mental health or similar helping professions that provide direct services to the general public (ex. social worker, medical doctors, and nurses) for validity purposes. In addition to completing the Self-Care Assessment Worksheet (SCAW) consisting of 70-items to assess self-care strategies (Saakvitne et al., 1996), study participants were asked to provide demographic information, perceived competence, burnout, well-being, and distress instruments. These listed instruments were selected for use in this study based on their theorized relationship to self-care. More, these instruments were chosen due to their popularity in the review of literature, noted statistical properties (or need for validation), and availability for use. All of these items were readily available to the public domain via Internet. The following section provides detailed information on the instruments used in this study.

Perceived competence scale (PCS). The Perceived Competence survey (PCS) (Williams & Deci, 1996) is a 4-item self-report inventory designed to assess constructs from Self-Determination Theory (SDT). This theory suggests that autonomy support aids the trainee to internalize and integrate regulations (ethics) and values. When using this scale, items are specifically written for relevant behaviors being studied, in this case self-care. The items are scored on a 7-point scale with responses ranging from 1 (*Not at all true*) to 7 (*Very true*). The PCS seeks to capture outcome ethical competency of self-care, while the SCBS (created in this study) seeks to measures the practices used to maintain self-care. PCS was selected for this study based on its availability for research use in the public domain and the belief that perceived competence and self-care are related. An overall score is achieved through averaging the responses of the 4-items. Higher scores indicate a higher level of perceived competence. Two studies reveal an alpha level above .80 for internal consistency and an alpha of .90 for reliability (Williams & Deci, 1996). Finally, good construct validity has been demonstrated when the PCS is correlated to other constructs of SDT, such as relatedness (r = .31) and autonomy (r = .27) (Wilson, Rodgers, Blanchard, & Gessell, 2003).

Maslach Burnout Inventory – Human Services Survey (MBI-HSS). Scholars have identified the MBI-HSS as the "gold standard" in burnout research in the helping professions (Pope & Hoge, 2010). This tridimensional inventory has three subscales addressing emotional exhaustion (EE), depersonalization (D), and personal achievement (PA). The MBI-HSS is a 22-item instrument that describes feelings of burnout and frequency of feelings related to burnout. Responses to items are captured using a 7-point Likert scale from 0 (*never*) to 6 (*daily*). The estimated completion time for this inventory is approximately 10 minutes (Maslach et al., 1996).

Burnout is indicated in higher scores on the EE and D subscales and a low score on the PA subscale (Maslach et al., 1996). Reversely, a high PA subscale score and low scores in the EE and D subscales indicates low burnout. Levels of burnout are captured in subscale range scores. Emotional exhaustion scores ranging 0-16 indicate a low level of burnout and scores above 27 indicate a high level of burnout. Depersonalization scores ranging from 0-6 indicate low level of burnout and scores above 13 indicate high level of burnout. Personal accomplishment scores ranging from 0-31 indicate a high level of burnout and a score above 39 indicates a low level of burnout (Maslach et al., 1996). For statistical analyses, it is recommended that individuals' actual numerical scores (raw scores) be used versus categorization into low, moderate, and high levels of burnout. Following this recommendation provides specific information about the individual's specific area of burnout and enables comparisons to be made between participants and the overall norm (Maslach & Jackson, 1981).

Maslach et al., (1996) found high reliability and validity for the MBI-HSS. The reliability coefficients for the three subscales are as follows: emotional exhaustion, .90; depersonalization, .79; and personal accomplishment, .71. Test-retest reliability coefficients for the subscales were .82 for emotional exhaustion, .60 for depersonalization, and .80 for personal accomplishment (all coefficients were statistically significant, $p < .001$). To provide information on the validity of the MBI-HSS, multiple studies show that confirmatory factor analysis testing on this inventory revealed all items have positive loadings (>.40) on all three principal components (Ackerly, Burnell, Holder & Kurdeck, 1988; Chao, McCallion, & Nickle, 2011).

Self-Care Assessment Worksheet (SCAW). The SCAW, developed by Saakvitne et al. (1996), measures frequency of self-care practices in the following six areas: physical, psychological, emotional, spiritual, professional workplace, and balance. The identification of

self-care practice is the emphasis of the SCAW, which originated as a workbook activity for helping professionals experiencing distress as a result of vicarious traumatization. This self-report 70-item questionnaire asks respondents to rate self-care practices on a 5-point Likert scale. The scale scores range from 1 (*never occurs*) to 5 (*frequently occurs*). High scores indicate a greater frequency of self-care practices across the six areas. Unfortunately, no psychometric properties have been established for this measure (Alkema et al., 2008). For this study, the worksheet was used in a pilot before using with a larger sample, demonstrating face and content validity. The SCAW was useful for respondents to rate the frequency of their engagement (or not) across a broad number of items, which may then be used to examine the relationship to other constructs.

Flourishing Scale (FS). Diener and Biswas-Diener (2010) created an 8-item summary to measure self-perceived well-being in the past 4 weeks through experience of positive feelings (flourishing). The four week time period is specific to this instrument due the high temporal stability (.71) of flourishing. Each item on this scale is answered on a 7-point Likert scale, ranging from 1 (*Strongly disagree*) to 7 (*Strongly agree).* Items are positively directed. Scores for this measure range from an 8 indicating a strong disagreement with all items to a score of 56 indicating a strong agreement with all items. Higher scores are representative of an individual's view of positive functioning in across different domains. In particular, the elements related to well-being for this scale are: success in relationships, self-esteem, purpose, and optimism. This scale was normed with U.S. and Singaporean college students (N = 698). Further, Deci and Ryan (2000) suggest that properties of flourishing are connected to an individual's need for competence, engagement, and purpose which are assessed on this measure. A single well-being score is calculated for this measure. This measure was selected for this study due to its strong

psychometric properties (Cronbach alpha = .86). Diener et al. (2010) report that 61% of the variance is explained by two underlying components with factor loadings over .58 on each one, providing evidence of factorial validity. This scale is reported to have high construct validity as a result of its unidimensionality and convergence with other relevant short scales to assess positive and negative feelings (Diener et al., 2010).

Distress. With permission of Jeffrey Barnett and Leigh Carter, a Contributors Distress (2014) measure was used to capture sources of professional and personal distress psychology trainees along the developmental trajectory. This measure was used to provide a contextual portrait to our efforts to develop the self-care inventory. This measure is based off existing literature on trainee distress through the developmental trajectory. It is important to note that psychometric properties are not validated. This 55 item scale uses a 10-point scale where a score of "0" represents not distressing at all, and "10" represents the most significant source of distress.

Data Collection

Prior to beginning data collection, I received approval from the University of Wisconsin-Milwaukee Institutional Review Board (IRB). The sample used in this study was gathered through a non-randomized, non-probability, purposive sampling design. Sampling focused on clinical and counseling psychology doctoral students in APA-accredited programs in the United States.

Electronic forms of the research participation request were announced to potential participants during the recruitment phase. The electronic research request provided a brief description of the study and web-based questionnaire, researchers' contact information, and a link to access the actual study. Prospective participants were encouraged to forward the

recruitment email to other clinical or counseling doctoral students. The survey was available via a survey specifically created for this study, which was designed for easy use and accessibility. Recruitment information stated limitations to confidentiality using this source of survey methodology.

The study's Informed Consent explicitly stated the limits of confidentiality which all participants received an electronic copy of at first access to the web-based survey. Also included in the Informed Consent was information about who was conducting the research, why/how they were selected to participate, approximate time to complete the web-based survey, and nature of the included questions. Finally, the form covered anonymity, participant withdrawal, potential risks, and rewards. Agreement with all content on the Informed Consent was required before participants could enter the study survey. Upon completion of the survey, participants were redirected to a separate survey to enter their information to receive a $5 Amazon gift card.

Recruitment for the full study took place through dissemination of research participation requests via email to CCPTP (listserv for counseling training directors) which is representative of all current APA-accredited counseling doctoral training programs. In addition, individual research requests were sent to 22 clinical psychology programs' training directors for dissemination, as the CUDCP listserv does not allow research requests. Additionally, inquiry was sent to APPIC for consultation on using their listserv as a recruitment tool. Unfortunately, APPIC does not allow research requests to be sent via listserv.

Data Analysis

The data gathered from the completed surveys were analyzed using SPSS software. A combination of descriptive and inferential statistics were used to analyze data. The main analysis used for this study was a factor analysis. The secondary analyses were Pearson

Correlations to examine relationships between self-care and perceived competence, burnout, and well-being.

This study is exploratory and investigative in nature. By conducting the factor analysis, a fixed number of extracted factors helped define the underlying components observed in the SCBS. Following this extraction, a principal components analysis was performed to reveal internal structures in the data in a way that best explains variance. Reliability analyses on each instrument used in this study were conducted using Cronbach's alpha. Bivariate correlations were performed in order to test hypotheses relationships for convergent and discriminant validity. For social sciences, a Pearson correlation of at least .30 should support predicted relationships. Generally, a correlation less than .30 is considered to be weak.

Research Hypotheses

RQ1

Null hypothesis (H_{01}). There is no statistically significant relationship between self-care, perceived competence, and wellness. It is expected that a moderate to strong positive relationship will exist between these variables.

Alternative hypothesis (H_{a1}). There is a statistically significant relationship between reported self-care, perceived competence, and wellness.

RQ2

Null hypothesis (H_{01}). There is no statistically significant relationship between global self-care means scores and burnout (using subscale scores of MBI).

Alternative hypothesis (H_{a1}). There is a statistically significant relationship between global self-care means scores and burnout subscale scores.

RQ3

Null hypothesis (H_{01}). There is no statistically significant between global self-care and well-being scores.

Alternative hypothesis (H_{a1}). There is a statistically between global self-care and well-being scores.

Summary

The primary focus of this study is to create a validated instrument to measure self-care practices with clinical and counseling doctoral trainees. This chapter provided a detailed description of the research design and rationale in addition to information regarding sampling, data collection, and data analysis. Coupled with demographic information the following measures were used in this study: Self-Perceived Competence (SPC) (Williams & Deci, 1996), Self-Care Assessment Worksheet (SCAW) (Norton, 1996), Flourishing Scale (FS) (Diener & Diener-Biswas) and the Maslach Burnout Inventory (MBI) (Maslach, 1996) were used. Results of the data analyses are presented in chapter 4.

Chapter 4: Results

Introduction

The purpose of this study was to establish the reliability and validity of an instrument designed to measure clinical and counseling doctoral students' practice of self-care behaviors. Current students enrolled in APA-accredited doctoral programs were invited to participate in an online survey in efforts to establish reliability and construct validity of the SCBS. This chapter is devoted to furthering the interpretation of this study's findings as it relates to the research questions.

Data Analysis

SCBS descriptive statistics. Descriptive statistics were produced for participants' item scores on the SCBS, where a higher mean score would indicate more reported use of the individual self-care item. Table 1 presents descriptive statistics for participants' endorsement of each self-care behavior, with higher means indicating a greater frequency of use.

Table 1

Descriptive Statistics on the Self-Care Items

Items	M	SD
Spend time with others your enjoy	3.42	.74
Maintain deep interpersonal relationships	3.69	.92
Stay in contact with important people	3.55	.80
Seek out projects that are exciting or rewarding	3.07	.89
Take time to chat with peers	3.57	.82

Allow yourself to laugh	4.05	.75
Quiet time to complete tasks	3.31	.82
Seek out comforting activities	3.35	.82
Be open to not knowing	3.34	.97
Eat healthy	3.45	.79
Medical care	3.41	.95
Time off	2.66	.88
Exercise	3.04	1.11
Pray/Meditate	2.51	1.16
Contribute to causes	2.74	.99
Advocacy	2.59	.96
Connect with spirituality	2.50	1.11
Spend time in nature	2.55	.82
Take vacations	2.25	.84

Items' scale, 1 = *Never*, 2 = *Rarely*, 3 = *Sometimes*, 4 = *Most of the Time*, 5 = *Always.*

Descriptive statistics were also produced for participants' scores on the other instruments used in this study. To further examine the scales used for comparison to the SCBS, reliability analysis for each scale was conducted using Cronbach's alpha. Table 2 shows descriptive statistics (mean and standard deviation) for participants and reliability analyses on Distress, Competence, Well-being, and Burnout.

Table 2

Descriptive Statistics and Reliability for Distress, Competence, Well-being, and Burnout

Instrument	*M, SD*	*alpha*
Distress	170.34, 58.62	.82
Competence	17.94, 2.16	.88
Well-being	46.54, 5.46	.84
Burnout Subscales	EE = 24.20,7.94 DEP = 14.86, 5.94 PA = 49.96, 7.42	.84EE, .79DEP, .87PA

Exploratory Factor Analysis and Reliability Analyses of SCBS.

In pursuance of exploring the underlying factor structure of the SCBS, an exploratory factor analysis was conducted. I used a principal components analysis with a Varimax rotation and excluded coefficients with an absolute value of less than .40. It is argued that suppression of coefficients at .40 provides more clarity in detecting non-significant loading (Yong & Pearson, 2013). The results indicated 14 factors accounting for a total of 64.86 variance observed. The 14-factor model had 11 items that did not load. More, 6-factors had a maximum of 2 item loading. Previous self-care models focus on 3 or 4 factors (Myers et al., 2004), hence I conducted a forced three-factor extraction and found a better model fit. On the three-factor model, the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy revealed a value of .78, indicating sufficient items for each component at a p-value <.001. Results of the exploratory factor analysis with a forced three-factor extraction can be seen in Table 3.

Table 3.
Initial Eigenvalues

	Total	% of Variance	Cumulative %
1	5.17	25.87	25.87
2	1.99	9.97	35.836
3	1.68	8.38	44.216

The first factor had an eigenvalue of 5.17 and explained 25.87% of the variance. The second factor had an eigenvalue of 1.99 and explained 9.97% of the variance. The third factor had an eigenvalue of 1.68 and explained 8.38% of the variance. Collectively, these three factors explained 44.22%. A total of 9 items loaded on to Factor 1, 6 items loaded on Factor 2, and 4 loaded on Factor 3. Therefore, a total of 19 items remained for further testing and 29 items were eliminated. Table 4 shows the factor model loading of each item (N = 19).

Table 4

Three-Factor Model Loading for Factor Analysis with Varimax Rotation of SCBS Items

Item	Factor 1	Factor 2	Factor 3
1. Spend time with others you enjoy	.74		
2. Maintain deep interpersonal relationships	*.74*		
3. Stay in contact with important people	*.67*		
4. Seek out projects that are exciting or rewarding	*.66*		
5. Take time to chat with peers	*.58*		
6. Allow yourself to laugh	*.58*		
7. Quiet time to complete tasks	*.58*		

8. Seek out comforting activities	*.58*		
9. Be open to not knowing	*.42*		
10. Eat healthy		*.77*	
11. Exercise		*.72*	
12. Spend time in nature		*.58*	
13. Medical care		*.56*	
14. Take vacations		*.51*	
15. Time off		*.48*	
16. Pray/Meditate			*.76*
17. Connect with spirituality			*.74*
18. Contribute to causes			*.66*
19. Advocate			*.56*

In order to establish adequate internal consistency for the SCBS, a Cronbach coefficient alpha was used to demonstrate reliability. Using all 19 items of the SCBS to represent the construct of self-care, an acceptable internal consistency (*alpha* = .83) was obtained. In reviewing the Item Total Statistics, I noted that deleting any of the items would not significantly improve the internal consistency. Thus, I retained all 19 items.

SCBS Reliability. Results of the reliability of the SCBS demonstrated high reliability, supporting the hypothesis that the instrument would exhibit adequate internal consistency for the construct of self-care with psychology doctoral trainees. Cronbach's alpha was found to be .83. This value reflects excellent reliability as it exceeds .80 and represents sound internal consistency. Comparatively, it is much larger than a Cronbach alpha of .60 desired for

acceptable instrument reliability. All items of the SCBS retained meet high standards needed to establish strong reliability. Cronbach's alpha would not significantly increase if any of the 19 scale items were removed. For instance, had the item "Pray/Meditate" been removed Cronbach's alpha would increase from .825 to .826. Likewise, the biggest decrease from .825 to .808 in alpha would have occurred had the item "Seek out comforting activities" been removed. Given these points, all 19 items appear to contribute to the measurement of the overall construct of self-care regardless of factor loading in the exploratory factor analyses.

Self-care showed negative correlations with competence and emotional exhaustion, and a significant positive correlation with personal accomplishment. It is important to note that despite these findings being statistically significant, the relationships between self-care and other variables are weak. These findings support that self-care is measuring a distinct construct from the other variables. The presence of relationships above .30 between flourishing, personal accomplishment, and competence demonstrates a relationship while the strength of the correlation is considered moderate. It is important to note that none of the significant variable correlations reached a level near 1.0, which would indicate indistinct variables. This could provide an additional way to assess this area of competence.

Bivariate Correlations

Findings of Pearson correlations between self-care and well-being, competence, burnout, and distress scores provide initial evidence of convergent validity with correlations that significantly differ from 0 and demonstrate moderate relationships between variables. Particularly, positive correlations were found between well-being (flourishing) and personal accomplishment (MBI), competence and well-being at strengths greater than .30.

More, these findings help establish sufficient discriminant validity, as these variable correlations demonstrated minimal to no relationships (defined as relationships below an absolute value of .30). Significant correlations with self-care did not reach past a minimal relationship (highest correlation found was .18 between self-care and personal accomplishment). This is further evidence that self-care is capturing a construct distinct from well-being, competence, burnout, and distress. Table 5 shows bivariate correlations.

Table 5
Summary of Intercorrelations for Scores on Self-Care, Well-being, Burnout (D, EE, PA), Distress, and Competence

Variable	1	2	3	4	5	6	7
1. Self-Care	--	.02	-.10	-.13*	.18**	.08	-.12*
2. Well-being	--	--	-.24**	-.25**	.42**	-.26**	.38**
3. Burnout (D)	--	--	--	.68**	-.32**	.24**	-.22**
4. Burnout (EE)	--	--	--	--	-.35**	.28**	-.16*
5. Burnout (PA)	--	--	--	--	--	-.13*	.25**
6. Distress	--	--	--	--		--	-.21**
7. Competence	--	--	--	--	--	--	--

Note. *$p < .05$, **$p < .01$

All in all, the SCBS demonstrated sound internal consistency of 19 items. Support for discriminant validity tests was fully supported by the results. Convergent validity was supported in the analyses. Hence, the results appear to establish validity for the SCBS instrument as a whole.

In addition to creation and validation of the SCBS, this study also sought to answer the following hypotheses:

RQ1. Does a significant relationship exist between self-care, competence, and wellness?

A significant negative correlation was found between self-care and perceived competence, $r = -.12$, $p < .05$. A significant correlation was not found between self-care and wellness. This may indicate that reported frequency of self-care as a process can reduce competence when not sufficiently implemented.

RQ2. Does a significant relationship exist between global self-care mean scores and burnout subscale mean scores?

As expected, a significant negative correlation was found between global self-care and Emotional Exhaustion on the MBI, $r = -.13$, $p < .05$. Also, a significant negative correlation was found between global self-care and Depersonalization. The correlation was observed as $r = -.10$, $p < .05$. Finally, a significant positive relationship between Personal Accomplishment and self-care was found, $r = .17$, $p < .01$. This may indicate that reported frequency of self-care implementation may reduce burnout. Specifically, higher personal accomplishment may lead to more engagement in self-care practices.

Summary of Results

It was hypothesized that self-care would be more strongly related to well-being, competence, burnout, and distress. Surprisingly, a significant negative relationship was found between self-care and competence ($r = -.12$). However, the observed strength was less than .30 which indicates a weak correlation. From a developmental perspective, perhaps participants in this study may not have been in graduate training long enough to establish a sense being competent, as the majority (56.7%) of the participants were at the “readiness for practicum” level.

In reviewing the burnout scale, the scores on the depersonalization and personal accomplishment subscales revealed significant weak correlations with self-care in this study. A sum score greater than 12 on the depersonalization subscale would represent an individual who is experiencing high levels of burnout in this area. Participants in this sample had a mean sum score of 14.86 with a standard deviation of 5.94 on this subscale. Possibly, participants in this sample are more likely to endorse feelings associated with depersonalization as they are becoming newly acquainted with training at the doctoral level. This possibility is likely given that many of the participants were in the beginning of their training during time of data collection. A significant weak positive relationship was found between personal accomplishment and self-care. A sum score of 33 or less highlights the possibility of burnout in this area. For this sample, a mean sum score of 49.96 with a standard deviation of 7.42 was reported. This may indicate that individuals are more willing to endorse accomplishment due to their trainee status. Possibly, the competitive nature in graduate training may foster individuals' endorsement to over report in this domain. Also, the majority of this sample did not have professional experience working with a master's degree, which may point to the lack of self-care practices and development of burnout.

Although significant relationships were found between global self-care, perceived competence, and burnout the strength of the relationships are considered weak, as they are less than a .30 absolute value. A successful observation of discriminant validity is present as a result of the weak relationships found between variables studied. This means that all instruments employed in this study measure theoretically dissimilar constructs. The presence of convergent validity can be found in the moderate to strong relationship between theoretically similar

concepts, in this study, for example endorsement of perceived competence, personal accomplishment and well-being.

Post Hoc Analyses

Independent samples t-tests. As a result of hypothesis testing, I decided to further examine information related to differences observed across the developmental trajectory and endorsement of self-care behaviors. Hence, I conducted an independent samples t-test to compare each group's reported global mean self-care score. Results revealed that trainees did not significantly differ between the three developmental groups readiness for practicum (M = 58.50, SD = 8.36), readiness for internship (M = 59.49, SD = 8.70), and entry to practice (M = 59.05, SD = 9.90) with an F statistic of .31 and p = .73.

Additional demographic variables were tested using t-tests to detect differences in self-care practice frequency. A between-subjects ANOVA was conducted with self-care differences with age, marital status, caring for dependents, practice area, program type, and master's degree holders. The analyses with these variables did not reveal a statistically significant difference. However, mean differences were detected between levels of SES, where higher self-care practice scores were observed for those who identified as upper or upper middle class. These results may indicate that those with access to more resources practice self-care more so than others.

Conclusion

Results of the reliability analysis and correlations related to self-care behaviors one of the hypotheses tested in this investigation. Adequate internal consistency for the SCBS was demonstrated with a sample of doctoral level trainees. More, construct validity of the SCBS was established with presence of both convergent and discriminant validity. Particularly, convergent

validity was established via comparisons of self-care with well-being. Self-care had weak correlations with all other variables in this study, which established discriminant validity. Exploratory factor analysis revealed self-care being composed of three distinct underlying factors. Finally, post-hoc analyses did not support a difference in self-care behaviors between the three developmental groups of trainees in this study.

The next chapter will provide a more in depth summary and offer conclusions based on the findings in relation to previous self-care research. Finally, study limitations and recommendations for future research related to the topic of self-care will be discussed.

Chapter 5: Discussion

Introduction

This chapter will review the purpose for conducting this study and subsequent findings related to the research hypothesis. Additionally, this chapter will incorporate the studying's results with previous research findings. The main objective of this study was to create and validate a measure for self-care practice to use with doctoral trainees. This correlational design identified relationships between self-care and burnout (MBI-HSS; Maslach et al., 1996), perceived competence (PCS; Williams & Deci, 1996), well-being (FS; Diener & Biswas-Diener, 2010) and personal/professional distress (Barnett & Carter, 2014).

The beginning with this discussion, each component of the three-factor self-care model is examined. Following is a summarization of the correlations between the variables of this study. Lastly, this chapter presents the study's limitations, implications, and directions for future research.

Interpretation of Findings

Self-Care Factor Analyses

Consistent with the conceptual literature on self-care, engagement with others has been highlighted as important for functioning (Norcross & Guy, 2007). Maintaining adequate work-life balance with a support system outside of work, has empirical support as shown by Stevanovic and Rupert (2004). Factor 1, explaining 25.87% of the variance, had a 9 item loading. These items reflected the cognitive-emotional/relational domain. Themes found on these items include social support, interpersonal interactions, and using humor as behavioral strategies for self-care. Examples of items found in Factor 1 are "Maintain deep interpersonal relationships" and "Allow yourself to laugh". Overall, a total of 4 items on Factor 1 seem to

relate to the relational aspect while the remaining 5 items seem to reflect a cognitive-emotional aspect. In the present study, personal accomplishment (engagement) was positively related to self-care which further supports this factor. Social support at work has been shown as related to personal achievement (Rupert & Kent, 2007). Overall, this factor reflects the importance of engaging in meaningful activities and maintaining connections with others in both professional and personal life as a form of self-care.

Previous literature has focused on the importance of daily self-care practices to maintain one's self (e.g. Baker, 2003; Norcross, 2000; Wise et al., 2012). The second factor that emerged included 6 items and accounted for 9.97% of variance observed. Factor 2 seemed to reflect the physical aspect of self-care by taking steps to self-regulate in order to maintain a healthy balance. Examples of these items include "Eat healthy" and "Take vacations". Three of these items involved taking time away from work and three reflected daily steps (diet, exercise, medical care) to maintain one's self. The items on this factor represent some overall practices which can be used to promote and

maintain healthy self-care. In sum, the items on this second factor, physical items, appear to highlight the importance of maintain physical and mental healthy for well-being.

Lastly, support was observed for a spiritual aspect of self-care. The third factor accounted for 8.38% of variance observed with a 4-item loading. Themes across these items include engaging in mindfulness practices and engaging in activities for the greater good. For example, items on this factor are "Connect with spirituality" and "Contribute to causes". The spiritual aspect is an important component of self-care and is observed across models of wellness (Carroll et al., 1999; Myers et al., 2000). These items reflect both professional and personal

aspect of self-care, which highlight the importance of engaging in self-care in both domains as helpful for overall functioning.

Validity Analyses

To assess the validity of self-care components convergent and discriminant validity were examined. Typically, convergent validity of a measure is examined through assessment of the relationship between the created measure and theoretically similar measures. Since another validated self-care measure does not exist, convergent validity was examined thorough the relationship between well-being, burnout, distress, and perceived competence. Correlations between self-care, burnout, distress and perceived competence were observed as significant. However, the strength of the relationships was weak across correlations. Interestingly, self-care failed to positively correlate with perceived competence as hypothesized. This might be due to the work overload and consistent challenge to maintain adequate self-care. Given that self-care involves many aspects of one's personal and professional life, one might expect stronger relationships between constructs especially self-care and well-being. Future research should explore other constructs found in the literature to detect convergent validity with self-care.

Discriminant validity between self-care and burnout was examined. Notably, examination of the correlated correlation coefficients to the discriminant validity measure (burnout) were stronger than those with the convergent measures. This may be due to the nature of how the self-care items were constructed using positively worded statements and the burnout scales using negatively worded statements. Another possibility is the use of Likert ratings for both self-care and burnout, versus open-ended rating scaling. Depending on the respondent's self-awareness, perception of well-being may be reported differently. The results of both

convergent and discriminant validity analyses indicate that self-care was being measured as a separate construct, which is important in the validity and utility of the created measure.

Post-hoc analyses

In light of the developmental aspect to this study, post-hoc analyses were conducted to compare mean differences across training levels. Using the number of semesters in practicum, I created groups representative of the three developmental levels as defined in the Competency Benchmarks document to examine burnout and self-care. I created cutoff scores for each of the levels where "readiness for practicum" was assigned to those who reported up to 3 semesters of practicum, 4 to 7 reported semesters of practicum as designated as "readiness for internship" and finally, 8 to 11 semesters of practicum was defined as "entry to practice". Surprisingly, when comparing readiness for practicum, readiness for internship, and entry to practice levels of training no significant differences were found for self-care or burnout. This possibly may be a sign of the nature of gradual complexity and autonomy, where each stage produces its own set of challenges to the trainee. For instance, trainees' entering internship may experience the same levels of distress due to transitions as a trainee entering a doctoral program. The transitions may move the trainee to be more focused on the transition and unable to balance self-care. As each trainee is rated across all competencies, participants might have responded according to their formal evaluations on their training progress.

As for the burnout scores, it could be an overall attitude reflected by the sample to underreport emotional exhaustion and depersonalization symptoms of burnout and over report perceived competence, well-being, and personal accomplishment. Contrary to findings from this sample, research suggests those newer to the field tend to struggle more than older or more experienced professionals with prioritizing self-care and maintaining healthy work/life balance

(Connolly & Myers, 2003; Coster & Schwebel, 1997; Grafanaki et al., 2005; Sherman & Thelen, 1998). This might be related to the novelty of this study focusing on doctoral trainees versus professional psychologists. Messick (1995) states that context is important and specific to the population being study, thus making validity an ongoing process. Given that trainees are constantly being evaluated, it seems logical that trainees would underreport symptoms associated with burnout as it might result in negative consequences to training progress. Finally, for interpretation of these scores, it is important to understand that burnout can be a situational and dynamic process. Hence, evaluation of competence should be longitudinal.

Limitations of the Study

As with all research, this study has several limitations to consider. One limitation of the current study is the correlational nature of the research design. Therefore, tentative predictions can be made using correlations however definitive conclusions regarding causation cannot be stated. All measures used in this study are self-report measures and subjected to response bias. Intentional or not response bias might be employed to self-protect responses to questions related to experiences of self-care, burnout, well-being, and perceived competence. Considerations of response bias are important to note considering this study sought to validate a self-care instrument. The validity of the created instrument could be challenged due to inaccurate or biased endorsements from participants. Also, social desirability might have affected the way participants responded in this study (Crowne & Marlowe, 1960).

In the same fashion, participants' response bias may be seen in their perception versus reality of self-care behaviors. For example, one participant might read the item "Exercise" based on their own experience of attending the gym 5 days per week, therefore endorsing a "3" for frequency of that practice. Likewise, another participants might read the item "Exercise" and

endorse her or his agreement that it is an important practice for self-care, yet not truly practice the behavior. The absence of a time anchor for counting items (ex. "In the past two weeks…") may have produced response bias. Without the time anchor, participants may have reflected on their own self-care behaviors in any range of time. Consequently, the expectation that participants all read and interpreted each item in the exact same way was impossible.

This study was also limited by the sample characteristics. To make more definitive conclusions regarding self-care behaviors with doctoral level trainees across the developmental trajectory additional research is needed. As this study had a large sample, the majority of subjects reported being at the beginning of their training. Given the convenience sampling strategy used to reach current clinical and counseling doctoral trainees, the generalizability of this study may be restricted to this population. Sample distribution characteristics were not balanced. The gender variable was not collected with the data and was separately coded according to first name created limitations. The coding did reveal gender distribution equivalent to what is represented in the field of psychology. Sample participants mostly represented the Midwest region, in their first year of training, and were in a counseling (versus clinical) program.

Another possible limitation may be in the advertisement of the study using online methods. Advertisement of the study was made via CCPTP and personal invitation to clinical programs across the country. The inability to recruit via APAGS and APPIC listservs, this sample may not be fully representative of clinical and counseling doctoral students across the country. Those who have additional IRB requirements to recruit students may not have received the distributed advertisement.

Finally, it should be noted that measurement error could be accounted for as instrument reliability was less than 1. The inattention to other variables that may play a significant role on

self-care implementation could account for the weak correlations. The roles of compassion fatigue, resilience, and mindfulness training have been highlighted in previous self-care literature with helping professionals, however not with the target population of this study. As well, supervisors, advisors, and faculty mentors should be considered as they may play a role in self-care practices.

Recommendations for Future Research

This study highlights the importance of engaging in self-care behaviors in order to avoid potential burnout and other unintended consequences. Future studies of self-care should be conducted using the SCBS and should incorporate additional psychometric evaluation. Psychometric validation of the distress measure is needed for future use. Additional items may need to be written to explore and understand any latent factors that did not fit the 3-factor model. I recommend that all 19 items be retained in future research as adequate reliability and construct validity was demonstrated with the SCBS. Additional information is needed to understand how these items are related to each other.

Future researchers should seek to examine how self-care relates to other variables of interest such as well-being, burnout, competence, and so forth. It would be important to understand how these named variables (and others) relate to underlying elements and overall self-care practice. More, construct validity for each of the underlying factors should be established. Therefore, trainees need to be evaluated with fairness through incorporation of more than one measure for competence in this domain. As stated, self-care is a competency packaged with reflective practice and self-monitoring which means that all three distinct skills need to be assessed in order to determine a trainee's demonstration of these behaviors.

Another suggestion is to recruit more racial-ethnic minorities and males to test for group differences. Along the same lines, recruitment should be focused on targeting potential participants at more advanced levels of training. The generalizability of the findings may improve should these efforts be accomplished.

In conclusion, future research could use the SCBS to study self-care practices with doctoral trainees. For example, one might be interested in understanding the role of self-care in how a trainee copes with specific challenges specific to the training trajectory (e.g. transitioning between training levels). More, future investigations could help explain how to maintain boundaries for using self-care as a way to self-preserve versus self-indulge. Future research may use the SCBS instrument as a tool for evaluation of wellness promotion in graduate training.

Implications

The development of a valid instrument to measure doctoral trainees' practice of self-care is beneficial in several ways to the field of psychology. An important contribution of this study is that it extends the previous literature and provides a useful tool for future research on self-care. Studying self-care reminds us that it is a necessity for all people to flourish, especially those offering mental health services to the general public. Specifically, mental health service providers must maintain an outward focus, which may decrease the attention spent on the self as an effective tool (e.g. Skolvolt et al., 2001; Witmer & Young, 1996). Scholars argue self-care is an ethical duty of psychologists as a safeguard against burnout or unintended negative outcomes (Barnett et al., 2007). In calling attention to this core competence, we may improve trainees' ability to provide adequate clinical practice.

Previous research has shown that those with less experience or younger may not exercise self-care adequately (e.g. Grafanaki et al., 2005; Maslach et al., 2001), hence training is a prime

time to pay due attention on cultivating the skill of self-monitoring and self-regulation to maintain healthy practice. It has been noted that self-care has not been widely incorporated into training programs (Barnett & Cooper, 2009). Training models are needed to promote adequate implementation of self-care and work-life balance, as this has been an identified area that is not currently being addressed in training programs (Barnett et al., 2007). It is essential that trainees understand the importance of self-care, as well as, how and when to implement practice. Similarly, as stated, those with more experience or older tend to practice adequate self-care, modeling or mentorship may be helpful to trainees in training programs, internships, and entering professional practice. The proposed communitarian approach (Johnson et al., 2014) may be useful for trainees and professionals to maintain dialogue about self-care and promotion of ethical practice.

As previously stated in this paper, training programs and clinical supervisors are in the unique position to have a profound impact on the development of trainees' beliefs and practice of self-care. All parties involved in the development of a competent psychologist should encourage ongoing self-reflection on self-care as it relates to personal and professional well-being. Likewise, efforts should focus on assisting students to make informed decisions about ethical responsibilities around self-care and its importance to overall healthy functioning.

As noted by Bamonti et al. (2014), students receive encouragement as the main method of infusing self-care into training. Fortunately, the validation of the SCBS in this study can be used to measure changes in self-care practices as a result to implementation of self-care infusion into training curricula. Training programming dedicated to fostering trainee growth and development in this foundational competency could allow for substantial decrease in burnout and promote healthy well-being. Such training programming might include offering workshops,

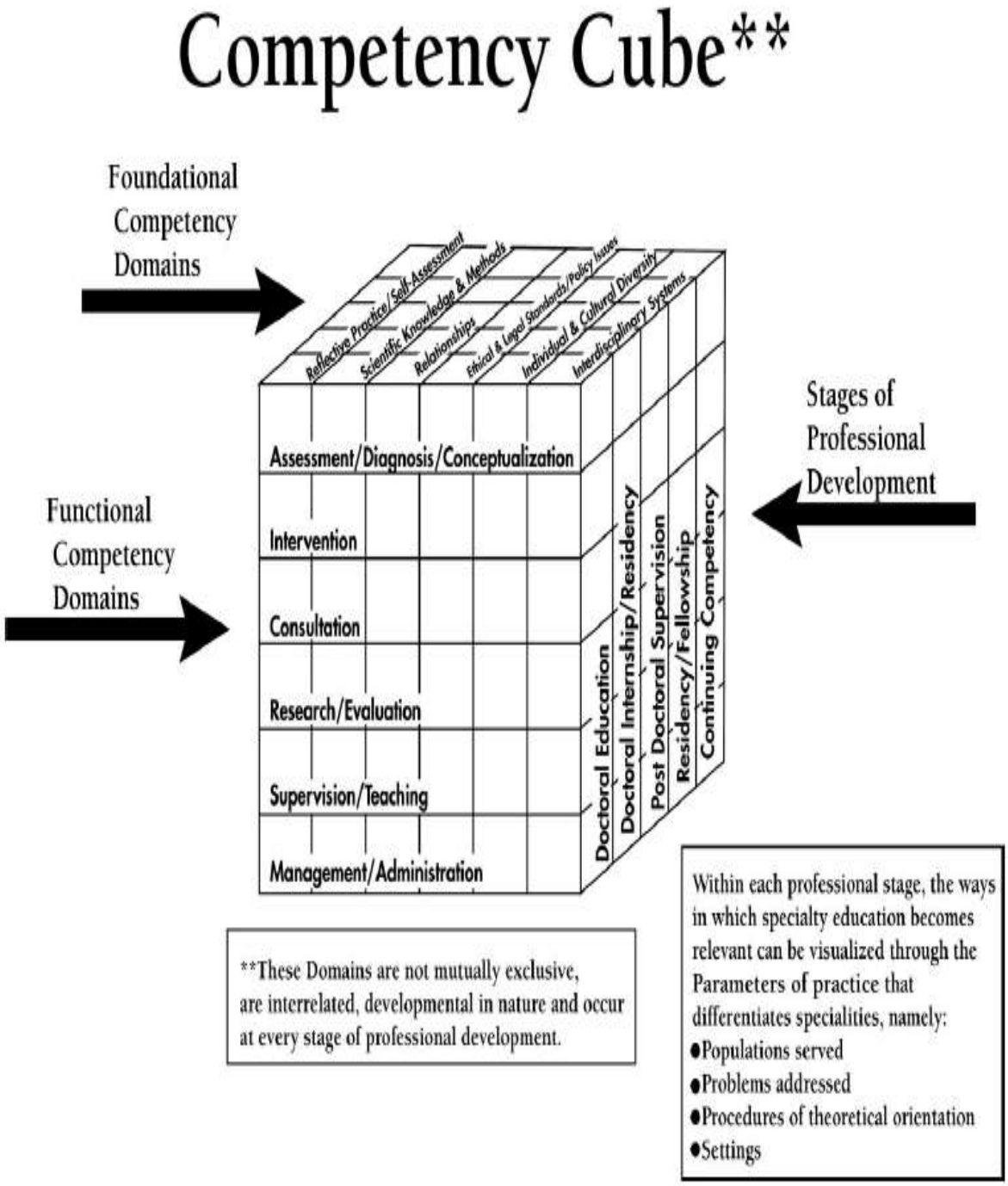
specific courses, or brown bag discussions on the topic of self-care for students. With this is mind, the integration of self-care into training curricula might lead to increased awareness of one's competence and ethical duty in this domain.

Conclusion

As developing mental health service providers, it is essential that trainees practice adequate self-care in order to provide quality care to clients. The importance of engaging in self-care practices to safeguard against burnout should continually be emphasized during training and beyond. The current study established a reliable and valid measure to capture the frequency of engaging in self-care behaviors. It is my hope that the SCBS will be used in future research, training programs, clinical practicum, and internship settings as a tool to raise awareness of the ethical imperative and core foundational competence of professional psychology. This study served as a gateway to advancing our knowledge of self-care as a field and provides an excellent be used for future empirically based research, training, and practice.

Figure 1

The Competency Cube model (Rodolfa et al., 2005)



Note. The original 12 competencies are included in this figure.

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Appendix A: Clinical/Combined Programs Solicited Via Personal Invitation

American University
Adler University - Chicago
Northern Illinois University
Southern Illinois University Carbondale
Indiana University - Bloomington
University of South Alabama
Utah State University
James Madison University
University of Virginia
Wisconsin School of Professional Psychology
La Salle University
Carlos Albizu University, San Juan Campus
Marshall University
Regent University
Philadelphia College of Osteopathic Medicine
Indiana University of Pennsylvania
Chestnut Hill College
Long Island University, C.W. Post Campus
George Fox University
Xavier University
Roosevelt University

Appendix B: Pilot Feedback on Initial Self-Care Practice Items

ITEM	COMBINED FEEDBACK	REVISED ITEM
MAKE TIME FOR SELF REFLECTION	**Good but generic* **Provide definition/examples (x7)* **Self-reflect on what? (work life balance, client work)* **Vague*	**Engage in self-reflection on clinical practice and professional development**
HAVE YOUR OWN PERSONAL PSYCHOTHERAPY	**Specify seeing a therapist rather than making it seem that you're counseling yourself (x4)* **The wording is a bit odd.* **Definitely related to self-care.* **Seems more related to access to resources, may not be option for all.*	**See a therapist**
WRITE IN A JOURNAL	**Specify personal journal. Could be interpreted as academic* **Add personal blog*	**Keep a personal journal or blog**
READ LITERATURE UNRELATED TO WORK	**May word it as "read for pleasure"* **This item is straight forward* **Literature like research articles, or does it mean books you're interested in?*	**Read for pleasure**
DO SOMETHING AT WHICH YOU ARE NOT EXPERT IN CHARGE	**Unclear-- context unspecific, provide example (x8)* **Graduate students do not feel like experts or in charge most of the time, so it's hard t know what we are comparing this against*	**ELIMINATE ITEM**
DECREASE STRESS IN YOUR LIFE	**Examples needed.* **Improve by stating something like "actively trying"* **This is a biased question for trainees.*	**Engage in stress reduction**
LET OTHERS KNOW DIFFERENT ASPECTS OF YOU	**Do you mean qualities, interests, hobbies? (x3)* **Who are others?* **I know what's being asked but the wording is odd* **Suggestion: Allowing or Letting others get to know you deeply, Expression of self in unconventional way*	**Maintain deep interpersonal relationships**

Notice your inner experience—listen to your thoughts, judgments, beliefs, attitudes, and feelings	**Suggestion: Attend to thoughts, belief, and emotions, Meditation* **I think that having an item like this is important, but I was wondering if it might be construed as rumination, if taken too far. Ruminators might score high on this item and not for the reason you intended.* **Does this speak to spirituality?*	**Practice mindfulness**
Engage your intelligence in a new area, e.g. go to an art museum, history exhibit, sports event, auction, theater performance	**I am not sure going to an auction, sports event, or theater performance is really engaging my intelligence. Rather, it's quite the opposite.* **This item is straight forward.* **Good, very related.*	**Attend a special event of interest**
Practice receiving from others	**I have no idea what this is asking for.* **Unclear as to how on practice this and what types of things qualify as receiving (x2)* **This is an odd question.* **This item is straight forward.* **Receiving what exactly?* **Be more specific, receiving physical support, emotional support, etc* **I read this more to mean allowing yourself to be taken care of or having your needs met by others.* **A little vague…is it asking for help?*	**Ask for help when needed**
Be curious	**Doesn't seem necessary to ask* **Seems redundant with other questions* **I'm curious both curricular and non-curricular activities. Personally, it is unrelated to self-care.* **I was very confused by this item and its relationship to self-care.* **In relation to what? How?* **Suggestion: Explore new things*	**ELIMINATE ITEM**

Say "no" to extra responsibilities sometimes	**May want to remove the sometimes as the scale already includes frequency ratings (x2)* **Good, related. (x2)*	**Say "no" to extra responsibilities**
Spend time with others whose company you enjoy	**Good, straightforward*	**Spend time with others whose company you enjoy**
Stay in contact with important people in your life	**I am not sure if there was one that suggested recognizing when relationships are not helpful* **Good*	**Stay in contact with important people in your life**
Give yourself affirmations, praise yourself	**Good, straightforward*	**Give yourself affirmations, praise yourself**
Love yourself	**Generic but goes along with "give affirmations"* **Unclear that this is related to self-care per se. A person might be very good at self-care but not love him/herself.* **Seems vague* **Examples needed* **This one made me roll my eyes. Almost all of the other items are behavioral expressions of love/concern for self.* **It just seems so general when other items are more specific. That might be ok – but it seems a little harder to evaluate.*	**ELIMINATE ITEM**
Re-read favorite books, re-view favorite movies	**Why re-read or review. Seems odd.* **Fair* **Realistically, grad students do not have this time ☺*	**Read or watch favorite movies and books**
Identify comforting activities, objects, people, relationships, places and seek them out	**I think this is a good and sound measure.* **Is the first part necessary? Could just be seek out those items, you've obviously identified them if you're seeking them out*	**Seek out comforting activities, objects, people, relationships, places**

Allow yourself to cry	**Lord knows I do this a lot.* **May want to either re-phrase this or have a separate item assessing how often someone has a desire to cry as well, so more important information can be captured* **This may be related to self-care or maybe not.* **I tend not to cry. Though sometimes it's cathartic; it's just not something that comes natural to me, so I don't see it important to my self-care.* **This item is clear and is more related than unrelated, but for some reason this make me uncomfortable.*	**Allow yourself to expression emotion**
Find things that make you laugh	** Maybe instead of "find things that make you laugh," it's changed to "allow yourself to laugh" or something of the like.* ** Not sure if this is asking how often I happen to find things that make me laugh, or if this implies that I actively seek out specific things that I know will make me laugh* ** Not really "finding" things to make me laugh.* * Not sure I seek things out, just answered more about how much I end up laughing	**Allow yourself to laugh**
Express your outrage in social action, letters and donations, marches, protests	**Outrage is a really strong word, though.* **"Outrage" is a loaded word. Perhaps "engage in advocacy activities (e.g., letters, donations, marches, protests) for causes that are important to you)* ** The "and" is misplaced in the sentence. Also, this question would be better without the premise that it's an expression of outrage. Philantropy alone is self-care.*	**Engage in advocacy activities**

	** I can sort of see how this is related but does not seem to fit as tightly as the other items.* ** The word 'outrage' has some negative connotation that may be a little strong* ** Maybe instead of "express outrage" just "engage" in social action...* ** I express my outrage to friends and family...not sure if that's what you mean by social action.* ** I see that these are helpful and related, but for student trainees it may be a biased estimator due to lack of time.* ** I think this gets to engagement in social action. "Express your outrage" may be presumptive, as the feelings that lead to this activity can take many forms.*	
Spend time with nature	** hah no nature in Milwaukee* **could be unrelated for some people, what if you hate nature and love staying in and watching netflix*	**Spend time in nature**
Find a spiritual connection or community	**Spiritual connection or community meaning a religious of spiritual group?* **Maybe 'spend time in' instead of 'find'* ** I am not spiritual so this didn't apply to me and I'm not sure what finding community would mean*	**Connect with spirituality**
Be open to inspiration	**Does this mean artistic inspiration? Academic inspiration? If it is academic inspiration, I'm not sure that would count as self-care.* ** This is vague. (x2)* * Isn't everyone "open" to be inspired? I'm not sure whether this is a conscious choice. **Could be more related than unrelated, but I am having a hard time conceptualizing what kind of inspiration I should be open*	***Activate creativity and imagination**

	towards. **Suggestion: openness to new experiences?*	
Cherish your optimism and hope	* Good, still a little vague * I'm a little confused as to what cherishing optimism and hope would look like. * Again, more related than unrelated, but these more abstract kinds of behaviors are slightly more confusing. * Is this referring to acknowledging optimism and hope? * Does this get at whether a person cherishes personal qualities more generally? Maybe a more general statement might be useful.	**Maintain optimistic outlook**
Be aware of nonmaterial aspects of life	**Be aware, or appreciate? (x2)* **"Non-material aspects of life" is very vague. I wasn't really sure what was meant by this, so some examples or further explanation would be helpful.* **very buddhist, may be leading question* **being aware is different from taking advantage of nonmaterial aspects* **I assume you mean things like support and love from friends, though it's somewhat unclear.* **Perhaps provide an example.* **This item seems unclear to me, although it seems like it could be related if I could understand the item better. I might like to see this in a less abstract form, such as appreciating experiences, loved ones, etc.* ** I'm not sure what you mean here.* ** I think this gets at whether a person considers nonmaterial aspects of life, like values perhaps.*	**ELIMINATE ITEM**

	Maybe the item can be clarified by defining nonmaterial aspects life.	
Try at times not to be in charge or the expert	* Again, I'm not sure what this is trying to get at or what it is asking *Fair * Not sure how this is relate to self-care * This seems too much like a very similar, previously presented item. * Is this referring to letting others take command so load is off of you?	**ELIMINATE ITEM**
Be open to not knowing	**Good*	**Be open to not knowing**
Identify what is meaningful to you and notice its place in your life	* None (I guess this goes back to my earlier statement of identifying toxic relationships/situations)	**Create two items: -Identify what is meaningful to you and its place in your life -Identify toxic relationships**
Meditate	**Good*	**Meditate/Pray**
Pray	**Good* ** I'm not religious so this would be a "none" answer for me.. completed unrelated to my well-being* ** May be related for some people, but not for not religion/not spiritual people.*	**(Combine with item above)**
Sing	** I have a horrible singing voice. Though I play instruments and that is related to my self-care* *This makes sense, but I don't know why this behavior is related to self-care, unless it's as an expression of creativity, in which case there could be several expressions of creativity listed in its place.* **I think it's related for some--but some people might not honestly enjoy singing. :)* ** Some of these behaviors may not be at all related to self-care for some people.*	**ELIMINATE ITEM**

Experiences of awe	** How is this different from being inspired, and also, this is just and odd measure.* ** This is similar to the inspiration questions. It's a bit too ambiguous.* **What exactly is awe? Maybe define awe.* **I really didn't understand this item.* **Awe could be wonderment, surprise, shock- all of which could be both positive and negative.*	**ELIMINATE ITEM**
Contribute to causes in which you believe	**This item is straight forward.*	**Contribute to causes in which you believe**
Read inspirational literature (talks, music, etc.)	**I don't think this matters* *"Inspirational literature" immediately makes me think of religious inspiration. Phrasing such as "Read literature that inspires me" would sound less loaded to me.	**Read literature that inspires me**
Take a break during the workday (e.g. lunch)	**Good (x2)* **Watching a funny video could be another example*	**Take a break during the workday (e.g. lunch)**
Take time to chat with peers or co-workers	*might want to specific non work-related chats * though--a sub-part of this survey could also have people indicate whether such breaks are possible. or encouraged. it think work culture can interfere. or even to evaluate whether someone feels that taking breaks are encouraged/allowed, etc.	**Take time to chat with peers or colleagues**
Make quiet time to complete tasks	*Good *This item is straight forward.	**Make quiet time to complete tasks**
Identify projects or tasks that are exciting and rewarding	*good, but maybe instead of identify you should look at "seeks out projects that are..."	**Seek out projects or tasks that are exciting and rewarding**
Set limits with your clients and colleagues	**Need to know what you mean by limits. Personal limits? Work limits?* **May want to make these separate*	**Maintain professional boundaries with colleagues**

	items; one for setting limits with clients, and the other for setting limits with colleagues	
Balance your caseload so that no one day or part of a day is "too much"	** yes--if this is possible. it might not be.* **Good*	**Balance your caseload so that no one day or part of a day is "too much"**
Arrange your work space so it is comfortable and comforting	** good and unbiased. Sometimes people look at whether you keep your work place neat, but for me, a messy workplace is normal and generally comfortable.* ** Maybe somewhat unrelated? I don't really care what my workspace is like, I'm more concerned that my living space is comfortable*	**Arrange your work space so it is comfortable and comforting**
Get regular supervision, advising, or consultation	* advising about what? * mostly with work * This is clear and related, but may be biased because supervision is required. * wasn't sure if this was meant in addition to what is required in our programs.	**Get additional advising or consultation for professional growth**
Negotiate for your needs with professors/supervisors	**Good* ** Is this needs related to workload? Time off? Assistance with projects? All of these?* ** this is great--but some practicum sites are better or more inviting than others.*	**Negotiate for your needs with professors/supervisors/peers**
Have a peer support group	** so... have friends?* ** Formal or informal? I assumed informal*	**Participate in a formal or informal peer support group**
Develop a non-trauma area of professional interest	** I think you need to clarify what "professional interest" means in this context.* ** Is this assuming that participants will do a lot of trauma work? Very little of my clinical practice is trauma-related.* ** What is a non-trauma area?* ** I'm not quite sure what this question is even getting at...*	**ELIMINATE ITEM**

	* *Why non-trauma? I don't think most people's main focus is trauma* ** Is this if trauma is your focus you should have also a non-trauma focus? Or is this saying only have non-trauma focus?* **I research kids with chronic illness does that count as a trauma area? I don't really think your area of interest is that important to self-care as long as you're engaging in the other self-care activities.* ** My focus is trauma, and I enjoy that.* ** I might reword this to say a non-clinician or non-practicing.* ** Not sure what this means. Is it: you don't have a clinical or research interest in trauma?* ** Not sure what this is assessing exactly. My interpretation is that the items assesses whether an individual has an area of professional interest that is not focused on pathology or is negative, and that instead focuses on positive aspects of the field (e.g., resilience). If that is what the item assesses, I am not sure that this is reflective of engaging in self-care necessarily. It may reflect that, but not necessarily. Seems more distal to self-care.* **Example?*	
Strive for balance within your work-life and workday	** This item is straight forward.* ** I didn't understand the difference between work-life and workday.*	**Strive for work-life balance**
Strive for balance among work, family, relationships, play and rest	**Good* **This item is straight forward.*	**Strive for balance among work, family, relationships, play and rest**
Eat regularly	**What does regular mean? (x2)* **Maybe add specific meals in addition to "Eat regularly." Meals*	**ELIMINATE ITEM**

	are often skipped to meet academic and professional deadlines (especially lunch) at the expense of self-care. **Maybe specify 3 meals per day*	
Eat healthy	**What does this mean?* **this one was clear* **Maybe specify vegetables, fruits, water, protein, little junk food*	**Eat healthy**
Get regular medical care for prevention	* Not sure what this refers to, like paps? *What does regular mean? *this one was clear.	**ELIMINATE ITEM**
Get medical care when needed	**Good question* **Clear*	**Get medical care when needed**
Take time off when needed	**Good question* **Clear*	**Take time off when needed**
Get massages	*Is this related * Not everyone uses massages for self-care * I might rephrase it to include other forms of pampering as well (i.e. manicures/pedicures, etc.)	**ELIMINATE ITEM**
Dance, swim, walk, run, play sports, sing, or do some other physical activity	* Singing not physical activity *This was clear *Good question	**Exercise**
Take time to be sexual with yourself, or with a partner	* I would reword this question: "take time to meet your sexual needs" or something like that to avoid the masturbation AND sexuality question. Some people have religious beliefs against masturbation, yet may have a healthy sex life. *Good question *Not sure if related	**Get sexual needs met**
Get enough sleep	* What's enough sleep? (x2)	**Get enough sleep**
Wear clothes you like	*Is there a better way to address this idea? *This one was clear. *Not sure what is meant here? *Not sure if related	**ELIMINATE ITEM**
Take vacations or day trips	*Good, clear	**Take vacations or day trips**

Make time away from telephones, email, social media	*This one was clear though some may argue that social media is their form of self-care. I wouldn't make an argument for it, but someone might. *Scheduled boundaries, maybe? *Good question	**Unplug from telephones, email, and social media**

Appendix C: Permission for Distress Scale

Re: Permission to use Distress Assessment
Jeffrey Barnett
Wed 11/4/2015 7:51 AM

Dissertation

To:Mercedes Santana;
Cc:Leigh Carter;
Hi Mercedes. Thank you for asking and it is my pleasure to provide this permission, noting this permission as you state below. I wish you all the best for success with your dissertation project. I would love to receive a copy of it when it is completed. Thanks and best wishes – Jeff

Jeffrey E. Barnett, Psy.D., ABPP
Associate Dean, Loyola College of Arts and Sciences
Professor, Department of Psychology

Humanities Center 236B
410-617-5382
Jbarnett@loyola.edu
www.loyola.edu

Appendix D: Research Participant Request

Greetings Doctoral Student,

I would like to invite you to participate in a research study focused on developing a psychometrically sound self-care practices tool for use with clinical and counseling doctoral students. Self-care has been theorized as related positively to wellness and negatively to burnout and impairment. This study seeks to gather information from the experiences of current clinical or counseling doctoral that have engaged in practicum. As a result of this study, I hope to better understand the utilization of self-care behaviors while establishing a sound self-report tool to assess doctoral students' use of self-care.

This study seeks to establish a valid and reliable self-report instrument to assess self-care, for future research, in addition to practical use in training doctoral trainees. In doing so, we also hope to explore the relationship between trainee self-care to overall wellness and engagement in doctoral training. Further research could explore the contributions of individual and systemic variables related to doctoral students' utilization of self-care.

If you choose to participate in this study, you will be asked to complete a 20 to 35 minute online questionnaire regarding your experience as a doctoral student. You will be asked to provide personal information in order to receive the participation reward. A separate survey will collect this information. Please note there is some risk that an unauthorized third party may find a way to circumvent our security systems or that transmission of your information over the Internet will be intercepted.

If you know of other current clinical or counseling doctoral students, please forward this research invitation to them. The like below contains further information about the study and will allow access to completing the online questionnaire.

SURVEY LINK HERE

After completion of the questionnaire, you will be rewarded with a $5 Amazon gift card as an appreciation of your willingness to help. Thank you for your time and consideration!

Sincerely,

Mercedes Santana, M.Ed.
Doctoral Student, Counseling Psychology
University of Wisconsin-Milwaukee

Appendix E: Consent to Participate

Title: Self-care Practices of Counseling and Clinical doctoral students
Person Responsible for Research: Mercedes Santana, M.Ed. under the supervision of Nadya Fouad, Ph.D., of the Department of Educational Psychology at the University of Wisconsin-Milwaukee.

Study Description: The purpose of this research study is to better understand the use of self-care practices for clinical and counseling psychology doctoral students. There is currently a lack of validated psychometric instruments to measure self-reflective practices, including self-care. The goal of this study is to create an instrument to better understand how doctoral trainees engage in self-care practices to maintain their ethical obligation. Approximately 250 subjects will participate in this study. If you agree to participate, you will be asked to complete a survey with questions relating to self-care, supervision utilization, burnout, well-being, and competence. This will take approximately 20-35 minutes of your time.

Risks/Benefits: Risks that you may experience from participating are considered minimal. There are no costs for participating. There are no benefits to you other than to further research in this area. After completion of the survey you will be rewarded with a $5 Amazon gift card. In order to issue your reward, a separate survey will ask for Amazon payment information (name and email). Collection of data and survey responses using the internet involves the same risks that a person would encounter in everyday use of the internet, such as breach of confidentiality. While the researchers have taken every reasonable step to protect your confidentiality, there is always the possibility of interception or hacking of the data by third parties that is not under the control of the research team.

Confidentiality: Identifying information such as age, gender, and type of graduate program will be collected for research purposes. Your responses will be treated as confidential and all reasonable efforts will be made so that no individual participant will be identified with his/her responses. The researchers will remove your identifying information after analyzing the data and all study results will be reported without identifying information so that no one viewing the results will ever be able to match you with your responses. Data from this study will be saved on a password-protected server for 5 years. Only persons responsible for this research (listed above) will have access to your information. However, the Institutional Review Board at UW-Milwaukee or appropriate federal agencies like the Office for Human Research Protections may review this study's records.

Voluntary Participation: Your participation in this study is voluntary. You may choose not to take part in this study, or if you decide to take part, you can change your mind later and withdraw from the study. You are free to not answer any questions or withdraw at any time. Your decision will not change any present or future relationships with the University of

Wisconsin Milwaukee. There are no known alternatives available to participating in this research study other than not taking part.

Who do I contact for questions about the study? For more information about the study or study procedures, contact Nadya Fouad, Ph.D. at nadya@uwm.edu.

Who do I contact for questions about my rights or complaints towards my treatment as a research subject? Contact the UWM IRB at 414-229-3173 or irbinfo@uwm.edu.

Research Subject's Consent to Participate in Research: To voluntarily agree to take part in this study, you must be 18 years of age or older. By signing the consent form, you are giving your consent to voluntarily participate in this research project. By entering this survey, you are indicating that you have read the consent form, you are age 18 or older and that you voluntarily agree to participate in this research study.

❍ I agree with the above statement and consent to participate in this study.

Appendix F: Demographic Questionnaire

Race/Ethnicity

- ❑ African-American
- ❑ Asian/Pacific Islander
- ❑ Latino/Hispanic
- ❑ Multiracial
- ❑ Native American/American Indian
- ❑ White
- ❑ Other

Age____

What region are you currently residing in?

- ❍ West
- ❍ Northeast
- ❍ Midwest
- ❍ Southwest
- ❍ Mid Atlantic
- ❍ South
- ❍ Southeast

Are you a first generation college student?

- ❍ Yes
- ❍ No

Are you an international student?

- ❍ Yes
- ❍ No

Marital Status

- ❍ Single
- ❍ Married
- ❍ Divorced
- ❍ Committed Relationship

Do you care for children at least 6 months out of the year?

- ❍ Yes
- ❍ No

Do you provide care for dependents other than your children?

- ❍ Yes
- ❍ No

Growing up, I would describe my family's socioeconomic status as...

- ❍ Upper Class
- ❍ Upper Middle Class
- ❍ Middle Class
- ❍ Working Class
- ❍ Poor

Have you completed a master's degree?

- ❍ Yes
- ❍ No

Please list the specialty of your master's degree (ex. social work, counseling). If you do not have a master's degree please enter "N/A". _____

Before entering doctoral training, how many years of professional work experience with your master's degree do you have? If you do not have a master's degree please enter "N/A".

_____

What type of doctoral degree program are you earning?

- ❍ PhD
- ❍ PsyD

What is your practice area?

- ❍ Clinical
- ❍ Counseling
- ❍ Blended

How would you describe your current student status?

- ❍ Full-time
- ❍ Part-time
- ❍ Predoctoral Internship

How many semesters of practicum have you completed as a doctoral student? (if in your first semester, please enter 1) _____

Please select the setting the best applies to your current practicum.

- ❍ K-12 School
- ❍ University Counseling Center
- ❍ Community Agency
- ❍ VA Medical Center
- ❍ Corrections Facility
- ❍ Medical Center/Hospital
- ❍ Group Home
- ❍ Other
- ❍ Private Practice
- ❍ Inpatient
- ❍ Intensive Outpatient Program
- ❍ Pre-practicum course

How many hours per week do you spend at practicum?

- ❍ None
- ❍ 1-10
- ❍ 11-20
- ❍ 21-30
- ❍ 30 or more

How many hours do you work for pay OFF campus?

- ❍ None
- ❍ 1-10
- ❍ 11-20
- ❍ 21-30
- ❍ 30 or more

Appendix G: Distress Inventory

Please rate the following items using a scale from 0-10. A "0" represents not distressing at all, and "10" represents the most significant source of distress.

	Rate
Coursework	
Dissertation/research work	
Internship search and application process	
Time management (coursework, meetings, jobs, etc.)	
Fulfillment of clinical requirements	
Practicum/Externship search and application process	
Student loans/financial constraints	
Competition among classmates	
Research or teaching assistant position	
Recent evaluation of your academic or clinical work	
Adjustment to a new location for graduate school	
Work with a violent client	
Limited clinical training and/or feelings of clinical incompetence	
Client endorsing suicidality	
Record keeping and documentation requirements for clinical work	
Professional organization/association responsibilities	
Return and/or adjustment to role as graduate student	
Adjustment to responsibilities, expectations, and environment of graduate program	
Potential emotional isolation of clinical work	
Challenges/conflicts in supervision	
Cohort/peer relation problems	
Demands of faculty and/or supervisors	
Professional challenges related to personal diversity	

Please rate the following items using a scale from 0-10. A "0" represents not distressing at all, and "10" represents the most significant source of distress.

	Rate
Romantic or marital differences	
Fatigue	
Guilt about not spending enough time with family/friends	
Pregnancy (emotional, physical, financial)	
Limited social outlets	
Illness or death of family member or friend	
Financial difficulties	
Balancing role as a parent	
Role as caretaker or provider for family member	
Geographic separation from social support	
Experience/management of personal mental or physical illness or disability	
Difficulty staying in touch with friends or family members	
Household chores or responsibilities (Daily upkeep, bills, etc.)	
Relational difficulties with parents, siblings, or other family members	
Personal health	
Marital separation/divorce	
Relocation: looking for a new place to live, buying a home, and so forth	
Personal life on hold during graduate school	
Balance of additional jobs/work outside of school	
Limited time to spend with romantic partner or spouse	
Inadequate time for exercise and/or leisure time activities	
Pressure from friends and/or family members to spend more time with them	

Appendix H: Self-Care Practices Survey

Using the scale below, rate the items in terms of your frequency utilization.
How often do you...?

	Never	Rarely	Sometimes	Most of the Time	Always
Eat healthy	❍	❍	❍	❍	❍
Get medical care when needed	❍	❍	❍	❍	❍
Take time off when needed	❍	❍	❍	❍	❍
Exercise	❍	❍	❍	❍	❍
Get sexual needs met	❍	❍	❍	❍	❍
Get enough sleep	❍	❍	❍	❍	❍
Take vacations or day trips	❍	❍	❍	❍	❍
Unplug from telephones, email, and social media	❍	❍	❍	❍	❍

How often do you...?

	Never	Rarely	Sometimes	Most of the Time	Always
Engage in self-reflection on clinical practice and professional development	❍	❍	❍	❍	❍
See a therapist	❍	❍	❍	❍	❍
Keep a personal journal or blog	❍	❍	❍	❍	❍
Read for pleasure	❍	❍	❍	❍	❍
Engage in stress reduction	❍	❍	❍	❍	❍
Maintain deep interpersonal relationships	❍	❍	❍	❍	❍
Practice mindfulness	❍	❍	❍	❍	❍
Attend a special event of interest	❍	❍	❍	❍	❍
Ask for help when needed	❍	❍	❍	❍	❍
Say "no" to extra responsibilities sometimes	❍	❍	❍	❍	❍

How often do you...?

	Never	Rarely	Sometimes	Most of the Time	Always
Spend time with others whose company you enjoy	❍	❍	❍	❍	❍
Stay in contact with important people in your life	❍	❍	❍	❍	❍
Give yourself affirmations, praise yourself	❍	❍	❍	❍	❍
Read or watch favorite movies and books	❍	❍	❍	❍	❍
Seek out comforting activities, objects, people, relationships, places	❍	❍	❍	❍	❍
Allow yourself to express emotion	❍	❍	❍	❍	❍
Allow yourself to laugh	❍	❍	❍	❍	❍
Engage in advocacy activities	❍	❍	❍	❍	❍

How often do you...?

	Never	Rarely	Sometimes	Most of the Time	Always
Spend time with nature	❍	❍	❍	❍	❍
Connect with spirituality	❍	❍	❍	❍	❍
Be open to inspiration	❍	❍	❍	❍	❍
Maintain optimistic outlook	❍	❍	❍	❍	❍
Be open to not knowing	❍	❍	❍	❍	❍
Identify what is meaningful to you and notice its place in your life	❍	❍	❍	❍	❍
Identify toxic relationships	❍	❍	❍	❍	❍
Pray/Meditate	❍	❍	❍	❍	❍
Contribute to causes in which you believe	❍	❍	❍	❍	❍
Read literature that inspires you	❍	❍	❍	❍	❍

How often do you...?

	Never	Rarely	Sometimes	Most of the Time	Always
Take a break during the workday (e.g. lunch)	❍	❍	❍	❍	❍
Take time to chat with peers or colleagues	❍	❍	❍	❍	❍
Make quiet time to complete tasks	❍	❍	❍	❍	❍
Seek out projects or tasks that are exciting and rewarding	❍	❍	❍	❍	❍
Maintain professional boundaries with colleagues	❍	❍	❍	❍	❍
Balance your caseload so that no one day or part of a day is "too much"	❍	❍	❍	❍	❍
Arrange your work space so it is comfortable and comforting	❍	❍	❍	❍	❍
Get additional advising or consultation for professional growth	❍	❍	❍	❍	❍
Negotiate for your needs with professors/supervisors/peers	❍	❍	❍	❍	❍
Participate in a formal or informal peer support group	❍	❍	❍	❍	❍
Strive for work-life balance	❍	❍	❍	❍	❍
Strive for balance among work, family, relationships, play and rest	❍	❍	❍	❍	❍

Appendix I: Flourishing Scale

Next are 8 statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item by indicating that response for each statement.
1-Strongly Disagree 2-Disagree 3-Slightly disagree 4-Neither agree nor disagree
5-Slightly agree 6-Agree 7-Strongly agree

	Rate
I lead a purposeful and meaningful life.	
My social relationships are supportive and rewarding.	
I am engaged and interested in my daily activities.	
I actively contribute to the happiness and well-being of others.	
I am competent and capable in the activities that are important to me.	
I am a good person and life a good life.	
I am optimistic about my future.	
People respect me.	

Appendix J: Maslach Burnout Inventory

	Never	A few times per year	Once a month	A few times per month	Once a week	A few times per week	Every day
I feel emotionally drained by my work.	❍	❍	❍	❍	❍	❍	❍
Working with people all day long requires a great deal of effort.	❍	❍	❍	❍	❍	❍	❍
I feel like my work is breaking me down.	❍	❍	❍	❍	❍	❍	❍
I feel frustrated by my work.	❍	❍	❍	❍	❍	❍	❍
I feel I work too hard at my job.	❍	❍	❍	❍	❍	❍	❍
It stresses me too much to work in direct contact with people.	❍	❍	❍	❍	❍	❍	❍
I feel like I'm at the end of my rope.	❍	❍	❍	❍	❍	❍	❍
I feel I look after certain patients/clients impersonally, as if they are objects.	❍	❍	❍	❍	❍	❍	❍
I feel tired when I get up in the morning and have to face another day at work.	❍	❍	❍	❍	❍	❍	❍

I have the impression that my patients/clients make me responsible for some of their problems.	❍	❍	❍	❍	❍	❍	❍
I am at the end of my patience at the end of my work day.	❍	❍	❍	❍	❍	❍	❍
I really don't care about what happens to some of my patients/clients.	❍	❍	❍	❍	❍	❍	❍
I have become more insensitive to people since I've been working.	❍	❍	❍	❍	❍	❍	❍
I'm afraid that this job is making me uncaring.	❍	❍	❍	❍	❍	❍	❍
I accomplish many worthwhile things in this job.	❍	❍	❍	❍	❍	❍	❍
I feel full of energy.	❍	❍	❍	❍	❍	❍	❍
I am easily able to understand what my patients/clients feel.	❍	❍	❍	❍	❍	❍	❍
I look after my patients'/clients' problems very effectively,	❍	❍	❍	❍	❍	❍	❍
In my work, I handle emotional	❍	❍	❍	❍	❍	❍	❍

problems very effectively.							
In my work, I handle emotional problems very calmly.	❍	❍	❍	❍	❍	❍	❍
Through my work, I feel that I have a positive influence on people.	❍	❍	❍	❍	❍	❍	❍
I am easily able to create a relaxed atmosphere with my patients/clients.	❍	❍	❍	❍	❍	❍	❍
I feel refreshed when I have been close to my patients/clients at work.	❍	❍	❍	❍	❍	❍	❍

Appendix K: Perceived Competence Scale

Please respond to each of the following items with respect to your learning.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I feel confident in my ability to learn.	❍	❍	❍	❍	❍
I am capable of learning material.	❍	❍	❍	❍	❍
I am able to achieve my goals.	❍	❍	❍	❍	❍
I feel able to meet the challenge of performing well.	❍	❍	❍	❍	❍

APPENDIX L: COMPETENCY BENCHMARKS IN PROFESSIONAL PSYCHOLOGY

I. PROFESSIONALISM

1. Professional Values and Attitudes: as evidenced in behavior and comportment that reflect the values and attitudes of psychology.		
READINESS FOR PRACTICUM	**READINESS FOR INTERNSHIP**	**READINESS FOR ENTRY TO PRACTICE**
1A. Integrity - Honesty, personal responsibility and adherence to professional values		
Understands professional values; honest, responsible	**Adherence to professional values infuses work as psychologist-in-training; recognizes situations that challenge adherence to professional values**	**Monitors and independently resolves situations that challenge professional values and integrity**
1B. Deportment		
Understands how to conduct oneself in a professional manner	**Communication and physical conduct (including attire) is professionally appropriate, across different settings**	**Conducts self in a professional manner across settings and situations**
1C. Accountability		
Accountable and reliable	**Accepts responsibility for own actions**	**Independently accepts personal responsibility across settings and contexts**
1D. Concern for the welfare of others		
Demonstrates awareness of the need to uphold and protect the welfare of others	**Acts to understand and safeguard the welfare of others**	**Independently acts to safeguard the welfare of others**
1E. Professional Identity		
Demonstrates beginning understanding of self as professional: "thinking like a psychologist"	**Displays emerging professional identity as psychologist; uses resources (e.g., supervision, literature) for professional development**	**Displays consolidation of professional identity as a psychologist; demonstrates knowledge about issues central to the field; integrates science and practice**

2. Individual and Cultural Diversity: Awareness, sensitivity and skills in working professionally with diverse individuals, groups and communities who represent various cultural and personal background and characteristics defined broadly and consistent with APA policy.		
READINESS FOR PRACTICUM	**READINESS FOR INTERNSHIP**	**READINESS FOR ENTRY TO PRACTICE**
2A. Self as Shaped by Individual and Cultural Diversity (e.g., cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status **) and Context**		
Demonstrates knowledge, awareness, and understanding of one's own dimensions of diversity and attitudes towards diverse others	**Monitors and applies knowledge of self as a cultural being in assessment, treatment, and consultation**	**Independently monitors and applies knowledge of self as a cultural being in assessment, treatment, and consultation**
2B. Others as Shaped by Individual and Cultural Diversity and Context		
Demonstrates knowledge, awareness, and understanding of other individuals as cultural beings	**Applies knowledge of others as cultural beings in assessment, treatment, and consultation**	**Independently monitors and applies knowledge of others as cultural beings in assessment, treatment, and consultation**
2C. Interaction of Self and Others as Shaped by Individual and Cultural Diversity and Context		
Demonstrates knowledge, awareness, and understanding of interactions between self and diverse others	**Applies knowledge of the role of culture in interactions in assessment, treatment, and consultation of diverse others**	**Independently monitors and applies knowledge of diversity in others as cultural beings in assessment, treatment, and consultation**
2D. Applications based on Individual and Cultural Context		
Demonstrates basic knowledge of and sensitivity to the scientific, theoretical, and contextual issues related to ICD (as defined by APA policy) as they apply to professional psychology. Understands the need to consider ICD issues in all aspects of professional psychology work (e.g., assessment, treatment, research, relationships with colleagues)	**Applies knowledge, sensitivity, and understanding regarding ICD issues to work effectively with diverse others in assessment, treatment, and consultation**	**Applies knowledge, skills, and attitudes regarding dimensions of diversity to professional work**

3. Ethical Legal Standards and Policy: Application of ethical concepts and awareness of legal issues regarding professional activities with individuals, groups, and organizations.		
READINESS FOR PRACTICUM	**READINESS FOR INTERNSHIP**	**READINESS FOR ENTRY TO PRACTICE**
3A. Knowledge of ethical, legal and professional standards and guidelines		
Demonstrates basic knowledge of the principles of the APA Ethical Principles and Code of Conduct [ethical practice and basic skills in ethical decision making]; demonstrates beginning level knowledge of legal and regulatory issues in the practice of psychology that apply to practice while placed at practicum setting	**Demonstrates intermediate level knowledge and understanding of the APA Ethical Principles and Code of Conduct and other relevant ethical/professional codes, standards and guidelines, laws, statutes, rules, and regulations**	**Demonstrates advanced knowledgeand application of the APA Ethical Principles and Code of Conduct and other relevant ethical, legal and professional standards and guidelines**
3B. Awareness and Application of Ethical Decision Making		
Demonstrates awareness of the importance of applying an ethical decision model to practice	**Demonstrates knowledge and application of an ethical decision-making model; applies relevant elements of ethical decision making to a dilemma**	**Independently utilizes an ethical decision-making model in professional work**
3C. Ethical Conduct		
Displays ethical attitudes and values	**Integrates own moral principles/ethical values in professional conduct**	**Independently integrates ethical and legal standards with all competencies**

4. Reflective Practice/Self-Assessment/Self-Care: Practice conducted with personal and professional self-awareness and reflection; with awareness of competencies; with appropriate self-care.		
4A. Reflective Practice		
Displays basic mindfulness and self-awareness; engages in reflection regarding professional practice	**Displays broadened self-awareness; utilizes self-monitoring; engages in reflection regarding professional practice; uses resources to enhance reflectivity**	**Demonstrates reflectivity both during and after professional activity; acts upon reflection; uses self as a therapeutic tool**
4B. Self-Assessment		
Demonstrates knowledge of core competencies; engages in initial self-assessment re: competencies	**Demonstrates broad, accurate self-assessment of competence; consistently monitors and evaluates practice activities; works to recognize limits of knowledge/skills, and to seek means to enhance knowledge/skills**	**Accurately self-assesses competence in all competency domains; integrates self-assessment in practice; recognizes limits of knowledge/skills and acts to address them; has extended plan to enhance knowledge/skills**
4C. Self-Care (attention to personal health and well-being to assure effective professional functioning)		
Understands the importance of self-care in effective practice; demonstrates knowledge of self-care methods; attends to self-care	**Monitors issues related to self-care with supervisor; understands the central role of self-care to effective practice**	**Self-monitors issues related to self-care and promptly intervenes when disruptions occur**
4D. Participation in Supervision Process		

Demonstrates straightforward, truthful, and respectful communication in supervisory relationship	**Effectively participates in supervision**	**Independently seeks supervision when needed**

II. RELATIONAL

5. Relationships: Relate effectively and meaningfully with individuals, groups, and/or communities.		
READINESS FOR PRACTICUM	**READINESS FOR INTERNSHIP**	**READINESS FOR ENTRY TO PRACTICE**
5A. Interpersonal Relationships		
Displays interpersonal skills	**Forms and maintains productive and respectful relationships with clients, peers/colleagues, supervisors and professionals from other disciplines**	**Develops and maintains effective relationships with a wide range of clients, colleagues, organizations and communities**
5B. Affective Skills		
Displays affective skills	**Negotiates differences and handles conflict satisfactorily; provides effective feedback to others and receives feedback nondefensively**	**Manages difficult communication; possesses advanced interpersonal skills**
5C. Expressive Skills		
Communicates ideas, feelings, and information clearly using verbal, nonverbal, and written skills	**Communicates clearly using verbal, nonverbal, and written skills in a professional context; demonstrates clear understanding and use of professional language**	**Verbal, nonverbal, and written communications are informative, articulate, succinct, sophisticated, and well-integrated; demonstrate thorough grasp of professional language and concepts**

III. SCIENCE

6. Scientific Knowledge and Methods: Understanding of research, research methodology, techniques of data collection and analysis, biological bases of behavior, cognitive-affective bases of behavior, and development across the lifespan. Respect for scientifically derived knowledge.		
READINESS FOR PRACTICUM	**READINESS FOR INTERNSHIP**	**READINESS FOR ENTRY TO PRACTICE**
6A. Scientific Mindedness		
Displays critical scientific thinking	**Values and applies scientific methods to professional practice**	**Independently applies scientific methods to practice**
6B. Scientific Foundation of Psychology		
Demonstrates understanding of psychology as a science	**Demonstrates intermediate level knowledge of core science (i.e., scientific bases of behavior)**	**Demonstrates advanced level knowledge of core science (i.e., scientific bases of behavior)**
6C. Scientific Foundation of Professional Practice		

Understands the scientific foundation of professional practice	**Demonstrates knowledge, understanding, and application of the concept of evidence-based practice**	**Independently applies knowledge and understanding of scientific foundations independently applied to practice**

IV. SCIENCE

7. Scientific Knowledge and Methods: Understanding of research, research methodology, techniques of data collection and analysis, biological bases of behavior, cognitive-affective bases of behavior, and development across the lifespan. Respect for scientifically derived knowledge.		
READINESS FOR PRACTICUM	**READINESS FOR INTERNSHIP**	**READINESS FOR ENTRY TO PRACTICE**
6A. Scientific Mindedness		
Displays critical scientific thinking	**Values and applies scientific methods to professional practice**	**Independently applies scientific methods to practice**
6B. Scientific Foundation of Psychology		
Demonstrates understanding of psychology as a science	**Demonstrates intermediate level knowledge of core science (i.e., scientific bases of behavior)**	**Demonstrates advanced level knowledge of core science (i.e., scientific bases of behavior)**
6C. Scientific Foundation of Professional Practice		
Understands the scientific foundation of professional practice	**Demonstrates knowledge, understanding, and application of the concept of evidence-based practice**	**Independently applies knowledge and understanding of scientific foundations independently applied to practice**

8. Research/Evaluation: Generating research that contributes to the professional knowledge base and/or evaluates the effectiveness of various professional activities		
7A. Scientific Approach to Knowledge Generation		
Participates effectively in scientific endeavors when available	**Demonstrates development of skills and habits in seeking, applying, and evaluating theoretical and research knowledge relevant to the practice of psychology**	**Generates knowledge**
7B. Application of Scientific Method to Practice		
No expectation at this level	**Demonstrates knowledge of application of scientific methods to evaluating practices, interventions, and programs**	**Applies scientific methods of evaluating practices, interventions, and programs**

V. APPLICATION

9. Evidence-Based Practice: Integration of research and clinical expertise in the context of patient factors.		
READINESS FOR PRACTICUM	**READINESS FOR INTERNSHIP**	**READINESS FOR ENTRY TO PRACTICE**
8A. Knowledge and Application of Evidence-Based Practice		
Demonstrates basic knowledge of scientific, theoretical, and contextual bases of assessment, intervention and other psychological applications; demonstrates basic knowledge of the value of evidence-based practice and its role in scientific psychology	**Applies knowledge of evidence-based practice, including empirical bases of assessment, intervention, and other psychological applications, clinical expertise, and client preferences**	**Independently applies knowledge of evidence-based practice, including empirical bases of assessment, intervention, and other psychological applications, clinical expertise, and client preferences**

10. Assessment: Assessment and diagnosis of problems, capabilities and issues associated with individuals, groups, and/or organizations.		
READINESS FOR PRACTICUM	**READINESS FOR INTERNSHIP**	**READINESS FOR ENTRY TO PRACTICE**
9A. Knowledge of Measurement and Psychometrics		
Demonstrates basic knowledge of the scientific, theoretical, and contextual basis of test construction and interviewing	**Selects assessment measures with attention to issues of reliability and validity**	**Independently selects and implements multiple methods and means of evaluation in ways that are responsive to and respectful of diverse individuals, couples, families, and groups and context**
9B. Knowledge of Assessment Methods		
Demonstrates basic knowledge of administration and scoring of traditional assessment measures, models and techniques, including clinical interviewing and mental status exam	**Demonstrates awareness of the strengths and limitations of administration, scoring and interpretation of traditional assessment measures as well as related technological advances**	**Independently understands the strengths and limitations of diagnostic approaches and interpretation of results from multiple measures for diagnosis and treatment planning**
9C. Application of Assessment Methods		
Demonstrates knowledge of measurement across domains of functioning and practice settings	**Selects appropriate assessment measures to answer diagnostic question**	**Independently selects and administers a variety of assessment tools and integrates results to accurately evaluate presenting question appropriate to the practice site and broad area of practice**
9D. Diagnosis		
Demonstrates basic knowledge regarding the range of normal and abnormal behavior in the	**Applies concepts of normal/abnormal behavior to case formulation and diagnosis in the context of stages of human development and diversity**	**Utilizes case formulation and diagnosis for intervention planning in the context of stages of human development and diversity**

context of stages of human development and diversity		

Assessment continued		
READINESS FOR PRACTICUM	**READINESS FOR INTERNSHIP**	**READINESS FOR ENTRY TO PRACTICE**
9E. Conceptualization and Recommendations		
Demonstrates basic knowledge of formulating diagnosis and case conceptualization	**Utilizes systematic approaches of gathering data to inform clinical decision-making**	**Independently and accurately conceptualizes the multiple dimensions of the case based on the results of assessment**
9F. Communication of Assessment Findings		
Demonstrates awareness of models of report writing and progress notes	**Writes assessment reports and progress notes and communicates assessment findings verbally to client**	**Communicates results in written and verbal form clearly, constructively, and accurately in a conceptually appropriate manner**

11. Intervention: Interventions designed to alleviate suffering and to promote health and well-being of individuals, groups, and/or organizations.		
10A. Intervention planning		
Displays basic understanding of the relationship between assessment and intervention	**Formulates and conceptualizes cases and plans interventions utilizing at least one consistent theoretical orientation**	**Independently plans interventions; case conceptualizations and intervention plans are specific to case and context**
10B. Skills		
Displays basic helping skills	**Displays clinical skills**	**Displays clinical skills with a wide variety of clients and uses good judgment even in unexpected or difficult situations**
10C. Intervention Implementation		
Demonstrates basic knowledge of intervention strategies	**Implements evidence-based interventions**	**Implements interventions with fidelity to empirical models and flexibility to adapt where appropriate**
10D. Progress Evaluation		
Demonstrates basic knowledge of the assessment of intervention progress and outcome	**Evaluates treatment progress and modifies treatment planning as indicated, utilizing established outcome measures**	**Independently evaluates treatment progress and modifies planning as indicated, even in the absence of established outcome measures**

12. Consultation: The ability to provide expert guidance or professional assistance in response to a client's needs or goals.		
READINESS FOR PRACTICUM	**READINESS FOR INTERNSHIP**	**READINESS FOR ENTRY TO PRACTICE**
11A. Role of Consultant		
No expectation at this level	**Demonstrates knowledge of the consultant's role and its unique features as distinguished from other professional roles (such as therapist, supervisor, teacher)**	**Determines situations that require different role functions and shifts roles accordingly to meet referral needs**
11B. Addressing Referral Question		
No expectation at this level	**Demonstrates knowledge of and ability to select appropriate means of assessment to answer referral questions**	**Demonstrates knowledge of and ability to select appropriate and contextually sensitive means of assessment/data gathering that answers consultation referral question**
11C. Communication of Consultation Findings		
No expectation at this level	**Identifies literature and knowledge about process of informing consultee of assessment findings**	**Applies knowledge to provide effective assessment feedback and to articulate appropriate recommendations**
11D. Application of Consultation Methods		
No expectation at this level	**Identifies literature relevant to consultation methods (assessment and intervention) within systems, clients, or settings**	**Applies literature to provide effective consultative services (assessment and intervention) in most routine and some complex cases**

VI. EDUCATION

13. Teaching: Providing instruction, disseminating knowledge, and evaluating acquisition of knowledge and skill in professional psychology.		
READINESS FOR PRACTICUM	**READINESS FOR INTERNSHIP**	**READINESS FOR ENTRY TO PRACTICE**
12A. Knowledge		
No expectation at this level	**Demonstrates awareness of theories of learning and how they impact teaching**	**Demonstrates knowledge of didactic learning strategies and how to accommodate developmental and individual differences**
12B. Skills		
No expectation at this level	**Demonstrates knowledge of application of teaching methods**	**Applies teaching methods in multiple settings**

14. Supervision: Supervision and training in the professional knowledge base of enhancing and monitoring the professional functioning of others.		
READINESS FOR PRACTICUM	**READINESS FOR INTERNSHIP**	**READINESS FOR ENTRY TO PRACTICE**
13A. Expectations and Roles		
Demonstrates basic knowledge of expectations for supervision	**Demonstrates knowledge of, purpose for, and roles in supervision**	**Understands the ethical, legal, and contextual issues of the supervisor role**
13B. Processes and Procedures		
No expectation at this level	**Identifies and tracks progress achieving the goals and tasks of supervision; demonstrates basic knowledge of supervision models and practices**	**Demonstrates knowledge of supervision models and practices; demonstrates knowledge of and effectively addresses limits of competency to supervise**
13C. Skills Development		
Displays interpersonal skills of communication and openness to feedback	**Demonstrates knowledge of the supervision literature and how clinicians develop to be skilled professionals**	**Engages in professional reflection about one's clinical relationships with supervisees, as well as supervisees' relationships with their clients**
13D. Supervisory Practices		
No expectation at this level	**Provides helpful supervisory input in peer and group supervision**	**Provides effective supervised supervision to less advanced students, peers, or other service providers in typical cases appropriate to the service setting**

I. SYSTEMS

15. Interdisciplinary Systems: Knowledge of key issues and concepts in related disciplines. Identify and interact with professionals in multiple disciplines.		
READINESS FOR PRACTICUM	**READINESS FOR INTERNSHIP**	**READINESS FOR ENTRY TO PRACTICE**
14A. Knowledge of the Shared and Distinctive Contributions of Other Professions		
No expectation at this level	**Demonstrates beginning, basic knowledge of the viewpoints and contributions of other professions/ professionals**	**Demonstrates awareness of multiple and differing worldviews, roles, professional standards, and contributions across contexts and systems; demonstrates intermediate level knowledge of common and distinctive roles of other professionals**
14B. Functioning in Multidisciplinary and Interdisciplinary Contexts		
Cooperates with others	**Demonstrates beginning knowledge of strategies that promote interdisciplinary collaboration vs. multidisciplinary functioning**	**Demonstrates beginning, basic knowledge of and ability to display the skills that support effective interdisciplinary team functioning**
14C. Understands how Participation in Interdisciplinary Collaboration/Consultation Enhances Outcomes		
No expectation at this level	**Demonstrates knowledge of how participating in interdisciplinary collaboration/consultation can be directed toward shared goals**	**Participates in and initiates interdisciplinary collaboration/consultation directed toward shared goals**
14D. Respectful and Productive Relationships with Individuals from Other Professions		
Demonstrates awareness of the benefits of forming collaborative relationships with other professionals	**Develops and maintains collaborative relationships and respect for other professionals**	**Develops and maintains collaborative relationships over time despite differences**

16. Management-Administration: Manage the direct delivery of services (DDS) and/or the administration of organizations, programs, or agencies (OPA).		
15A. Appraisal of Management and Leadership		
No expectation at this level	**Forms autonomous judgment of organization's management and leadership** Examples: • Applies theories of effective management and leadership to form an evaluation of organization • Identifies specific behaviors by management and leadership that promote or detract from organizational effectiveness	**Develops and offers constructive criticism and suggestions regarding management and leadership of organization** Examples: • Identifies strengths and weaknesses of management and leadership or organization • Provides input appropriately; participates in organizational assessment
15B. Management		

No expectation at this level	**Demonstrates awareness of roles of management in organizations**	**Participates in management of direct delivery of professional services; responds appropriately in management hierarchy**
15C. Administration		
Complies with regulations	**Demonstrates knowledge of and ability to effectively function within professional settings and organizations, including compliance with policies and procedures**	**Demonstrates emerging ability to participate in administration of clinical programs**
15D. Leadership		
No expectation at this level	**No expectation at this level**	**Participates in system change and management structure**

17. Advocacy: Actions targeting the impact of social, political, economic or cultural factors to promote change at the individual (client), institutional, and/or systems level.

READINESS FOR PRACTICUM	READINESS FOR INTERNSHIP	READINESS FOR ENTRY TO PRACTICE
16A. Empowerment		
Demonstrates awareness of social, political, economic and cultural factors that impact individuals, institutions and systems, in addition to other factors that may lead them to seek intervention	**Uses awareness of the social, political, economic or cultural factors that may impact human development in the context of service provision**	**Intervenes with client to promote action on factors impacting development and functioning**
16B. Systems Change		
Understands the differences between individual and institutional level interventions and system's level change	**Promotes change to enhance the functioning of individuals**	**Promotes change at the level of institutions, community, or society**

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