Factors Influencing Psychological Help Seeking Attitudes and Behavior in Counseling Trainees

Dissertation

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Abstract

The purpose of the study is to examine help seeking attitudes and behaviors in graduate students studying to be counselors (e.g. mental health, school, community/agency Masters students; PhD students in Counselor Education). A random sample of 1,000 student members of the American Counseling Association was surveyed. Of the 1,000 questionnaires mailed, 310 were returned for a rate of 31%. Attitudes about psychological help seeking were assessed using the Attitudes Toward Seeking Professional Psychological Help scale (short form; Fischer & Farina, 1995). The stigma associated with seeking psychological help can also be salient to help seeking attitudes and behaviors. Two scales measuring stigma concerns for seeking psychological help were selected for the current study: the Self Stigma of Seeking Help (private stigma; Vogel, Wester, Haake, 2003), and the Social Stigma for Receiving Psychological Help (public stigma; Komiya, Goode, & Sherrod, 2000). Finally, participants’ level of comfort with disclosing distressing information to others was measured using the Distress Disclosure Index (Kahn & Hessling, 2001).

Existing research also suggests that individuals’ perceptions of practical (e.g. cost, time, transportation) and emotional (e.g. stigma concerns) barriers to counseling influence their help seeking behaviors. Counseling trainees were asked about their
perceived barriers to seeking psychological help as they influenced concerns about the affordability, accessibility, availability, and acceptability of seeking psychological help.

In order to answer questions regarding counseling trainees’ psychological help seeking attitudes and behaviors, the statistical tools of t-tests of independent samples, analysis of variance, and multiple regression were applied. Results indicated that counseling trainees who had not previously sought psychological help held more negative attitudes toward seeking that help, and had higher levels of stigma concerns (public and private) about seeking psychological help. Level of graduate training did not appear to impact stigma concerns about seeking help. Finally, in the multiple regression analysis, predictor variables of self (private) stigma concerns, previous experience of counseling, social (public) stigma concerns, gender, and comfort with distress disclosure explained 32% of the variance in participants’ attitudes toward seeking professional psychological help scores (ATSPPHS).
Dedication

To my life partner and dearest companion, Kathleen Lorraine Gallivan

Foreword

“But where and how is the poor wretch to acquire the ideal qualifications which he will need to in his profession?
“The answer is in an analysis of himself.”

– Sigmund Freud
Acknowledgments

It takes a village to earn a PhD. I owe my deepest gratitude to a large number of people who are my family, friends, colleagues, teachers, students, and mentors. Their support, caring, encouragement, work, and example have inspired me and made this accomplishment possible. I share this with all of them.

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My deepest gratitude goes to my partner of over fourteen years, Kate Gallivan. Together we have always had the power to go wherever we imagine.
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Publications


**Fields of Study**

**Major Field:** Education and Human Ecology
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Chapter One

Introduction

1.1 Introduction

The counseling profession promotes the beneficial properties of therapy (e.g. insight; personal growth; positive and healthy behavior change; increased daily functioning; problem solving; relational and social skill development) for those who have severe mental health issues, as well as for those who feel stuck or overwhelmed by challenges and problems in life (American Counseling Association; Corey, 2008; Gladding, 2008). Research suggests that anywhere from less than one quarter to less than one half of people who might benefit from therapy actually seek it out and engage in the process (Cepeda-Benito & Short, 1998; Corrigan, 2003; Komiya, Good, & Sherrod, 2000). Studies cite barriers to help seeking, both practical and perceived, that may stand in the way of individuals who could benefit from therapy. Some of the barriers most frequently cited include time, cost, lack of insurance coverage, and the stigma related to seeing a therapist (Komiya, Good, & Sherrod, 2000; McCarthy, Pfohl, & Bruno, 2010; Segal, Coolidge, Mincic, & O’Riley, 2005; Vogel, Wade, & Haake, 2006).
Research has presented evidence that those engaged in the helping professions, such as counseling, experience the effects of life’s problems and challenges (Dearing, Tangney, & Maddux, 2005; Gilroy, Carroll, & Murra, 2002; Givens & Tjia, 2002; Mahoney, 1997; Thoreson, Miller, & Krauskopf, 1989). Balancing the effects of life’s troubles with the demands of work as a professional counselor is cited in counselor preparation programs as a critical element to a counselor’s effectiveness. Individuals who train to be helpers and healers also face barriers to seeking mental health services similar to those cited by the general public, and some specific to the circumstances of their training environments (Carroll, Gilroy, & Murra, 2003; Dearing, Maddux, & Tangney, 2005; Gilroy, Carroll, & Murra, 2002; Givens & Tjia, 2002; McCarthy, Pfohl, & Bruno, 2010). Counselors have been shown to benefit personally and professionally from engaging in counseling as clients (Gilroy, Carroll, & Murra, 2002, Rønnestad & Skovholt, 2001).

Competent professional counselors exhibit certain personal and technical/skill-based competencies (Kerl, Garcia, McCullough, & Maxwell, 2002; Skovholt, Jennings, & Mullenbach, 2004). Among positive personal characteristics cited in the literature are “the capacity for empathy, genuineness, acceptance, access to and appropriate sharing of feelings, giving and receiving feedback effectively, honesty, and establishing and maintaining relationships” (p. 322, Kerl, Garcia, McCullough, & Maxwell, 2002). Some research has also suggested that practicing counselors may require individual therapy at times in their own personal lives, yet many may be reluctant to seek professional
psychological help for reasons that it may reflect negatively on their professional image and ability to function as a therapist (Gilroy, Carroll, & Murra, 2002).

1.2 Statement of the Problem

Those training to enter the profession of counseling are aware of the benefits of and barriers to seeking psychological help, whether that awareness comes through direct previous experience or the training their receive in their graduate programs. There is little in the research that examines or attempts to explain help seeking attitudes in and behavior of counseling trainees. Existing research and theoretical work regarding the development of counseling trainees does discuss how trainees might benefit from seeking therapy to help solve their own problems, deal with stress in life or in their program, as part of their personal growth, and for prevention of burn out and impairment. However, only two studies in the literature examine actual help seeking behavior in counseling and clinical psychology trainees (Dearing, Maddux, & Tangney, 2005) and trainees in counselor education programs (McCarthy, Pfohl, & Bruno, 2010). The current study seeks to add to the knowledge in the literature by further examining counseling trainees’ experience of and attitudes toward seeking professional psychological help.

Our professional ethical standards suggest that counselors be vigilant concerning their own mental health (ACA, 2005), and cognizant of how impairment of the practitioner may negatively impact the client. Impairment of counselors and counseling trainees is an ethical and practical concern of the profession. Academic excellence (or adequacy) is not sufficient to determine if a counseling trainee is appropriate for clinical practice in the field. Faculty in counselor education programs are responsible for insuring
that trainees are personally stable and technically skilled enough to undertake the practice of counseling (Kerl, Garcia, McCullough, & Maxwell, 2002; Lumadue & Duffey, 1999). It might then be considered a duty of the counselor or counseling trainee to seek out methods of wellness and health promotion and formulate a consistent practice of self care. It might also be argued that counselor educators and the programs in which they teach can play a unique role in establishing such healthy habits in their counseling trainees (Christopher, Christopher, Dunnagan, & Schure, 2006; Myers, Mobley, & Booth, 2003; Skovholt, Grier, & Hanson, 2001). In this way, future counselors will be conditioned to seek help, engage in personal growth and wellness activities to their own benefit, and, ultimately, that of their clients.

Counseling trainees can and do experience stress, personal problems, and serious challenges to their health and wellbeing, just as any individual, and perhaps are at greater risk due to the nature of their studies and the type of work in which they will be engaging as professionals (Bober & Regehr, 2007; Kerl, Garcia, McCullough, & Maxwell, 2002; Lumadue & Duffey, 1999; Ronnestaad & Skovholt, 2003). Counseling trainees are seeking entrance into a profession that promotes help seeking and values professional mental health service as a productive and effective means of solving personal problems, encouraging personal growth, and enhancing overall quality of life (Gladding, 2008; Mackey & Mackey, 1993; Williams, Coyle, & Lyons, 1999). While learning the techniques and methods of effective counseling, students are developing their professional identities (Pfohl, 2004; Stratton, Kellaway, & Rottini, 2007), which
necessarily include a philosophy and ethic that values the therapeutic process and promotes help seeking as positive behavior.

Research suggests that those who might most benefit from counseling are less likely to seek it out. Lang (2005) published the results of a study that showed distressed patients expressed less likelihood they would seek counseling due to anticipating greater impact from external and internal barriers on the decision making about seeking counseling. Ciarrochi and Deane (2001) studied the relationship between individuals’ ability to manage emotions (emotional competence) and their likelihood of seeking psychological help. In the study, a survey of 300 undergraduate students, those participants with indications of less emotional competence (less ability to cope with emotional problems) were also less likely to seek professional help for their emotional problems. The authors suggested this might be an indication that those who most need counseling are less likely to seek it out (Ciarrochi & Deane, 2001).

Although counseling trainees seek help at a higher rate than the general public (Dearing, et al., 2005; McCarthy, et al., 2010), research also suggests counseling trainees experience psychological and emotional problems at a higher rate than the general public (White & Franzoni, 1990). This greater rate of help seeking may be evidence of their training in the benefits of counseling, as well as training that is intended to reduce perceptions of stigma related to counseling, since, although experiencing greater impairment, counseling trainees are more likely to seek psychological help (Dearing, Maddux, & Tangney, 2005; McCarthy, Pfohl, & Bruno, 2010). This is inconsistent with
the existing research cited above that suggests those with the greatest need are least likely to seek out counseling services.

If counselors are subject to the “the heart-ache, and the thousand natural shocks that flesh is heir to,” (Shakespeare) then every counselor, present and future, might benefit from the experience of counseling as a consumer. Freud and Jung each experienced need for psychological help at some point in their lives (Bair, 2003; Gay, 1989), and engaged in individual therapy (albeit by analyzing themselves). One of the founding figures in the history of mental health counseling, Clifford Beers, was himself diagnosed with a mental illness and was institutionalized twice for mental health issues (Beers, 1921). However, despite the historical, philosophical, practical and ethical normalization of help seeking within the counseling profession, the stigma associated with seeking psychological help and engaging in mental health treatment persists, influencing public and private perceptions, as well as help seeking behavior and practices (Brown & Bradley, 2002; Corrigan & Miller, 2004; Corrigan & Penn, 1999; Komiya, Good, & Sherrod, 2000; Pinel, 1999; Vogel, Wade, & Haake, 2006).

Counseling trainees and professionals are aware of the stigma that persists concerning having a mental illness or seeking mental health treatment, and negative attitudes toward being diagnosed with a mental illness or defect, and seeking psychological help, remain evident to this day (Corrigan, Watson, & Ottati, 2003; Komiya, Glenn, & Sherrod, 2000; Vogel, Wade, & Haake, 2006). A number of studies in the literature have examined the significant influence of stigma concerns on peoples’ attitudes toward seeking psychological help (Komiya, Good, & Sherrod, 2000; Vogel
Wade, & Haake, 2006). Previous studies examining counseling trainees and help seeking attitudes have identified some trainees’ stigma concerns (Dearing, et al, 2005; McCarthy, et al., 2010), but there has been no exploration of how those concerns may impact trainees’ help seeking attitudes and behavior.

As individuals who aspire to provide mental health services to others, counseling trainees’ own help seeking attitudes and behaviors are worth examining. Studying the help seeking behaviors, attitudes and intentions of counseling trainees is important for a number of reasons:

1. It helps to understand how students conceptualize their own mental health and well being, and its relationship to engaging in effective counseling with a trained professional for their own continued personal and professional growth and well being.

2. It deepens trainees’ understanding of reflective and ethical practice, sensitizing them to the multiple resources for insuring their own professional effectiveness. Ethical practice dictates proper supervision and monitoring of clinical behavior and methods. Supervision is prescribed by ethical standards as well, some of which preclude the supervisor from engaging in the practice of counseling with a supervisee.

3. It provides opportunities for proactive pedagogy with regard to trainees’ stress and impairment levels. Increasing focus on trainees’ needs for behavioral, cognitive, and emotional counseling that assists them in managing personal problems as well as the stresses of graduate training
creates an academic environment that is more aware and therefore better equipped to respond to trainees’ developmental needs, personally and professionally. This focus may even reduce the likelihood of reactive or remedial intervention with students who may be at risk for misconduct on ethical or academic grounds.

1.3 Background

Research has identified several factors that influence people’s attitudes toward seeking professional psychological help. Gender differences have been shown to be significant when it comes to seeking mental health services, with women reporting more positive attitudes than men (Gilroy, Carroll, & Murra, 2002; Wallace & Constantine, 2005). Previous experience of counseling contributes significantly to the positive help-seeking attitudes (Ciarrochi & Deane, 2001; Gonzalez, Alegria, & Prihoda, 2005). The evidence is mixed in terms of help seeking attitudes among racial & ethnic minorities. Some studies show Asian and African Americans have more negative attitudes (Atkinson & Gim, 1989; Duncan, 2003), while others show no significance difference in attitudes based on race or ethnicity (Wallace & Constantine, 2005). The most frequently cited barriers to seeking mental health services include time, cost, and insurance coverage (Dearing, et al., 2005; Givens & Tjia, 2002; McCarthy, Pfohl, & Bruno, 2010; Watson, 2006);

There is little research in the literature that has actually examined counselors’ or counseling trainees’ attitudes toward seeking mental health services. There is one published study on counselor education trainees’ attitudes and behaviors regarding
seeking mental health services (McCarthy, et al, 2010). A few published studies in the field of counseling psychology have examined trainees’ and psychologists’ help seeking attitudes and behaviors (Carroll, Gilroy, & Murra, 2003; Dearing, Maddux, & Tangney, 2005; Farber, 1999; Gilroy, Carroll, & Murra, 2002). Studies in the field of medicine have examined help seeking attitudes and behaviors in physicians and medical students (Givens & Tjia, 2002; Spencer, 2005). Although a few publications in the field of social work acknowledge and advocate for comprehensive assistance for students with mental illness (Collins, 2006; GlenMaye & Bolin, 2007; Manthorpe & Stanley, 1999) only one publication dealt with the willingness on the part of social work students to seek psychological help (Zion-Cohen, 1999) and this related to the development of an assessment instrument to measure the phenomenon.

Therapists who have engaged in personal counseling have experienced benefits, and have also reported concerns about participating in the process as clients (Gilroy, Carroll, & Murra, 2002). Some practitioners harbor concerns about colleagues’ perceptions of their competence if it were known they were seeing a therapist (Carroll, Gilroy, & Murra, 2003; Givens & Tjia, 2002). Another concern of practitioners in the field centers on the potential damage to their professional status, risk of embarrassment, and the potential loss of client referrals were it known they were coping with emotional or psychological problems themselves (Gilroy, Carroll, & Murra, 2002). Counseling psychology trainees (Dearing, et al., 2005) and counselor education trainees (McCarthy, Pfohl, & Bruno, 2010) also express concern over faculty members’ reactions if it were known a student was seeking therapy.
On the other hand, there are some expressed benefits to counseling trainees and professionals who choose to seek counseling. Some professionals who engaged in counseling themselves felt it would increase their capacity for empathy for their clients; awareness of the hard work of personal therapy; and appreciation for the potential benefits of psychopharmacological options for their clients' treatment (Gilroy, Carroll, & Murra, 2002). In Dearing, et al.’s (2005) study counseling psychology trainees indicated they saw participation in personal counseling as an opportunity for personal and professional growth.

Counseling trainees may hesitate to attend counseling themselves for a number of different reasons. Among graduate students in the helping and health professions (e.g. medicine, counseling) the most frequently cited barrier is time (Dearing, et al., 2005; Givens & Tjia, 2002). Money and insurance coverage are also significant considerations (Dearing, et al., 2005; Farber, 1999). Students also consider the stigma associated with seeking therapy, and express concerns over confidentiality and how faculty, supervisors, and peers might react were it know they were in counseling (Dearing, et al., 2005; Farber, 1999; Givens & Tjia, 2002).

Given the identified benefits of engaging in counseling, and the potential harm if personal problems and challenges go unaddressed, what are counseling trainees’ attitudes and behaviors regarding seeking mental health services? Do counseling trainees experience specific barriers to seeking such help? It is the purpose of this study to examine these questions, and explore the potential barriers to help seeking that counseling trainees may face.
1.4 Purpose of the Study

The purpose of the current study is to:

1. Determine what factors influence counseling trainees’ attitudes and behaviors in seeking psychological help
2. Identify counseling trainees’ perceived barriers to help seeking and how those might influence their psychological help seeking attitudes and behavior
3. Determine if counseling trainees hold perceptions of public and private stigma concerning seeking psychological help that may influence their help seeking attitudes and behaviors
4. Identify factors (e.g. gender, previous experience of counseling, stigma concerns, and comfort with distress disclosure) that may be explanatory or predictive of counseling trainees’ attitudes toward seeking psychological help

In part, this study will utilize the current research, based upon previous studies in the area of counseling trainees’ attitudes toward and utilization of counseling services, as a foundation for the design of this survey research study. This study will also be designed to expand on the existing research with counseling trainees in an effort to increase understanding of what factors and traits influence counseling trainees’ psychological help seeking attitudes. The ultimate goal of this study is to provide information to counselor education programs and educators that may assist them in the preparation of future professional counselors.
1.5 Research Questions

1.5.1 Research Question One

What are the demographic characteristics of the survey respondents? What are their attitudes toward seeking professional psychological help; private and public stigma concerns about seeking help; likelihood of disclosing distressing information to others as measured by the instruments in the questionnaire (e.g. means, standard deviations for the instruments)? Are there differences in mean scores on the measures for the study (e.g. ATSPPHS, attitudes toward seeking professional psychological help; SSOSH, self-stigma of seeking help; SSRPH, social stigma for receiving professional psychological help; DDI, (Distress Disclosure Index) comfort with disclosing distressing information) based upon independent variables (key demographic categories) of gender, previous counseling experience, and race? What perceived barriers to seeking psychological help did participants endorse, and at what level (e.g. not a barrier; somewhat a barrier; significant barrier)? Are there differences in participants’ number of endorsed barriers based upon the independent variables of gender, previous counseling, or race?

The first research question involves descriptors and descriptive statistics relative to the population being studied. Demographic data on the participant counseling trainees will be examined, including gender, and age, race/ethnicity. Participants will be asked to indicate their degree sought, their program, and year of study (e.g. first year, second year, or more). Participants’ attitudes toward seeking psychological help will also be reported based upon their aggregate scores obtained from responses to the Attitudes Toward Seeking Professional Psychological Help scale (Fischer & Turner, 1970). Participants
will be asked whether or not they have ever gone for counseling in their lifetimes, and approximately how months they were in counseling. Participants’ perceptions of stigma related to help seeking, both private (self) and public stigma, will be reported based on scores obtained from the Self-Stigma of Seeking Help scale (SSOSH) (Vogel, Wade, & Haake, 2006) and Stigma Scale for Receiving Psychological Help (SSRPH) (Komiya, Good, & Sherrod, 2000), respectively. Finally, participants’ comfort level with disclosing personal information of a distressing nature to others will be assessed using Kahn and Hessling’s (2001) Distress Disclosure Index.

There is evidence in the literature to suggest there are certain perceived barriers to seeking psychological help that influence individual decisions to seek that help. This question is based on previous research on the impact of perceived barriers on individuals’ decisions to seek professional psychological help (Cepeda-Benito & Short, 1998; Dearing, Maddux, & Tangney, 2005; McCarthy, Pfohl, & Bruno, 2010; Stefl & Prosperi, 1985). Participants will be asked to rate the importance of nine different barriers to helps seeking (e.g. transportation; cost of services; taking time off) based upon a 5 point Likert scale. This question and the method of assessment are related to previous research in help seeking literature, as well as in research conducted on the help seeking of counseling trainees (Dearing, Maddux, & Tangney, 2005; Stefl & Prosperi, 1985), which has noted that time and cost are the barriers that typically play the most important roles in influence help seeking. Rating will be assessed and compared to the ratings reported in the previous research.
1.5.2 Research Question Two

Is there a difference in participants’ concern about the stigma of seeking psychological help based upon their level of counseling training?

Participants’ scores on the SSOSH (measuring private or self stigma) and the SSRPH (measuring public stigma) will be reported in response to question number one. The scores will be revisited here, to examine differences in perceptions of stigma among counseling trainees who participate in the study based upon their level of training (first year masters, second year masters, masters graduate/doctoral student).

The null hypothesis for Question #2 presumes that there will be no difference in perceptions of private and public stigma (SSOSH and SSRPH scores respectively) among participants based upon their level of training (e.g. year in program). Analysis of Variance will be performed on SSOSH (self or private stigma) scores, and another on SSRPH (public stigma) scores obtained from the three groups (first year, second year, masters graduate or doctoral level) to determine if there is significant difference among the group mean scores.

1.5.3 Research Question Three

What factors might explain or predict participants' attitudes toward seeking professional psychological help?

Multiple regression will be utilized to examine which of the factors reported by participants might best account for their attitudes (positive or negative) about seeking mental health services. The independent variables in the regression model will include gender; length of study; previous experience in counseling; public stigma (SSRPH score);
private stigma (SSOS score); and likelihood of disclosing distressing information (DDI score). The dependent variable will be participants’ attitudes toward seeking professional psychological help, as measured by the Attitudes Toward Seeking Professional Psychological Help scale (Fischer & Turner, 1970).

1.6 Definition of Terms

Counseling trainees refers to masters-level students in Counselor Education programs throughout the United States, and who are student members of the American Counseling Association. Participants will be asked to report their gender as either “male” or “female;” age as a number indicating years; and race based upon a series of questions from the 2010 United States Census to determine participants’ racial and ethnic heritage.

Psychological help seeking in this study refers to behavior engaged in by individuals in order to find and attend personal counseling with a professional. The term “professional” refers to any individual with training and certification or licensure to provide counseling, psychotherapy, or mental health services, such as counseling and psychotherapy (e.g. psychologist, psychiatrist, social worker, mental health counselor). The term “professional psychological help” is framed, for the purposes of this study, by the Attitudes Toward Seeking Professional Psychological Help scale (Fischer & Turner, 1970), and refers to such psychological help as counseling and therapy.

1.6.1 Concentration or Degree Program

Participants will be asked to indicate their degree program concentration as School Counseling, Mental Health Counseling, Community/Agency Counseling, Counselor Education, Psychology, or other.
1.6.2 Year of Graduate Training

Participants will be asked to report their year of enrollment in their graduate program, first year, second year, or graduated. Once data are collected, year of enrollment (i.e. year of training) will be coded to reflect discreet categories that differentiate participants’ level of training in terms of length of time they have engaged in graduate studies. Also, it will be assumed that those participants ranked at two years of graduate training or more will have had some field experience training as counselors in an actual therapeutic environment.

1.6.3 Barriers to Seeking Psychological Help

For the purposes of this study, perceived barriers to seeking psychological help (e.g. counseling or therapy) will be defined within the framework suggested by Stefl & Prosperi, (1985); that is, that issues of accessibility, affordability, availability, and acceptability of psychological services and the seeking of same influence people’s decision making and help seeking behaviors. Barriers relating to accessibility might include having someone to accompany the person to their appointment, and transportation; affordability issues also time and cost; those barriers related to availability can include knowing that counseling services exist and where to find them; and acceptability of services relates to fears of being looked down upon or devalued by self or others as a result of seeking counseling (Stefl & Prosperi, 1985). Barriers will also be discussed in terms of being “Emotional” (e.g. internal; discomfort; being overly emotional; talking about private topics with stranger; what others would think) and
“Practical” (e.g. cost; time; transportation; child/other care) (Mohr, Hart, Howard, Julian, Vella, Catledge, & Feldman, 2006).

1.6.4 Attitudes Toward Seeking Professional Psychological Help

Attitudes toward seeking professional psychological help (positive and negative) will be defined by participants’ scores on the Attitudes Toward Seeking Professional Psychological Help scale, short form (ATSPPHS, Fischer & Farina, 1995). Possible scores on the inventory range from 0 to 30, with positive attitudes toward seeking psychological help correlating with higher scores, and negative attitudes correlating with lower scores.

1.6.5 Public Stigma

When a person’s overall identity includes a status that is stigmatized by the wider society, their identity on the whole is deemed ruined or spoiled, because that one perceived defect eclipses other qualities, and influences others’ perceptions of their actions and character (Goffman, 1963). Public stigma is therefore defined as the perception that a person is “flawed because of a personal or physical characteristic that is regarded as socially unacceptable” (Vogel, Wade, & Haake, 2006, p. 325). In this study, public stigma will be measured using the Stigma Scale for Receiving Psychological Help (SSRPH; Komiya, good, & Sherrod, 2000), a five item scale with possible scores ranging from 0 to 15, with higher scores indicating higher levels of perceived public stigma.

1.6.6 Private stigma

Self-stigma or private stigma is “the reduction of an individual’s self-esteem or self-worth” caused by labeling oneself “as someone who is socially unacceptable”
Corrigan (2003) suggests that people who seek mental health services, and/or have a mental health diagnosis are influenced by stigmatizing beliefs and attitudes in the wider society. Negative stereotypes about persons with mental illness are pervasive in the media and popular culture (Granello & Pauley, 2000) and may be internalized by those who seek or are in treatment due to psychological or emotional problems. Self-stigma will be measured using the Self-Stigma of Seeking Help (SSOSH) scale, a 10 item inventory with scores ranging from 0 to 40, with higher scores indicating participants’ “greater concern that seeking help from a psychologist or other mental health professional would negatively affect one’s self-regard, satisfaction with oneself, self-confidence, and overall worth as a person” (Vogel, Wade, & Haake, 2006, p. 327).

1.6.7 Distress Disclosure

Distress disclosure, or one’s comfort with disclosing distressing information of a personal nature, will be assessed using the Distress Disclosure Index (DDI), developed by Kahn and Hessling (2001). The DDI is a 12-item instrument using a Likert-type scale (0= Disagree, 1 = Somewhat Disagree, 2 = Somewhat Agree, 3 = Agree) with scores ranging from 0 to 36. Higher scores indicate a greater likelihood on the part of the individual to disclose information of a distressing nature to others. Examples of items on the DDI include “When I feel upset, I usually confide in friends,” and “If I have a bad day, the last thing I want to do is talk about it.”
1.7 Limitations of the Study

The sample for this study may or may not be representative of all counselor education trainees in USA. Although responses may be collected from counseling trainees throughout the United States, only those counseling trainees who have joined the American Counseling Association as student members will be accessed to participate in the study.

The use of survey research methodology in this study raises concerns about rate of return of the questionnaires, and whether or not there will be enough respondents to generate significant results for the study. Attempts will be made to insure a good rate of return, including an introductory letter in the survey packet that explains the study and asks them to look for their survey packet in the mail. A reminder post card will also be sent to participants who have not responded within two weeks of the original survey mailing.

Another limitation of the study relates to the nature of self-report instruments in the practice of assessing attitudes and characteristics of respondents, particularly when the subject matter is of a personal or delicate nature. Use of an instrument to monitor respondents’ levels of “faking good,” such as the Marlowe Crown, was considered, but not utilized ultimately to maintain a shorter length to the overall questionnaire, thereby reducing respondent burden and improving likely response rates.

Self selection to participate also represents a limitation of the current study. While student members of the ACA were randomly selected to receive the mailing, it was
incumbent upon the ACA student member, once contacted, to complete and return the questionnaire, which can ultimately bias the data received.

1.8 Summary

Research suggests anywhere from one half to three quarters of people who might benefit from counseling never receive services. Public concerns and barriers to help seeking, both real and perceived, have been articulated in the results of several studies. Counseling trainees experience stressors and challenges as they prepare to enter a profession that assists individuals in dealing with the stressors and challenges of life. Little is known about the help seeking attitudes and behaviors of these future counseling professionals. Counselor education programs promote wellness and self-care, yet some studies report students continue to experience impairment during their training, while faculty and site supervisors continue to formulate policies and strategies for effective intervention and remediation.

Engaging in the counseling process as clients may provide counseling trainees with enhanced opportunities for developing interpersonal skills; self-knowledge and personal insight; the capacity for empathy; and greater complexity of case conceptualization. Students could benefit from counseling as an opportunity for observational and experiential learning, as in many group counseling skill classes.
Chapter Two

Review of the Literature

2.1 Introduction

Because counselors are human, they are subject to the same stressors and problems they are trained to treat. History, anecdote, common sense, and research all suggest that counselors and therapists face problems and challenges in their own lives that are similar to those faced by their own clients (Kottler, 1993; Stratton, Kellaway, & Rottini, 2007). The personal problems and challenges experienced by professional counselors may best be met with the help of another professional.

Little is known about the professional help seeking attitudes and behaviors of trainees in Masters level counseling programs. While training to become professional counselors, trainees themselves may be in need of engaging in professional counseling services to improve their situation, personal outlook, and overall effectiveness in life and work (Dearing, Tangney, & Maddux, 2005; Enochs & Etzbach, 2002; Ronnestad & Skovholt, 2001; Skovholt & Ronnestad, 2003; Witmer & Young, 1996).

Graduate school can be stressful. Graduate students who are training to be counselors may feel enormous pressure to perform and may feel overwhelmed and
anxious (Ronnestad & Skovholt, 2003). Today’s counseling graduate students are likely to have full time jobs, families, and other responsibilities. This is especially true for older students who enroll in graduate school in an effort to change careers. Standards tend be higher in graduate school, and students may be responsible for demonstrating progress by means that are more self-directed and independent of the classroom. Many graduate programs have requirements that meet specifications set down by government agencies and offices regulating the profession into which the graduates will be seeking participation as practitioners. Graduate programs in counseling prepare professionals, and part of the training necessarily includes requiring trainees to demonstrate their maturity, self-awareness, decision making and interpersonal skills, and the ability to maintain their ethical responsibility (ACA, 2005; ACES, 2003; Ronnestad & Skovholt, 2001; Wampold, 2001).

The practice of counseling can make significant demands on the mental, physical, and emotional wellbeing of the practitioner. In their practica and internships, trainees may face intense emotional experiences, as well as life and death issues with their clients (Enochs & Etzbach, 2002; Skovholt, Jennings, & Mullenbach, 2004). Research suggests counseling trainees are at greater risk than the general public for psychosocial and emotional challenges due to the nature of their studies and the type of work they will engage in as professionals (Dearing, Tangney, & Maddux, 2005; Skovholt & Ronnestaad, 2003; White & Franzoni, 1990; Witmer & Young, 1996). White and Franzoni (1990) reported MMPI results from 180 counseling students showed lower levels of mental health in the sample than in the general population. Counselors are witness to reports of
atrocities, violence, and loss. They cannot help but be affected and need some means of caring for and healing the fatigue and psychological wounds of their work (Adams, Boscarino, & Figley, 2006; Creamer & Liddle, 2005; McAdams & Foster, 2000).

2.2 How Does Counseling Help Trainees?

The literature points to a number of areas in which participation in personal counseling could be beneficial to counseling trainees. These include personal growth; deepening of therapeutic skills through observational learning; appreciation for the client’s experience of therapy thereby increasing empathetic capacity of the counseling trainee in the working alliance; and greater habituation of counselor self-care practices (Neukrug & Williams, 1993).

Professional development toward greater clinical effectiveness in counselors and trainees may be a cyclical process that reinforces learning points throughout a career (Jennings, Goh, Skovholt, Hanson, & Banerjee-Stevens, 2003). Part of that process could be periodic involvement in personal therapy on the part of the counseling trainee or professional. The American Counseling Association defines counseling as “a relatively short-term, interpersonal, theory-based process of helping persons who are basically psychologically healthy resolve developmental and situational problems” (ACA, Crisis Facts Sheet,). Counseling trainees are engaged in a developmental process throughout their training (and even their careers), therefore, an integrated understanding of how personal counseling may facilitate the process of personal and professional development could be beneficial to their training.
The counselor education literature cites self-awareness, increased insight, and confidence as positive qualities for counseling professionals to develop as they train to be effective professionals (Jennings, Goh, Skovholt, Hanson, & Bannerjee-Stevens, 2004; Ronnestad & Skovholt, 2003; Skovholt & Ronnestad 2003). In their qualitative study of ten peer-identified “master therapists,” Skovholt, Jennings, and Mullenbach (2004) concluded that these highly effective clinicians were characterized by a level of advanced intrapersonal growth. The characteristics identifying this level of development in these therapists included such qualities as “Self-Acceptance;” an “Intense Will to Grow;” “Self-Aware;” “Congruent;” “Reflective;” and “Welcome Openness to Life” (Skovholt, Jennings, & Mullenbach, 2004). Training in the helping professions has focused and continues to focus on increasing providers’ self-awareness in their work with patients and clients (Benbassat & Baumal, 2005; Howard, Inman, Altman, 2006).

Certainly, clinical supervision is an appropriate and effective outlet for discussing and working on issues such as dynamics in the counseling dyad (e.g. transference and countertransference), development and refinement of clinical techniques and interventions, and development of one’s professional identity as a counselor, all of which can be directly related to a counselor’s effectiveness in treating a client (Goodyear & Bernard, 1989; Granello, Beamish, & Davis, 1997; Pfohl, 2005; Stratton, Kellaway, & Rottini, 2007; Sumerel & Borders, 1996). Personal challenges that might be fodder for professional counseling for the trainee may not come up in the supervisory dyad with counseling trainees; yet may impact the trainees’ effectiveness in the counseling session (Stratton, Kellaway, & Rottini, 2007). Some of the benefits of counseling highlighted in
recent research may also have benefits for the professional growth and development of the counseling trainee or novice. Seeking personal counseling may be an opportunity for counseling trainees to work on personal skills and awareness, which are often cited as being integral to being an effective clinician (Skovholt, Jennings, & Mullenbach, 2004; Ronnestad & Skovholt, 2003; Ronnestad & Skovholt, 2001; Wampold, 2001).

The practitioner’s ability to establish and maintain a good working alliance with the client through in-session behaviors that strengthen the therapeutic relationship has been suggested as a critical element in the effectiveness of the practitioner. Wampold (2001) stressed the importance of the counselor’s ability to form relationships with clients in therapy. “[T]herapists within treatment account for a large proportion of the variance [in treatment outcomes]. Clearly, the person of the therapist is a crucial factor in the success of therapy” (Wampold, 2001, p. 202). Some of the factors that positively influence counseling success are connected to the therapist’s ability to establish an interpersonal bond with the client (relationship), and also the quality of that bond (Jennings, Goh, Skovholt, Hanson, & Banerjee-Stevens, 2003; Lambert, 1989; Lambert & Bergin, 1994).

Ronnestad and Skovholt (2003) state that counseling trainees are eager, as part of their training, to observe how professional counselors conduct therapy, thus enabling trainees to learn through observing a more experienced clinician in practice. The authors suggested observing Internship Supervisors or filmed therapy sessions (e.g. *Three approaches to psychotherapy* films; Rogers, Perls, and Ellis; edited by Shostrom). Engaging in counseling as a client would afford trainees observational learning
opportunities (participant observation). Personal counseling for the trainee has the potential to enhance intrapersonal skills central to being an effective counselor (e.g. self-awareness and insight). Trainees’ participation in personal counseling may also strengthen interpersonal skills (e.g. communication skills) in an in situ learning experience.

Neukrug & Williams (1993) in their review of the literature focusing on counselors usage of personal therapy, cited a number of studies in the 1960’s, 70’s and 80’s that indicated relatively high rates of therapy usage by practicing psychologists, social workers, and psychiatrists (e.g. Ford, 1963; Norcross, Strausser-Kirtland, & Missar, 1988; Pope, 1987; Wampler & Strupp, 1976; Watkins, 1983). The meta-analysis by Neukrug and Williams (1993) of those published accounts yielded a list of benefits to therapists who participated in some counseling modality (e.g. individual, group, couple, family) as a client:

1. an increase in the emotional health of the therapist
2. a deepened understanding of intra- and interpersonal functioning and increased self-awareness
3. a decrease in therapeutic "blind spots"
4. an increase in the therapist's personal conviction about the ability of therapy to work
5. an increased respect for the role of the client
6. a mechanism to provide role models for therapists
7. a decrease in counselor acting out behavior, such as making inadequate responses to client statements, showing anger and frustration toward the client, being seductive or sexual with the client, and acting on logistical mistakes such as showing up late for appointments (Neukrug & Williams, 1993, pp. 51-52).

Items 3-7 above suggest that trainees’ participation in personal therapy as clients, enabling them to observe as well as participate as clients, renders some benefit to their development as effective practitioners (Neukrug & Williams, 1993).

Farber (1999) suggested a preventative approach to training future psychologists to seek help when they are in need. This may also include encouraging a philosophy of prevention in future therapists, to engage in periodic counseling themselves to insure (vaccinate) against extreme impairment or a reactive approach to addressing issues of stress and wellness that may impact the therapist’s ability to perform effectively with clients. Unfortunately, there is still very little information in the literature about the effectiveness and benefits of counseling trainees’ participation in personal therapy. It may be necessary to draw on a few examples from the literature that discusses this phenomenon in other helping professional (e.g. medical students, social work trainees, etc.) as well as practicing therapists in order to fully understand the benefits psychological help may hold for counselors-in-training.

A study conducted by Ronnestad and Skovholt (2001) involved a qualitative inquiry into the key formative experiences of 12 psychotherapists. The authors identified four critical arenas of learning based upon the developmental experiences reported by the
participants: “early life experience, cumulative professional experience, interaction with professional elders, and experiences in adult personal life” (Ronnestad & Skovholt, 2001, p. 181). One of the implications of the study involved the importance of integrating personal life experiences as a means of professional as well as personal growth and development (Ronnestad and Skovholt, 2001). Relationships in families of origin, both positive and negative, and loss of or support from spouses were among the impactful personal experiences the therapists cited as formative to their clinical development and performance. Whereas Ronnestad and Skovholt (2001) did not report that any of the counselors in the study had sought personal counseling as a strategy for integrating these life experiences, counseling trainees do seek personal therapy while in training, and engaging in such therapy could increase trainees’ abilities to utilize these experiences in their professional and personal growth.

2.2.1 Interpersonal Skills and Communication

Increasing interpersonal skills and communication during therapy can be beneficial to treatment outcomes. Effective counseling requires effective communication skills, and counselors’ training indicates that creating trust is essential to the foundation of communication (Jennings, Goh, Skovholt, Hanson, & Bannerjee-Stevens, 2001; Wampold, 2001). It is still widely held that the therapeutic bond requires counselors to empathize with their clients and form working alliances with them. This may include, but not be limited to, communicating respect to the client and assuring the client that counselor is interested in the client’s reason for being there. As applies to items 1,2,3,5,
and 7 above, engaging in personal counseling during their training might strengthen the trainee’s skills in ways the supervisory dyad does not.

In one study conducted by Street, Makoul, Arora, and Epstein (2009) the authors identified seven “pathways” by which communication in the patient-provider relationship has the potential to improve longer-term outcomes for clients. These were: increased access to care; greater patient knowledge and shared understanding; higher quality medical decisions; enhanced therapeutic alliances; increased social support; patient empowerment; and better management of emotions (pg. 295, Street, Makoul, Arora, & Epstein, 2009). These characteristics are gained through trust, understanding, and the counselor-client agreement established throughout the therapeutic relationship. The authors suggest that the presence of these qualities in clients lead to better overall health in clients, even after therapy has terminated. Therefore, the proximal outcomes of interpersonal interactions in the counseling relationship (understanding, trust, counselor-client agreement) lead to intermediate outcomes of greater adherence and self-care in clients, with greater potential for long term health benefits (Street, Makoul, Arora, & Epstein, 2009).

2.2.2 Self-awareness and Insight

Training as a professional counselor involves a process of personal as well as professional growth. Bernard (1979) suggested “it is difficult to become a more efficient and skilled counselor without also experiencing greater personal growth” (p. 63). Hensley (2002) cited self-awareness as part of the developmental process of the professional self.
Counseling offers opportunities to the individual for gaining greater insight and self-awareness. Fostering greater client self-awareness has been thought to benefit clients’ positive progress in therapy (Brott, 2004; Han 2004; Jinks, 1999). Group and individual counseling experiences have been shown to produce greater capacity for self-awareness in clients (Han, 2004; Jinks, 1999). A study conducted by Jinks (1999) involved qualitative analysis of four long-term individual therapy clients. Self-reports on the part of clients characterizing a greater sense of control in their lives were accompanied by feelings of self-awareness, greater insight, assertiveness, increased decision making ability, capacity for taking action, and confidence (Jinks, 1999). These same opportunities for building greater capacities for self awareness and insight are available to counseling trainees who participate in therapy.

2.3 Psychological Help Seeking

The counseling literature indicates that the majority of people who could benefit from psychological services (e.g. counseling, individual and group therapy) do not seek them out (Corrigan, 2004; Komiya, Good, & Sherrod, 2000; Narrow, Regier, Norquist, Rae, Kennedy, & Arons, 2000; Snowden, 1999). Some reports estimate that more than half of those suffering from mental illness do not seek professional help (Cepeda-Benito & Short, 1998; Komiya, Glenn, & Sherrod, 2001), and as few as 20% of those who could benefit from mental health services actually seek them out (Corrigan, 2004, Mohr, et al., 2006). Less than 40% of individuals seek any type of professional help within a year of the onset of a psychological disorder (Andrews, Issakidis, & Carter, 2001; Narrow, Reiger et al., 2000; Vogel, Wester, Larson, & Hackler, 2007). Epidemiological studies
have suggested that between 40% and 90% of those with serious and persistent mental illness are not receiving comprehensive treatment (Corrigan, 2004).

There is speculation that people employ other strategies and methods for coping with life’s problems and challenges, such as counsel from friends, family, or clergy; some people may use inappropriate, non-productive, or potentially harmful methods to relieve symptoms, such as drug or alcohol use/abuse; or they may simply wait for time to relieve their distress. While individuals may naturally seek help in times of trouble and distress, they may not necessarily be favorably inclined to seek help from professional sources.

Narrow, Regier, Norquist, Rae, Kennedy, and Arons (2000) evaluated data from the National Institute of Mental Health Epidemiological Catchment Area (ECA) program to examine mental health service usage by people with severe mental illness in the United States. The data set represented “A total of 18,571 household and 2290 institutional residents age 18 and over […] in five areas: New Haven, Baltimore, Durham, St. Louis, and Los Angeles. The sample size for these analyses is 20,291” (p. 148). Ten ambulatory and seven inpatient settings were used in gathering data, and the types of service utilization examined focused on general medical (GM) and specialty mental health and addiction (SMA) services, some of which were in institutional settings, and others in private practice setting.

While Narrow, et al., (2000) reported that private practice specialists were most frequently used by participants in the study, the percentage of total visits to these private practitioners was significantly greater for participants without severe mental illness (e.g. as opposed to study participants rated with severe mental illness) (Narrow, et al, 2000).
These findings may support the assertion that counseling is sought by relatively normally functioning people for assistance with life’s problems (Corey, 2006; Gladding, 2007). Also, results showed that, after controlling for socioeconomic status, Hispanics and Blacks were much less likely to have received services or care for their severe mental illness (Narrow, et al., 2000). These findings, based upon a large epidemiological data set, are supported in other studies in the literature, which suggest that those who need mental health services most tend not to seek them out, or persist in therapy (Corrigan, 2004; Gonzalez, Alegria, & Prihoda, 2005; Snowden, 1999) and also suggest that individuals from racial minorities seek help less often than Whites/European Americans (Constantine, Wilton, & Caldwell, 2003; Duncan, 2003; Gonzalez, Alegria, & Prihoda, 2005; Snowden, 1999). A few of the studies are based on similar, if not the same, large epidemiological data pools as Narrow, et al., (2000) (Gonzalez, Alegria, & Prihoda, 2005; Snowden, 1999). The majority, however, are based upon small convenience samples of college undergraduates (Atkinson & Gim, 1989; Constantine & Gainor, 2004; Constantine, Wilton, & Caldwell, 2003; Duncan, 2003; Milville & Constantine, 2006; Price & MacNeill, 1992).

2.3.1 Help Seeking by Demographic

A number of studies have examined help seeking attitudes and behaviors of various groups (Atkinson & Gim, 1989; Deane & Todd, 1996; Delphin & Rollock, 1995; Duncan, 2003; Fischer & Turner, 1970; Fischer & Cohen, 1972; Kelly & Achter, 1995; Milville & Constantine, 2006; Morgan, 1992; Price & MacNeill, 1992; Vogel & Wester, 2003). Rates of help seeking may vary between (or even among) groups of people,
depending upon such shared or differing factors as gender, race, age, and sexual orientation (Atkinson & Gim, 1989; Cepeda-Benito & Short, 1998; Cochran, Keenan, Schober, & Mays, 2000; Delphin & Rollock, 1995; Duncan, 2003; Fischer & Cohen, 1972; Gonzalez, Alegria, & Prihoda, 2005; McClennen, Summers, & Vaughan, 2002; Milville & Constantine, 2006; Pederson & Vogel, 2007; Price & MacNeill, 1992; Segal, Coolidge, Mincic, & O’Riley, 2005; Wallace & Constantine, 2005).

**Gender**

Research has consistently found that women have more favorable attitudes toward seeking psychological help and express more willingness to seek that help than men (Fischer & Turner, 1970; Gim, Atkinson, & Whiteley, 1990; Kelly & Achter, 1995; Leong & Zachar, 1999; Price & McNeill, 1992; Wallace & Constantine, 2005). Gonzalez, Alegria, and Prihoda (2005) examined and analyzed help seeking data in the National Comorbidity Survey (NCS), a data source of over 8,000 participants who were asked, among other things, about their attitudes toward seeking mental health services. Results demonstrated strong support for research that highlights women’s positive attitudes and help seeking behaviors regarding mental health services (Narrow, Regier, et al., 2000; Snowden, 1999). Men’s responses in the NCS data indicated they were 50-60% less likely than women to have positive attitudes toward seeking help, and 50% less likely than females in the study to be willing to seek psychological services.

Studies involving convenience samples tend to confirm these findings from larger studies. Women have consistently expressed more positive attitudes toward seeking professional psychological help in the majority of studies examining help seeking
attitudes and behaviors of various populations (racial groups, Atkinson & Gim, 1989; Delphin & Rollock, 1995; Milville & Constantine, 2003). In a study involving a convenience sample at a large university, Leong and Zachar (1999) reported differences between males and females in attitudes toward seeking psychological help, with males expressing significantly less positive attitudes than females. Results indicated that males in the study held less benevolent feelings toward individuals with mental illness; and had more socially restrictive feelings about individuals with mental illness (Leong & Zachar, 1999).

Some theory and a few studies published in the literature have attempted to examine some of the causes for men’s seemingly more negative and restrictive attitudes toward seeking counseling and having or being diagnosed with a mental illness (Blazina & Marks, 2001; Cusack, Deane, Wilson, & Ciarrochi, 2006; Pederson & Vogel, 2007). Interestingly, a study conducted by Blazina and Marks (2001) showed some evidence that men who had experienced personal counseling themselves had more positive responses to promotional brochures for men’s discussion and self-help groups than did men who had never been to counseling.

Race

Some of the research suggests that, while there may be need for mental health services within racial minority groups, people who identify as members of racial minorities may be less likely to seek that help than their Caucasian counterparts. It is estimated that African Americans receive mental health care at half the rate of European Americans (U. S. Department of Health and Human Services, et al., 1999). This
underutilization of psychological help on the part of Blacks and African Americans, and that of other racial minorities, has sometimes been attributed to less access to and inability to afford mental health services (Alegria, Canino, Rios, Vera, Calderon, Rusch, et al., 2002, Atkinson & Gim, 1989; Milville & Constantine, 2006; Price & MacNeill, 1992; Snowden, 1999). Individual perceptions based upon sociocultural developmental experiences may also influence psychological help seeking (e.g. cultural mistrust, racial identity) and have been found to correlate with help seeking attitudes and behaviors (Delphin & Rollock, 1995; Duncan, 2003; Wallace & Constantine, 2006).

Gonzalez, Alegria, and Prihoda (2005) used data obtained from the National Comorbidity Survey (NCS) to explore help seeking attitudes and behaviors in populations based upon age, gender, and race/ethnicity. The NCS assessed respondents’ attitudes toward seeking mental health services using three questions, each based upon a four-point Likert scale:

1. If you had a serious emotional problem, would you definitely go, probably go, probably not go, or definitely not go for professional help?

2. How comfortable would you feel talking about personal problems with a professional—very comfortable, somewhat, not very, or not at all comfortable?

3. How embarrassed would you be if your friends knew you were getting professional help for an emotional problem—very embarrassed, somewhat, not very, or not at all embarrassed? (Gonzalez, Alegria, & Prihoda, 2005, p. 614).
Of note are Gonzalez and colleagues’ (2005) findings in their examination of the data that African American respondents to the NCS showed more positive attitudes toward seeking mental health services than did Anglo (European-American, Caucasian) respondents. This contrasts with findings in other studies (Constantine, Wilton, & Caldwell, 2003; Duncan, 2003; Wallace & Constantine, 2005) where members of racial minorities surveyed about their attitudes toward seeking psychological help typically expressed less positive attitudes than White participants. When comparing attitudes toward help seeking within racial minority respondents, younger respondents to the NCS (ages 15-17 and 18-25) in racial minority groups indicated less positive attitudes toward and less likelihood of seeking mental health services than older members of racial minorities (Gonzalez, Alegria, & Prihoda, 2005).

Snowden (1999) reviewed the 1991 National Institute of Mental Health Epidemiologic Catchment Area Program data to investigate medical and mental health service usage, specifically comparing those of Blacks and Whites in key catchment areas in the United States (e.g. New Haven, Baltimore, Durham, St. Louis, and Los Angeles). The researcher examined institutionalized people and found that Blacks were more likely to lack insurance, use emergency rooms, and not utilize therapists in private practice. This may relate to Narrow, et al.’s (2000) findings, which suggested that individuals seeing private practitioners tended to attend therapy longer, particularly those with less severe diagnoses. These findings also relate to other concerns related to psychological help seeking, such as accessibility and affordability of services (Dearing, et al., 2005; McCarthy et al., 2010).
A number of studies have examined the salience of race and the concomitant socio-cultural perceptions and influences on help seeking attitudes and behaviors. These studies, largely based upon convenience samples of college students, involved members of different racial groups, and suggest that people who do not identify with the dominant culture shy away from it and its systems (e.g. mental health; psychological help) (Atkinson & Gim, 1989; Constantine, Wilton, & Caldwell, 2003; Duncan, 2003; Gloria, Hird, & Novarro, 2001; Milville & Constantine, 2006; Price & MacNeill, 1992; Wallace & Constantine, 2005).

One factor frequently examined with racial sub groups relates to cultural mistrust of whites, institutions, authority figures, and those from different cultures or strangers (Duncan, 2003; Milville & Constantine, 2006; Price and MacNeill, 1992; Wallace & Constantine, 2004). Here the literature cites the phenomena of acculturation and enculturation as being related to more or less willingness to seek help, as well as more or less positive attitudes toward seeking that psychological help. Acculturation is defined as adherence to and comfort with norms of the dominant culture within a society or nation (e.g. Anglo or White culture in the United States), and enculturation is defined as adherence to and comfort with norms of one’s own identified cultural group (e.g. Mexican American (Gloria, Hird, & Novarro, 2001; Milville & Constantine, 2006); African American (Duncan, 2003; Wallace & Constantine, 2006); Asian American (Atkinson & Gim, 1989)). Individuals who are more enculturated to their own race and culture can have stronger connections to traditional customs and systems and may be suspicious of more mainstream institutions and systems of treatment (e.g. seeking
professional psychological help at agencies or hospitals). High acculturation (to the
dominant culture), low family support and low significant other support correlates to
more positive attitudes toward seeking professional help (Constantine, Wilton, &
Caldwell, 2003; Duncan, 2003; Milville & Constantine, 2006). Also high acculturation,
low family support and high significant other support correlated to more positive help
seeking attitudes (Milville & Constantine, 2006). Duncan’s (2003) findings supported
this, at least in part. Older Black men with fewer supports tended to express more
positive attitudes toward seeking professional psychological help than younger Black
men.

In their study of Asian students at a large Midwestern university, Atkinson and
Gim (1989) also found that students who demonstrated greater levels of acculturation to
United States culture also demonstrated more favorable attitudes toward and an increased
likelihood of seeking psychological services than did Asian students in the study who
demonstrated higher levels of enculturation (adherence to culture of origin norms and
values). Indeed, inconsistencies and conflicts between acculturation and enculturation are
often a source of stress for many non-white people in the United States, thus,
acculturative stress may lead to the presence of psychological symptoms that may be
associated with a need to seek professional help. However, whether individuals
struggling with acculturative stress seek this help appears to be questionable for a number
of reasons, such as preference for seeking traditional healing, concerns about social
stigma, feelings of alienation, and cultural mistrust (Constantine, Okazaki, & Utsey,
Delphin and Rollock (1995) examined the potential impact of racial identity development on attitudes toward seeking psychological help. The authors surveyed 180 African American undergraduate students from a large university in the Midwestern United States (92 female; 88 male). The authors surveyed participants about their level of alienation from their university environment, their level of racial identity development, their attitudes toward seeking professional psychological help, and attitudes toward the university counseling center. A hierarchical multiple regression model of racial identity development levels and university alienation against participants’ attitudes toward seeking help was conducted. The regression model explained only 7% of the variance in participants’ ATSPPHS scores. While participants’ attitudes toward seeking help were moderately impacted by their levels of alienation from the university environment, cultural mistrust did not demonstrate any significant impact on attitudes. It would seem that, while it may make intuitive sense that cultural and racial identity may impact help seeking attitudes, there is little in the research that supports the theory that racial identity development relates significantly to help seeking attitudes.

2.3.2 Help Seeking by Other Graduate Trainees

Counseling trainees are not alone among people who are undergoing specialized training to enter helping professions, and may be subject to similar pressures, stressful experiences, and demanding lives. There is evidence that trainees in other helping
professions also suffer from stress, pressures of life and school, internships and families, and experience psychological distress or have mental health problems.

Studies report higher rates of depression and suicide in medical students than in the general population (Milagros, Ockene, Ockene, Barrett, Ma, & Herbert, 1997; Mosley, Perrin, Neral, Dubbert, Grothues, & Pinto, 1994). The highest rates of depression in medical students occur by the second year of medical school (Givens & Tjia, 2002). For example, Givens and Tjia (2002) investigated depressed and non-depressed medical students’ use of mental health services. Time was cited as the greatest barrier to seeking help. This concern was the same for both depressed and non-depressed medical students surveyed. The second greatest barrier cited by depressed medical students was concern over confidentiality. These were also concerns for non-depressed students, but non-depressed students did not rank these concerns as highly as did the depressed students.

Stigma related to receiving mental health care was a concern among the students surveyed (Givens & Tjia, 2002). Fear of documentation, as well as concerns around lack of confidentiality, may also reflect an awareness of negative consequences for those who are known to be in mental health treatment. Obstacles reported by more than one third of the students included lack of time, lack of confidentiality, concern that ‘no one will understand my problems,’ the stigma of mental health care, and feeling that ‘my problems are not important’” (Givens & Tjia, 2002, p. 920).

Similar to counseling trainees, medical students tend to show higher rates of emotional and personal problems (e.g. depression and suicide) than the general
population (Givens & Tjia, 2002; Milagros, Ockene, Ockene, Barret, Ma, & Herbert, 1998). Givens and Tjia (2002) surveyed first and second year medical students at a university medical school in San Francisco about their potential depression levels and use of mental health services. Participants completed the Beck Depression Inventory (BDI) and responded to a list of potential barriers or concerns about seeking mental health services. Of the 46 medical students who showed elevated levels of depression according to their BDI scores, only 10 were engaged in personal therapy to address their depression. Most commonly cited barriers to seeking psychological help were lack of time; lack of confidentiality; concern that “No one will be able to understand my problems;” stigma associated with using mental health services; feeling that “My problems are not important;” cost; feeling that “Using services will mean I am weak;” fear of unwanted intervention; and fear of documentation on academic record.

Other studies lend credence to the suggestion that the nature of symptoms of depression itself may contribute to some of the perceived barriers cited by participants in this study (Mohr, et al., 2001). Feelings of worthlessness (“My problems are not important”), hopelessness (e.g. “No one will be able to understand my problems”), and helplessness (“Using services will mean I am weak”) are consistent with the symptomology of depression. Medical students were also concerned about how others would perceive them were it known they were seeking psychological help (e.g. lack of confidentiality; stigma; documentation on academic record) (Givens & Tjia, 2002). These stigma-related barriers reported by Givens and Tjia (2002) seem consistent with concerns of counseling graduate students in terms of how others will perceive their performance
and abilities as students and future practitioners (Dearing, et al., 2005; McCarthy et al., 2010).

Weintraub, Dixon, Kohlhepp, and Woolery (1999) present some interesting ideas as a result of their survey of past and current psychiatric residents from three residency programs in the Louisville, KY area. Past residents were contacted through information obtained from the American Psychiatric Association professional database. The authors noted a decline in participation in personal therapy on the part of current psychiatric residents when compared to past residents, even when accounting for focus of their studies (e.g. psychoanalysis versus psychobiological program focus). One interesting finding was that survey participants who had engaged in therapy prior to their studies were more likely than those who had not to seek therapy while in their residency. The authors speculated that the decline in residents seeking therapy may be accounted for, in part, by the shift in the profession of psychiatry from a psychoanalytic orientation to a more medical and behavioral orientation. Surveyed participants were asked if they felt being trained to engage in therapy with their clients was important to them as practitioners. Those who indicated a desire to train in and deliver therapy to their patients were also more likely to seek therapy themselves than those who said they were not interested in training in or delivering therapy to their patients (Weintraub, Dixon, Kohlhepp, & Woolery, 1999).

2.3.3 Help Seeking by Counseling and Psychology Trainees

The saying “A lawyer who represents himself has a fool for a client” may be appropriate to the situation of psychological help seeking for mental health professionals
as well. There are times when one’s current level of personal insight and professional
knowledge may be inadequate resources for a professional counselor to solve or even
address their own life challenges and crises. Having the capacity to treat (e.g. mental
disorders, physical ailments) does not make one immune to the effects of disease. Just as
doctors become physically ill, counselors will experience emotional and psychological
distress, and, as a result, may or may not decide to seek help.

Counseling trainees are undergoing a developmental training process, in part
academic and skills oriented, in part a journey of personal growth (Council for the
Accreditation of Counseling and Related Education Programs, 2001) that may call on
them to gain greater self-awareness (ACES, 1993; CACREP, 2001; Rønnestad &
Skovholt, 2003.) It is expected that counselors know themselves well, understand their
strengths and limitations, and take steps to obtain any help necessary to maintain their
own mental, physical, and emotional well being in order to serve the public effectively
and ethically (ACA, 2005; Corey, Corey, & Callahan, 2003; Enochs & Etzbach, 2004;
Witmer & Young, 1996). Engaging in personal therapy is one means of strengthening the
interpersonal and intrapersonal competencies counseling trainees need to develop if they
are to practice effectively and ethically (Gilroy, Carroll, & Murra, 2002).

Counseling trainees are taught to value counseling as a means of solving
problems, learning adaptive life skills, and improving quality of life. Some of the
research cited here shows evidence that those trainees who value counseling and hope to
deliver counseling services themselves may be more likely than the general public to seek
professional help as a means of coping with their own personal problems (Corrigan,
Investigations of professionals in mental health fields have found that between 45 and 80 percent of them have had some form of therapy (Deutsch, 1984; Garfield & Kuntz, 1976; Guy, Stark, & Poelstra, 1988; Norcross, Strausser, & Faltus, 1988; Prochaska & Norcross, 1983). In Neukrug and Williams’ (1993) survey of counselors (drawn from 2,000 counselors in the American Counseling Association database) they found that 67 percent of participants—61 percent of the men and 71 percent of the women—had been involved in individual counseling. However, little research has explored the usage of and attitudes toward seeking psychological help on the part of counseling trainees.

Holzman, Searight, and Hughes (1996) surveyed clinical psychology trainees from APA-accredited training programs throughout the United States about their participation in personal therapy. A majority of the respondents reported having been in therapy at least one point in their lives (74%) and 53% of those respondents reported having been in therapy at more than one point in their lives. Of the 74% who reported having been in therapy, 74% had been or were in therapy during their graduate training. Ninety-nine percent (99%) of respondents who had been in therapy during graduate training reported they were still in therapy or would consider entering therapy again. Fifty-six percent (56%) of respondents in therapy during their graduate studies reported they did not discuss their personal therapy with their clinical supervisor (Holzman, Searight, & Hughes, 1996).

Holzman et al (1996) reported that respondents who indicated having been in therapy also reported an average length of time in therapy of 1.5 years. This is well above
averages for national population samples, which report typical average lengths of time in therapy between 4 to 16 sessions (Garfield, 1994). Respondents most frequently reported reasons for going to therapy were “personal growth, desire to improve as therapist, adjustment or developmental issue, depression, problems with spouse or significant other, and issues in family” (Holzman, et al., 1996, p. 100). The most common reasons cited for not seeking therapy were “no need for it,” and “finances,” (Holzman, et al., 1996, p. 100).

Strozier, Bowen, and Vogel (2003) studied usage of psychological help in Masters students studying to be Marriage and Family therapists at a college in Macon, GA. In a survey of 40 Masters trainees enrolled in family therapy and family services programs at the college, factors of age, gender, race/ethnicity and program enrollment did not correlate strongly with utilization of therapy services. The one factor that correlated significantly with seeking professional help (e.g. engaging in therapy) was the length of time a student had been enrolled in the program. Those marriage and family trainees who were enrolled in their program for a longer period of time were more likely to have sought psychological help. In fact, the authors reported that usage of therapy services by family therapy trainees accelerated at about the time trainees began their practicum placements (Strozier, Bowen, & Vogel, 2003).

Another study by Farber (1999) was based on a national sample of counseling psychology doctoral students who were working in their internship placements at the time of being surveyed. The sample of 178 participants was 65% female and 77% Caucasian. In the results of her survey, Farber (1999) reported that although participants reported
they had sought counseling as an opportunity for professional growth, few had in fact sought counseling for that purpose prior to becoming students (3 participants, or 1.7%).

This, along with some of Holzman, et al.’s (1996) and Strozier, et al.’s (2003) findings, suggests that counseling trainees see some developmental benefit in engaging in personal therapy during their clinical training, whether to deal with stress or depression or as an opportunity to learn about the process of therapy as a participant-observer. Then again, while 64% of the counseling psychology interns in Farber’s (1999) study had sought help at some time in their lives, only 46.6% of those who had sought therapy indicated they would definitely seek counseling in the future, and 11.8% indicated they were not sure whether they would seek counseling in the future. Two respondents (1.1%) indicated that they would not seek counseling in the future.

Dearing, Maddux and Tangney (2005) conducted a national survey of over 900 randomly selected psychotherapists in training from the American Psychological Association student member database. Their research focused on factors influencing participants’ decisions to seek and initiate counseling during their graduate studies (as opposed to counseling initiated prior to graduate studies). Results of the survey found that 70 percent had been in therapy at some point prior to being surveyed, and 54 percent indicated having been in therapy at some point during their graduate studies.

In the Dearing et al (2005) study, 959 psychology graduate students were mailed questionnaires. After accounting for those surveyed who were not registered in the target disciplines (clinical or counseling psychology) the original response rate was 35.7% (n=342). The authors wanted to investigate clinical and counseling psychology trainees
only, and, within that group, only those who had sought therapy during their graduate
studies. This, in addition to other circumstances (e.g. incomplete instruments, mailing
list problems) further reduced the size of the sample (n=262) for a response rate of
27.3%.

Dearing et al., (2005) used the ATSPPH short form (Fischer & Farina, 1995) to
measure participants’ attitudes toward seeking professional psychological help. The
instrument was originally developed to use a 4-point Likert scale (1=Disagree to
4=Agree), and return an aggregate score between 10 and 40, with higher scores indicating
more positive attitudes toward seeking psychological help. Dearing and colleagues
elected to use a 5-point Likert scale in relation to each of the 10 items on the ATSPPHS,
and did not evaluate scores in terms of an aggregate, but rather by examining the average
response to each item (M = 4.21, SD = 0.51). As a result, it is not possible to compare
ATSPPH short form responses from the Dearing study to those of the current study.

Dearing et al. (2005) investigated 11 items that might present potential concerns
in counseling psychology doctoral trainees when seeking professional psychological help.
Degree of concern was indicated using a 5-point Likert scale, such that a score of 1 rated
the concern as “not at all important” and a score of 5 rated the concern as “extremely
important” (Dearing, et al, 2005). The list of potential concerns (barriers) was based upon
existing research that has cited issues of accessibility, affordability, acceptability, and
availability as being central barriers to individual help seeking behaviors (Cepeda-Benito
& Short, 1998; Stefl & Prosperi, 1985). The barriers rated by participants as creating the
greatest concerns for them were cost (M = 3.74, SD = 1.36); time (M = 3.28, SD = 1.35);
and confidentiality ($M = 3.06$, $SD = 1.59$). This relates to the research on medical students cited above where medical students indicated time and confidentiality as concerns or barriers to seeking psychological help (Givens & Tjia, 2002).

Participants in the Dearing study were asked about their perceptions of faculty attitudes concerning their graduate students’ participation in therapy. The majority of responses indicated that faculty were perceived to have either neutral or positive attitudes toward their students’ participation in therapy. Correlations between examined factors showed that students who had sought therapy during their graduate studies tended to have more positive attitudes toward seeking psychological help ($r = .32$); endorsed therapy as an integral part of training ($r = .33$); were concerned about the cost of therapy ($r = .21$) and confidentiality ($r = .23$); and perceived faculty as having positive attitudes toward students seeking therapy ($r = .28$).

Similar to the Dearing, et al. study, McCarthy, Pfohl, and Bruno (2010) surveyed counselor education trainees (n=147) about their help seeking attitudes, behaviors, and perceived barriers to seeking counseling. As in previous studies using the ATSPPH short form (Fischer & Farina, 1995) results indicated that female participants had significantly more positive attitudes toward seeking professional psychological help than did male participants. Forty-four percent (44%) of respondents indicated they had participated in personal counseling at some point in their lives. This finding indicates a substantially lower rate of psychological help seeking in counselor education trainees in this study (44%) when compared to help seeking rates in the Dearing, et al.’s 2005 study of counseling psychology doctoral students (70%). Help seeking rates in the McCarthy, et
al. sample more closely approximate those reported in the general public (Corrigan, 2004; Komiya, Good, & Sherrod, 2000; Narrow, Regier, Norquist, Rae, Kennedy, & Arons, 2000; Snowden, 1999). One possible explanation for the difference in help seeking rates between the two studies might be that the Dearing et al. (2005) study was conducted on a larger, randomly selected population drawn from a professional organization database, while the McCarthy et al. (2010) study was based on a convenience sample from a small Northeastern university.

Participants in the McCarthy et al. (2010) study were also asked to rate potential obstacles to seeking professional help with a 10 point scale, with higher numbers indicating the participant’s greater concern about the impact of that particular obstacle. Time, money, and insurance were indicated as the top three obstacles to help seeking, with the fourth highest rated obstacle being “stigma from professors” (McCarthy, Pfohl, & Bruno, 2010).

Farber (1999) reported that students indicated uncertainty as to how strongly their professors supported personal therapy for psychologists as a matter of personal growth or professional development. The strongest certainty was reported in students' assessment that therapists should seek psychological help if they are experiencing stress or problems to the point of impairment in their functioning with clients. This may be due to the fact that ethical codes in the APA, ACA, and other professional organizations for mental health professionals have sections that discuss the impact of counselor or therapist impairment on the client, and urge practitioners to take steps to insure their professional functioning in the best interest of the client. However, when it comes to whether or not
faculty within a training program promote a philosophy that encourages practitioners to actively seek psychological help as a means of personal or professional development, respondents' levels of certainty concerning this message dropped off to a more neutral stance. This could indicate that training programs in general do not actively or strongly promote therapy as a means of personal and professional growth to counseling and other mental health trainees. Based on responses to the survey in this study, counseling psychology students indicated their sense of faculty's position on seeking psychological help to be neither supportive nor discouraging (Farber, 1999).

Another concern or source of ambivalence regarding psychological help seeking may be counseling trainees’ awareness of the evaluative aspect of their relationship with faculty. While faculty may philosophically support help seeking by their trainees, students who actually experience emotional and personal problems may be concerned over the impact same may have on trainees’ actual or perceived ability to function, and how that may reflect upon them in the eyes of their faculty. These concerns may be conceptualized as barriers to help seeking.

2.4 Barriers and Motivators to Help Seeking

Although counselors’ and therapists’ ability to help individuals, couples and families with their problems has been increasing over the decades, there has not been a commensurate increase in the utilization of those services (Corrigan, 2004). In an effort to understand the discrepancy between the potential need for, and actual help seeking, researchers have studied perceived barriers and the influence of individuals’ attitudes toward help seeking behaviors for more than 30 years (Atkinson & Gim, 1983; Cariocchi

The current study seeks to extend existing research by further examining the relationships between seeking help for psychological problems and the motivators (Fischer & Turner, 1970; Vogel & Wester, 2003) and barriers (Dearing, Maddux, & Tangney, 2005; McCarthy, Pfohl, & Bruno, 2010) that may support or hinder counseling graduate students (i.e. trainees) in obtaining those services. Both barriers and motivators may be further characterized as being either external (circumstances within the environment or situation) or internal (intrapsychic experience related to self-image, perceptions, values, stigma, beliefs, attitudes) to the individual (e.g. potential help seeker).

2.4.1 Barriers Defined

There is extensive discussion and exploration in the literature of barriers that inhibit people’s utilization of mental health services (Cepeda-Benito & Short, 1998; Corrigan, 2003; Corrigan, 2004; Corrigan & Matthews, 2003; Corrigan and Penn, 1999; Dearing, Maddux, & Tangney, 2005; Givens & Tjia, 2002; Kahn & Williams, 2003; Mohr, et al., 2006; Stefl & Prosperi, 1985; Vogel, Wade, & Haake, 2006). These barriers have material affects on help seeking behaviors of individuals in the general population. There is some basis for thinking that counseling trainees’ course of study and experience might lessen the impact of these barriers on their psychological help seeking; yet extant
research indicates these barriers do hold salience for counseling trainees who may consider seeking professional help. Research also discusses trainees’ concerns over barriers which may be considered unique to them due to their training and goals to enter and serve in the counseling profession (Dearing, Maddux, & Tangney, 2005; Farber, 1999; McCarthy, Pfohl, & Bruno, 2010; Holzman, Searight, & Hughes, 1995).

In a telephone survey of over 2,000 participants, Stefl and Prosperi (1985) examined the impact of various barriers on individual mental health service utilization. The authors considered all areas related to some level of access to services, and identified four key conceptual areas for barriers:

1. **Availability** – where services are located; knowledge services exist
2. **Accessibility** – availability of transportation; having someone to accompany you
3. **Acceptability** – fear of being looked down on by others; fear of family or friend reactions (stigma)
4. **Affordability** – cost of services; taking time off work

Other research has sought to further refine the source or impetus of barriers that may affect whether or not people seek psychological help. Mohr et al. (2006) developed their own scale of barriers based upon previous research to assess participants’ perceptions of what makes it hard to seek professional psychological services. The authors refer to some of the barriers as “practical” and others as “emotional.” Some of the identified practical barriers were time, cost, transportation, child or other care. Emotional barriers were identified as what friends/family would think (stigma); discomfort talking...
about personal issues; talking about private issues with a stranger; and concerns about appearing emotional in front of another person (Mohr, et al., 2006).

2.4.2 Practical Barriers

Practical barriers to seeking professional psychological help are those situations or circumstances in the environment that may decrease an individual’s likelihood of seeking counseling. These include, but are not limited to, lack of money or insurance coverage that enable the individual to afford such services; access to counseling services presented by regional location (e.g. rural versus urban), or transportation difficulties; the availability of counseling services; or an individual’s ability to make time for counseling in an otherwise busy or hectic schedule (Dearing, Maddux, & Tangney, 2005; Givens & Tjia, 2002; Lang, 2005; Mohr, et al., 2006; Stefl & Prosperi, 1985).

In one of the earlier studies of help seeking, Stefl and Prosperi (1985) reported the number one barrier to seeking professional help, based on a telephone survey of over 2,000 participants, was affordability. Recent studies, including the few surveying counseling psychology and counselor education trainees, site affordability and lack of insurance coverage as key barriers to psychological help seeking (Dearing, et al, 2005; Farber, 1999; McCarthy, et al, 2010; Mohr, et al., 2006). In addition, previous studies of counseling and psychology graduate students cite taking time off from work or school as a significant barrier (Dearing, et al, 2005; McCarthy, et al, 2010).

2.4.3 Emotional Barriers

In an extensive study of barriers to mental health care concerning primary care patients, Mohr, et al., (2006) identified such salient emotional barriers as discomfort
talking about personal issues; concerns about being seen while emotional; talking about personal topics with a stranger; and, like Stefl and Prosperi (1985), concerns about what family and friends might think. These identified emotional barriers may be conceptualized as intrapersonal perceptions that are influenced by apprehensions about being seen as weak, defective, or vulnerable to others. The research literature points to these stigma-related concerns about mental illness as a leading deterrent to help seeking (Corrigan, 2004; Vogel, Wade, & Haake, 2006; Wahl, 1999; Wallace & Constantine, 2005).

Erving Goffman’s (1963) seminal text, Stigma: Notes On the Management of Spoiled Identity has been widely cited in counseling and psychological research when conceptualizing the impact of stigma on people with mental illness (Alonso, Buron, Bruffaerts, He, Posada-Villa, et al., 2008; Brown & Pinel, 2003; Corrigan & Miller, 2004; Corrigan & Penn, 1999; Corrigan, Thompson, Lambert, Sangster, Noel, & Campbell, 2003; Pinel, 1999). In his treatise, Goffman discusses discredited and discreditable identities as being the potential targets of stigma-related behaviors, such as prejudice and discrimination. According to Goffman, discredited identities are those characterized by a visible or readily identifiable characteristic, such as race or a physical disability. A discreditable identity is one that can be concealed from notice, yet, once the identity is known (e.g. homosexuality, criminal record, mental illness) the individual’s personal status in society is downgraded and they are viewed by others as defective or deviant (Goffman, 1963). Individuals who have been to therapy, or who have a mental
health diagnosis, are sometimes able to conceal that fact, or withhold related information so as not to be identified as “defective” (or even “different”) in any way.

There is evidence to suggest that the experience of stigma varies for individuals with a concealable difference (e.g. sexual orientation versus gender; Eberhardt & Fiske, 1994; Frable, Platt, & Hoey, 1998). The decision to conceal a discreditable identity may be accompanied by concerns about how one would be viewed by others (e.g., negatively) were the information known, and an ongoing sense of anxiety about how, and under what circumstances the concealed identity might be made known or visible (Corrigan & Penn, 1999; Goffman, 1963; Vogel, Wade, & Haake, 2006). Individuals may feel compelled to avoid the anticipated negative reactions from significant others in their social network or personal support system (e.g. family, friends, bosses, faculty, etc.) that may occur were it known they sought psychological help (Vogel, Wade, & Haake, 2006). Then again, some individuals may ultimately choose to disclose their discreditable identity if the stress and pressure of concealment outweighs the anticipated negative reactions and consequences of commensurate stigma (Corrigan & Matthews, 2003; Goffman, 1963).

The negative judgments and behaviors of others toward someone when it is known that a person is seeking psychological help are certainly external to that person; however, concerns about the reactions of others are part of an internal process (intra-psychic). Stigma consciousness is the expectation of being judged on the basis of one’s group membership (Pinel, 1999). Brown and Pinel (2003) differentiated stigma consciousness from the construct of stereotype threat. Stereotype threat refers to an individual’s experience of pressure over whether his or her own behavior will be
perceived or evaluated through the perspective of a social stereotype (e.g. “Girls are not as good as boys at math”; Brown & Pinel, 2003). Stigma consciousness as a construct refers to an individual’s awareness that he or she may be cast in a stereotypical way, regardless of his or her individual behavior, solely on the basis of others’ perceptions and attitudes (Pinel, 1999). Stigma consciousness is associated with or similar to self-stigma – awareness of and concern over possessing an identity marker that is discredited or discreditable (Brown & Pinel, 2003; Corrigan, 2004; Goffman, 1963; Pinel, 1999).

In terms of self-stigma (private stigma), it may be difficult for any individual to incorporate the status of a mental illness into the sense of self, and counseling trainees are no exception. Some of the same techniques used to hide a concealable stigma from the public may be utilized to ignore this specific piece of self-knowledge. Counseling trainees may fear their opportunity to become a professional counselor would be at an end because their mental health diagnosis could call their competence and appropriateness for the profession into question.

Factors of self-concealment and comfort with disclosing distressing information to others have also been examined in terms of their relevance in psychological help seeking (Cepeda-Benito & Short, 1998; Hinson & Swanson, 1993; Kelly & Acter, 1995; Vogel & Wester, 2003; Vogel, Wester, Wei, & Boysen, 2005). Both of Vogel’s studies (2003; 2005) found that comfort with disclosing distressing information was a unique predictor for intent to seek help and attitudes toward psychological help seeking. Another study found that those who expressed discomfort with disclosing distressing information...
were five times less likely to seek mental health services (Diala, Muntaner, Walrath, Nickerson, LaVeist, & Leaf, 2000).

Research examining the possible connection between self-concealment and psychological help seeking has returned mixed results. Also, self-concealment and comfort with disclosing distressing information to others, while similar in some respects, represent unique intrapersonal constructs. Self-concealment has been defined as an individual tendency to conceal distressing or embarrassing personal information from others (Kelly & Achter, 1995; Larson & Chastain, 1990). Kahn & Hessling (2001) conceptualized distress disclosure as the result of an active process, involving the interplay of inhibition (concealment) and engagement (disclosure). The authors referred to disclosure as an active process of confronting distress, which may be discussed in terms of a decision to engage with one’s difficult personal processes (distress) in the presence of, or with the help of, another person. Concealment, on the other hand, requires an active process of inhibiting oneself, restricting communication and affect, in the presence of others. Therefore, one’s internal process with personal distress may either lead one to actively engage by discussing the distress with another (disclosure); or one’s process may lead to active inhibition in order to hide problems or distress from others (concealment).

This is a particularly interesting dynamic as it may relate to counseling trainees. Self-disclosure is a topic in counselor training that receives much attention with respect to its use in the therapeutic relationship. Counselors are trained to be vigilant about disclosing personal information to their clients. While not prohibited, its use is examined
and restricted or permitted on a situational basis, with considerations of ethical and best practices being of paramount importance. Therefore, in their professional training, counselors are taught to be wary of disclosure in therapeutic settings, and balancing personal comfort with disclosing distressing information may have salience for counseling trainees’ seeking psychological help for themselves, as well as balancing their personal and professional identities (Messinger & Topal, 1997; Pfohl, 2005; Stratton, Kellaway, & Rottini, 2007).

2.4.4 Motivators

Motivators may be characterized as those internal states (e.g. personal distress level) or external circumstances (e.g. previous experience of counseling) that may increase people’s likelihood of, or tendency to, seek psychological help for their problems (Deane & Chamberlain, 1994; Deane & Todd, 1996; Gonzalez, Alegria, & Prihoda, 2005). Kushner and Sher (1989) conceptualized motivators as approach factors. Motivators (approach factors) that are internal to an individual may also be considered emotional and practical, as barriers may be (Mohr, et al, 2001). The emotional process of assessing a situation or course of action is an internal process, just as things external to the individual (in the environment) can be conceptualized as presenting practical circumstances to be considered.

Kushner & Sher (1989) cited an interesting interplay between an emotional motivator (the “approach factor” of psychological distress) and an emotional barrier (the “avoidance factor” of treatment fearfulness). In their study, those with higher levels of reported psychological distress also indicated higher levels of treatment fears, suggesting
that those who experience distress are emotionally motivated to seek help (they are in psychic pain), yet, their understanding that they need help increases fearfulness about the impending process of going for psychological help. Therefore, those who are psychologically distressed and apprehensive about treatment may be an emotionally conflicted group when it comes to seeking psychological help.

Other research studies suggest that levels of psychological distress (emotional motivator) may be more salient in motivating people to seek psychological help than the social stigma of violating culturally prescriptive norms (emotional barriers) (Constantine, Wilton, & Caldwell, 2003; Neighbors, et al., 2007; Richman, Kohn-Wood, & Williams, 2007; Snowden, 1999). In a survey study conducted by Constantine, Wilton, and Caldwell (2003) the sample (n=158) was comprised of Black American and Latino American students taken from the undergraduate population of a large, predominantly White university in the Northeastern United States. The purpose of the study was to examine factors that might mediate participants’ willingness to seek psychological help, such as perceived level of social support; satisfaction with social support levels; and level of endorsed (relevant) symptomology (i.e. individual assessment of distressing symptoms) relating to common mental health stressors (e.g. “depression, anxiety, homesickness, academic performance concerns, vocational concerns, concentration difficulties, stress management, sleep problems, relationship difficulties with romantic partner, family relationship problems, low self-esteem, racism/discrimination, sexual abuse, alcohol or drug abuse, and grief/loss”, p. 157, Constantine, Wilton, & Caldwell, 2003). Overall, Latino American respondents indicated greater endorsement of
symptomology than did Black American respondents. Level of symptomology endorsement (i.e. psychological distress) was positively correlated to greater willingness to seek help in both Latino American and Black American respondents (Constantine, Wilton, & Caldwell, 2003).

Previous experience of counseling is a practical motivator with a strong relationship to positive attitudes toward seeking psychological help. Those who have had previous treatment have more positive attitudes toward seeking psychological help, and express greater willingness to seek counseling in the future than those who have not previously experienced counseling (Deane & Todd, 1996; Figueroa et al., 1984; Gonzalez, Alegria, Prihoda, 2005; Kahn & Williams, 2003; Tijhuis, Peters, & Foets, 1990).

There is evidence to suggest that when people come in contact or gain experience with people who are stigmatized, or with situations that tend to attract stigmatizing judgments, their attitudes tend to improve if that contact results in a positive experience (Reinke, Corrigan, Leonhard, Lundin, & Kubiak, 2004). This “contact factor” has been shown to decrease people’s stress about and negative attitudes toward seeking psychological help themselves, as well as toward others who choose to seek that help. Figueroa, Calhoun, and Ford (1984) found that previous experiences with mental health services – whether for self, family member or a friend – was the single most influential factor in their participants’ (undergraduate students’) positive attitudes toward seeking professional psychological help. Buckley and Malouff (2005) conducted an experiment in which participants were given one of two treatments: a video of 3 positive accounts from
people who had engaged in counseling themselves, or a video discussing psychological aspects of the self. Those in the group that viewed the video of positive accounts of undergoing counseling expressed more positive attitudes toward psychological help seeking than the other group (e.g. as measured by the ATSPPH scale, Fischer & Turner, 1970) (Buckley & Malouff, 2005).

If the experience of participating in counseling does have a positive impact on attitudes toward seeking psychological help, then trainees’ exposure to undergoing counseling during their graduate studies could facilitate their professional growth as advocates for their clients and their profession. Conversely, it may stand to reason then that if a person's previous experience with counseling was negative, a commensurately strong negative attitude toward help seeking might manifest. In Farber’s (1999) results, one doctoral student indicated that, while having undergone counseling previously, they would most likely not engage in counseling in the future. While the reason for this decision was not reported, if this were due to a negative therapeutic experience as a client, this could serve as further evidence of the power of the therapeutic experience on attitudes and behaviors relative to seeking psychological help.

There is evidence in the literature to suggest that those who are training to be counseling professionals and who have sought psychological help themselves tend to value therapy as a part of the professional training and growth (Bruss & Kopala, 1993; Dearing, Maddux, & Tangney, 2005; Farber, 1999; Norcross, Strausser-Kirtland, & Missar, 1988; Skovholt and Ronnestad, 2003). Clinical and counseling psychology students in the Dearing et al (2005) study who sought therapy during their graduate
training tended to endorse the idea of requiring personal therapy during graduate training. In the Farber (1999) study, participants most frequently reported “professional growth” as their reason for attending personal therapy while in graduate school.

Guy, Stark and Poelstra (1988) found that counseling professionals who engaged in therapy during their graduate training tended to also seek help later in their professional careers. Reasons for this finding may be that those who need psychological help at one point in their lives may be more likely to need it again in the future; or, once a behavior is established, then, for whatever reason, it is likely to be repeated in the future. This finding is also consistent with the measured phenomenon that those who have positive attitudes toward psychological help seeking then to seek that help out themselves.

2.5 Summary

Counseling trainees may have need of personal counseling at some time in their lives, including during their training and professional counseling careers. It may be helpful to counselor educators to consider promoting and assisting their counseling trainees to seek counseling as a means of enhancing their training and fostering their personal and professional growth. Barriers to seeking help, emotional and practical, may limit trainee’s access to the assistance they need. Counselor educators and field supervisors have an obligation to monitor and address personal difficulties or problems that may be impacting the trainee’s effectiveness during their field experiences. When counselor educators understand their students’ attitudes and behaviors related to help seeking, they can better assist them in their professional development.
The current study will attempt to explore and provide further insight into some of the factors that influence counseling trainees’ professional psychological help seeking attitudes and behaviors. The primary factors influencing their decisions that will be examined are practical barriers, such as time, cost, and access; and emotional barriers, such as stigma concerns and comfort with disclosing distressing information. Motivators such as positive attitudes toward seeking professional psychological help and having previously sought counseling will also be explored. The premise of this research is that, if counselor educators can better understand the factors that influence their trainees’ attitudes toward seeking psychological help and their ultimate help seeking behaviors, they will be better prepared to meet the academic and developmental needs of those trainees. That understanding may also lead to enhanced curricular interventions to foster a positive environment that promotes trainees’ help seeking for personal and professional growth.
Chapter Three

Methods

3.1 Introduction

This section discusses the design of the survey research study, including the instruments used to comprise the questionnaire, the participants and proposed methods to recruit them, and the statistical techniques used to analyze the data collected. Student members of the American Counseling Association were invited to respond to a questionnaire, providing information about their previous experience receiving professional counseling, perceived levels of social and self stigma as related to psychological help-seeking, and their attitudes toward seeking professional psychological help. The data collected was analyzed to determine the answers to the research questions posed in this study.

3.2 Survey Method

The basis for the design of this survey study was the Tailored Design Method, developed by Dillman (2000). One of the key concerns of a mail survey is the impact of participant return rate on sample size. Since first proposing the original survey design method (e.g. Total Design Method, Dillman, 1978) initial survey results showed return rates using this method ranging between 58% and 92%, with an average return rate across
48 surveys of 74%. In order to increase response rate for self-administered mail surveys, Dillman (2000) proposes the following:

- The purpose of Tailored Design is to increase participant trust, in part by reducing perceived costs of participation, and increasing perceived rewards for participating
  - “The likelihood of responding to the request to complete a self-administered questionnaire, and doing so accurately, is greater when the respondent trusts that the expected rewards of responding will outweigh the anticipated costs” (p. 27, Dillman, 2000).

- Aspects of the questionnaire and implementation process are tailored to create trust, and influences greater participant expectation for reward while decreasing expectations of cost; for example
  - send a token of appreciation
    - e.g. a sticker saying “Empathy – Positive Regard – Authenticity”
  - show positive regard for fellow counseling students/trainees; support our group values of professional identity, quality training, and placing value on seeking counseling services
  - minimize requests for personal information, while emphasizing value of research to inform the needs of counselors-in-training
- clarify confidential nature of the survey; how the data will be used; each questionnaire will be recorded in the database with a unique identifier, no name or other identifying information

- The goal of successful Tailored Design is to “reduce error from coverage, sampling, measurement, and nonresponse” (p. 27, Dillman, 2000).

3.3 Sampling

One thousand student members of the American Counseling Association were randomly selected from the student membership list and were contacted to participate in the survey. All students (Masters and Doctoral level counseling trainees) received a questionnaire packet (Appendix A) which included a letter introducing the investigator as a fellow counseling trainee and telling them the purpose of the survey; two copies of the Informed Consent to Participate forms (one for participant’s records, one to be returned); a questionnaire; a stamped return envelope addressed to the investigator; and a thank you in the form of a sticker saying “Empathy – Positive Regard – Authenticity” (core principles of Rogerian therapy) as an incentive to encourage their participation, (Dillman, 1978; Dillman, 1991; Dillman, 2000; Dillman, Christenson, Carpenter, & Brooks, 1974).

3.3.1 Return Rate

The following steps were taken to maximize the participant return rate

- Introductory letter explaining purpose of the study, encouraging participation and offering incentive
• mailing of the questionnaire
• reminder email three weeks after initial questionnaire mailing, asking those who had not responded to consider doing so

3.3.2 Use of Incentives in Survey Research

Survey research literature suggests that incentives increase response rates to mail surveys (Dillman, 1978, 2000; Gendall & Healey, 2008). However, increased response rates as a result of incentives are not without a number of problematic outcomes that impact the composition of the respondent pool (Groves, Presser, & Dipko, 2004; Petrolia & Bhattacharjee, 2009).

In an effort to assess incentive effects on mail survey response rates, Petrolia and Bhattacharjee (2009) conducted a survey on individuals’ knowledge of and preferences regarding fuel ethanol. Questionnaires were mailed to participants throughout the United States using a stratified random sample technique across all 50 states, weighted by state population. There was an initial mailing of surveys, followed by a follow up reminder letter two weeks later, and a second copy of the questionnaire mailed two weeks after the reminder letter. The 3,000 surveys sent to participants were divided into three treatment groups: 1,000 surveys were sent with no incentive ($0.00); 1,000 surveys were sent with a prepaid incentive ($1.00); and 1,000 were sent with a promise of a postpaid incentive ($5.00) upon return of the completed questionnaire. Incentives increased response rate, with the highest return rate coming from the $1.00 pre-paid incentive group (31%). The authors noted the incentives had an effect on the demographics of responders (Petrolia & Bhattacharjee, 2009). Increased responses seemed to come from respondents who were
less educated, and who were less familiar with the subject area focus of the survey. Interestingly, item nonresponse was also significantly correlated with less education, less familiarity with survey topic area, and gender.

There is evidence in the research to suggest that response rates increase when the survey topic is of interest to prospective participants (Groves, Presser, & Dipko, 2004). However, Groves, et al., (2004) also found that monetary incentives increased responses from participants who were less interested and not as knowledgeable in the survey topic area, which seemed to mitigate response rates from interested participants. In the current study, it is highly likely that participants (counseling trainees) will have some level of interest in a survey researching an aspect of their own training and development (e.g. seeking professional psychological services).

If it is possible to assume that counseling trainees may be somewhat motivated to respond to a survey that speaks directly to aspects of their own experience, aspects of the profession for which they are preparing, and aspects of their developmental process as counseling trainees, then a more personalized incentive may be an effective means of encouraging participants to respond and return their completed questionnaires. It may also be appropriate to assume that individuals enrolled in graduate programs tend to be intelligent and intellectually motivated, since they are extending their education beyond the undergraduate level. Graduate counseling trainees may tend to be intelligent, motivated, and interested in a survey topic that relates to the graduate training process in which they are engaged.
3.4 Participants

Participants were student members of ACA who are training to be counselors at graduate programs throughout the United States.

3.4.1 Recruitment

The American Counseling Association (ACA) is an international professional organization for counselors, educators, and supervisors, with a student member database that includes over 17,000 graduate students in counselor preparation programs throughout the United States. A mailing list of 1,000 randomly selected names and addresses from the ACA student member database was purchased for the purposes of mailing the questionnaire for this study.

3.5 Protocol

The questionnaires, to be completed using pen and paper, were self-administered by the participants. Each questionnaire packet included an introductory letter, informed consent forms (2), stamped return envelope, and a questionnaire (Appendix A). The packet also included a sticker with the words “Empathy – Positive Regard – Authenticity” as a thank you (incentive) which recruits were told they were free to keep regardless of their participation. The participants, per instructions in the cover letter (see Appendix A), were asked to place the completed questionnaire and one signed copy of the consent form into the postage paid envelope provided, and place it in the mail, to be returned via the United States Postal Service.
3.5.1 Instructions for completion and return of the questionnaire

Every packet mailed to prospective participants contained an introductory letter introducing the co-investigator, discussing the nature and purpose of the study, and why they were being contacted. The letter also informed participants that they could return the completed questionnaire, along with a signed consent form, in the enclosed return addressed, stamped envelope. The Informed Consent to Participate form further notified prospective participants of the scope of the study, parties responsible for carrying out the research, their rights (e.g. not to participate), risks and benefits. The questionnaire included instructions at the beginning of each section (e.g. demographic questions, instruments), as well as guides for the Likert scaling of the instruments and specific instructions for completion of certain items (e.g. Items 4, 5a). Appendix A contains examples of all materials and exact wording of the instructions.

3.6 Instrumentation

The first part of the questionnaire was a series of demographic questions to gather information on the participants such as age, gender, race or ethnicity, degree program concentration (e.g. agency, mental health, school, marriage and family, psychology, etc.), degree sought (e.g. Masters, PhD, EdD, etc.), and year of study (e.g. first year, second year, graduated Masters/Doctoral student). Participants were also asked if they had any previous experience of counseling, and the approximate length of time they had been in counseling.

Participants were asked to rate perceived practical and emotional barriers to seeking counseling or therapy based upon availability, accessibility, acceptability, and
affordability (Stefl & Prosperi, 1985). A list of ten barriers to seeking psychological help was provided, based on Stefl and Prosperi’s (1985) initial assessment list, with the addition of two items; “Fear of what faculty might think” (specific to the experience of counseling trainees currently enrolled in counselor preparation programs) and “Other” (and opportunity for participants to specify a barrier of their own choosing). Participants were asked to rate the degree the factor of situation presented a barrier to their help seeking. The three-point scale provided for rating the barriers was 1-a significant barrier, 2-somewhat of a barrier, and 3-Not a barrier.

The final section of the questionnaire was comprised of the following instruments: the Distress Disclosure Inventory (DDI; Kahn & Hessling, 2001) measuring comfort with disclosing distressing information to others; the Stigma Scale for Receiving Psychological Help (SSRSH; Komiya, Good, & Sherrod, 2000) measuring perceptions of social (public) stigma for receiving psychological help; the Attitudes Toward Seeking Professional Psychological Help Scale – Short Form (ATSPPHS; Fischer & Farina, 1995) measuring attitudes toward seeking help; and the Self-Stigma of Seeking Help (SSOSH; Vogel, Wade, & Haake, 2006) measuring self (private) stigma for seeking psychological help. The entire instrument took an average of 10-15 minutes to complete.

3.6.1 Barriers to Psychological Help Seeking

Perceived barriers to seeking psychological help (e.g. time, money, stigma) and their degree of importance in participants’ decisions to seek counseling were assessed based on Stefl and Prosperi’s (1985) barriers to mental health service utilization. These barriers have been used in other studies drawn on for the design of the current study.
(Dearing, et al., 2005; McCarthy, et al., 2010), and the constructs of the Affordability, Accessibility, Acceptability, and Availability of psychological services have been utilized throughout the help seeking literature since Stefl and Prosperi (1985) first operationalized them (Cepeda-Benito & Short, 1998; Vogel & Wester, 2003). Barriers were grouped in terms of type (e.g. barriers related to Availability, Accessibility, Acceptability, and Affordability) and included such items as “Not knowing services are available” (Availability), “Fear of being looked down on” (Acceptability), and “Cost of services” (Affordability). One additional barrier related to Acceptability was added, specifically, “Fear of what faculty might think,” which continues previous research with counseling psychology and counselor education trainees (Dearing, et al., 2005; McCarthy, et al., 2010).

Participants were also given the opportunity to specify and rate an additional barrier as “Other,” with space to write in the specific barrier they wished to add to the list.

3.6.2 Attitudes Toward Seeking Professional Psychological Help Scale – Short Form

The Attitudes Toward Seeking Professional Psychological Help – Short Form (ATSPPHS, Fischer & Farina, 1995), and its longer version, the Attitudes Toward Seeking Psychological Help Scale (Fischer & Turner, 1970), have been utilized in a considerable amount of research examining psychological help seeking attitudes and behaviors over the past four decades (Atkinson & Gim, 1989; Cepeda-Benito & Short, 1998; Constantine & Gainor, 2005; Deane & Todd, 1996; Dearing, Maddux, & Tangney, 2005).
The Attitudes Toward Seeking Professional Psychological Help short form (ATSPPHS, Fischer & Farina, 1995) is a 10-item scale developed to assess respondents’ attitudes toward seeking professional psychological help (e.g. positive or negative). Respondents indicate their level of agreement or disagreement with items (e.g. “If I believed I was having a mental breakdown, my first inclination would be to get professional attention”) on a 4-point Likert-type scale (e.g. 0 = disagree to 3 = agree). Scores for the instrument range from 0 to 30, with higher scores indicating more positive attitudes toward seeking psychological help (Fischer & Farina, 1995). In an effort to impact internal validity of the instrument, half of the items on the scale (e.g. Items 2, 4, 8, 9, and 10) are reverse-scored.

The development of the ATSPPHS short form was conducted on a convenience sample of college students (Fischer & Farina, 1995). The authors reported internal reliability to be 0.84. Subsequent studies have reported internal reliability at 0.87 (Cepeda-Benito & Short, 1998), 0.75 (Duncan, 2003). The test-retest reliability for the
short form at 4 weeks was reported to be .80. It was also found in the development of the scale that ATSPPHS scores correlated with having sought counseling in the past ($r = .39$, $p < .001$).

In its original form, the ATSPPHS short form uses terms for help seeking and professionals who provide psychological help as “psychotherapy,” “psychological help,” and “psychologist” (Fischer & Farina, 1995). Previous studies have modified the wording of both the original and short forms of the ATSPPH scale without compromising its ability to measure help seeking attitudes accurately and consistently (Atkinson & Gim, 1989; Atkinson et al., 1984; Gloria, Hird, & Navarro, 2001; Komiya & Eells, 2001; McCarthy, Pfohl, & Bruno, 2010). For the purposes of this study, considering the members of the participant group are training to become counselors themselves, the term “counselor” was used in place of “psychologist” in item 2 and “counseling” was used in place of “psychotherapy” in item 3 on the ATSPPHS short form.

3.6.3 Self-Stigma of Seeking Help (SSOSH) scale

The Self-Stigma of Seeking Help scale, developed by Vogel, Wade, and Haake (2006), is a 10-item scale intended to assess self-stigma associated with seeking professional help. The developers define Self-stigma as “the reduction of an individual’s self-esteem or self-worth caused by the individual self-labeling herself or himself as someone who is socially unacceptable” (p. 325). The purpose of the instrument is to assess the degree to which seeking help from a professional for mental or emotional problems may impact or threaten individual self-concept and self-esteem. Participants rate statements on a 5-point Likert scale (0=strongly disagree; 2=neither agree nor
disagree; 4=strongly agree), yielding an aggregate score between 0 and 40, intended to represent the unidimensional factor of self-stigma level relative to seeking professional help. Developers of the scale conducted two studies to test the reliability and factor structure of the scale. Internal consistency for the two studies was reported at .91 (N=583) and .89 (N=470).

Tests of the factor structure for the scale were conducted utilizing principle axis factor analysis and confirmatory factor analysis (maximum likelihood method, LISREL, v. 8.54) in Study 1 and Study 2 respectively. The results of the principle axis factor analysis in Study 1 accounted for 53% of the total variance (eigenvalue=5.31) with all items loading > .50. This showed a unidimensional factor solution which the authors interpreted as indicating the instrument measures one construct (Vogel, Wade, & Haake, 2006). In Study 2 the maximum likelihood method employed in testing the factor structure of the SSOSH examined goodness of fit of the data to the model. The authors used three indices of goodness of fit: the comparative fit index (CFI) with values greater than .95 indicating the model fits the data well; the root mean square error of approximation (RMSEA) with values less than .06 indicating the model fits the data well; and standardized root mean square residual (SRMR) with values less than .08 indicating a good fitting model. Results of the maximum likelihood method for Study 2 were $X^2(35, N=470) = 103.3, p<.001, CFI = .98, RMSEA = .04, SRMR = .04$), indicating a good fit of the data to the factor model (Vogel, Wade, & Haake, 2006).

Construct and criterion validity of the SSOSH were tested in Study 2 by comparing SSOSH scores with participants’ scores on the Intentions to Seek Counseling
Inventory (ISCI); the Disclosure Expectations Scale (DES) which assesses perceived risks and benefits to disclosing problems to a therapist; the Social Stigma for Receiving Psychological Help scale (SSRPH) (Komiya, Good, & Sherrod, 2000) which assesses concerns about public stigma associated with going for psychological help; and the Attitudes Toward Seeking Professional Psychological Help scale, which measures relative positive and negative attitudes concerning psychological help seeking. Higher scores on the SSOSH (greater levels of self-stigma associated with seeking professional help) were positively associated with higher scores on the Anticipated Risks subscale of the DES, and negatively associated with higher scores on the Anticipated Benefits subscale of the DES, ATSPPH (higher scores indicate more positive attitudes toward seeking psychological help), and ISCI (higher scores indicate greater intent to seek counseling) respectively.

Developers tested the ability of the self-stigma scale to predict or explain attitudes toward seeking professional psychological help with a convenience sample of undergraduate students enrolled in introductory psychology courses at a large midwestern university. Multiple regression was conducted with the ATSPPHS as the dependent variable. To isolate the unique contribution of self-stigma (SSOSH scores) to the regression model, other predictors in the model were entered in step one as a block (e.g. gender, previous experience of counseling, social/public stigma).

The regression model explained 57% of the variance in ATSPPHS scores (F=34.8, p<.001, adjusted R² = .57). Anticipated benefits of counseling (β = .39, t = -8.1, p < .001) had the greatest ability to explain or predict attitudes toward help seeking in the
regression model, followed by self-stigma concerns (β = -0.30, t = -6.0, p < 0.001), previous experience of counseling (1=yes, 2=no; β = 0.21, t = -2.7, p < 0.01), and Anticipated risk of counseling (β = -0.12, t = -2.7, p < 0.01). Public stigma (SSRPH) was significant as a predictor until SSOSH was entered (self-stigma). SSRPH dropped from β = -0.15 to β = -0.05. These results provided initial evidence of the correlation between public and private stigma (SSRPH and SSOSH scores) and showed that scores on the Self-stigma for Seeking Help scale were a stronger predictor than scores on the social (public) stigma scale (SSRPH).

3.6.4 *Stigma Scale for Receiving Psychological Help (SSRPH)*

The construct of social (or public) stigma related to receiving psychological help was measured using the Stigma Scale for Receiving Psychological Help (Komiya, Good, and Sherrod, 2000). Corrigan (2004) defined public stigma as the perception that someone who seeks psychological help is flawed and socially unacceptable. Public stigma as measured by the Stigma Scale for Receiving Psychological Help (SSRPH) (Komiya, Good, & Sherrod, 2000) is defined as “individuals’ perceptions of how stigmatizing it is to receive psychological treatment” (p. 139). The scale has five items (e.g. Item 1: “Seeing a professional for emotional or interpersonal problems carries social stigma”) and is scored using a four point Likert scale, with responses ranging from “strongly disagree” (0) to “strongly agree” (3). Total scores for the inventory range from 0 to 15, with higher scores indicating greater levels of perceived social (public) stigma. The internal consistency for the instrument has ranged from 0.73 to 0.76 (Komiya, Good, Sherrod, 2000; Vogel, Wade, & Haake, 2006).
Factor analysis for the instrument was conducted using the maximum likelihood method. Eigenvalues decreased dramatically after one factor (3.70, 0.09, 0.06), indicating a strong basis for a single factor. Also, the first factor accounted for approximately 100% of the variance in the model. The authors, therefore, established the SSRPH as a unidimensional scale measuring individual perceptions of social stigma (public stigma) relative to seeking psychological help. Scores on the SSRPH correlated negatively with scores on the ATSPPH, short form (Fischer & Farina, 1995), indicating that individuals who perceive greater social (public) stigma associated with psychological help seeking (higher scores on the SSRPH) have less favorable attitudes toward seeking that help (lower scores on the ATSPPH-SF).

Similar to the development of the SSOSH (Vogel et al., 2006) the SSRPH was tested for its predictive and explanatory ability relative to attitudes toward seeking professional psychological help. ATSPPHS mean for the sample was 14.66 (SD=6.05). Adjusted R-square for the model was .24 indicating the model explained 24% of the variance in ATSPPHS scores. Analysis of standardized beta coefficients showed that gender and SSRPH had the most explanatory and predictive power in the model. Stigma as measured by the SSRPH had a greater effect (t=-5.83, β=-0.30) than gender (t=-4.10, β=-0.22).

Women in the pilot studies for the SSRPH scored lower on the instrument than did men, indicating that women had lower levels of perceived concern about public stigma related to psychological help-seeking than men. This is consistent with existing research, which suggests that women have more positive attitudes toward seeking
professional psychological help (Atkinson & Gim, 1989; Delphin & Rollock; 1995; Fischer & Cohen, 1972; Vogel, Wade, & Haake, 2006) and might therefore have less concern about what important others might think of their seeking that help.

In their development of the SSOSH, Vogel, Wade, and Haake (2006) reported correlations between the SSRPH and SSOSH ($r = .48; r = .46$). This suggests some overlap in the constructs behind the two instruments, which could be expected. Those concerned that others might think negatively about them, were they to seek psychological help, might then, reasonably, think less of themselves for doing so.

3.6.5 Distress Disclosure Inventory

A number of studies in the literature have examined the relationship between attitudes toward seeking help and comfort with disclosing distressing information. Studies have also examined help seeking attitudes in relation to people’s relative tendency to conceal personal information about themselves from others. The tendency to conceal distressing information has been linked to increases in physical and emotional problems, according to some of the existing literature (Kelley, Lumley, & Leisen, 1997; Larson & Chastain, 1990; Pennebaker, 1989, 1997; Pennebaker, Kiecolt-Glaser, & Glaser, 1988; Pennebaker & O’Heeron, 1984). The ability to tolerate, or even be relatively comfortable with, the act of disclosing distressing information to someone may be an important element in a person’s ability to engage in counseling, where disclosure and confronting distressing feelings or situations may be necessary.

Previous studies have examined the relationship between psychological help seeking attitudes and levels of self-concealment (Cepeda-Benito & Short, 1998; Kelly &
Achter, 1995; Wallace & Constantine, 2005) using the Self Disclosure Scale (SDS; Larson & Chastain, 1990). Kahn and Hessling (2001) suggest that disclosure and concealment may be more than opposite ends of a continuum and therefore require clearer definition as constructs examined in this study. Disclosure is a process that requires an individual to directly confront their distress (Kelly & McKillop, 1996; Larson & Chastain, 1990; Pennebaker, 1989, 1997), whereas concealment is a process that focuses effort and attention on hiding aspects of self and personal experiences, perhaps to reduce the occurrence of disclosure. Counselors work with issues concerning disclosure (both the client’s and their own) on a regular basis in the practice of their profession. While as a professional in the counseling dyad may more attention and focus may be required to regulate concealment of personal information (e.g. self-disclosure) in their role as clinician, a counselor’s ability to appropriately disclose distress (e.g. in their own personal counseling) may be linked to their overall health, functioning, and well being.

For the purpose of this study, counseling trainees’ levels of distress disclosure was measured using the Distress Disclosure Index (DDI, Kahn & Hessling, 2001). Participants’ scores on the DDI were examined to determine what, if any, relationship levels of distress disclosure might have on help seeking attitudes and behaviors (e.g. ATSPPH scores; whether they have sought counseling).

The Distress Disclosure Index (DDI, Kahn & Hessling, 2001) is a 12 item instrument based upon a 4-point Likert scale (0 = strongly disagree; 3 = strongly agree). Instrument development studies, including item analysis, and tests of reliability and validity for the instrument were conducted exclusively on convenience samples of
undergraduate students at a large Midwestern university, who were mostly White (average 88%). Indicators of convergent validity included significantly higher DDI scores (greater tendency to disclose distress) for female participants (M=42.21, SD = 9.16, n=156) than males (M=36.33, SD = 8.98, n=111), t(265) = 5.21, p < .001. There were also strong, positive correlations reported between DDI scores and measures of self-disclosure, social support, and extraversion. Also, discriminate validity for the DDI was examined by comparison to participants’ levels of neuroticism (Neuroticism subscale, Five-Factor Inventory) and social desirability (Marlowe-Crown Social Desirability Scale), where correlations were weak (-.06 and .12 respectively).

Related studies have used the Self Concealment Scale (SCS, Larson & Chastain, 1990) to examine the impact of concealment/disclosure on help seeking (Cepeda-Benito & Short, 1998; Kelly & Achter, 1995; Vogel & Wester, 2003). However, results were mixed, and even contradictory, between and among the studies, and so the use of the DDI rather than the SCS may improve results for this study. Existing literature demonstrates the psychometrics of the DDI are superior to those of the SCS (reliability coefficients of .92 to .95 versus .83 to .88; Cepeda-Benito & Short, 1998; Kahn & Hessling, 2001; Larson & Chastain, 1990; Vogel & Wester, 2003), although the DDI demonstrated somewhat lower consistency in test-retest reliability alpha levels (.80 at 2 months; .81 at 3 months). The DDI showed a moderate negative correlation with the SCS, indicating that those who scored high on the SCS (i.e. high self-concealers) would have less comfort with disclosing distressing information to others (Vogel & Wester, 2003).
3.7 Data Collection

The initial mailing of the thousand questionnaire packets was done over a period of approximately 2 weeks in mid-August, 2010. ACA student members who were invited to participate in the mailing were asked to respond by October 10, 2010. A reminder was sent to the mailing list three weeks after the initial mailing, thanking invitees for their response if it had already been sent, and urging those who had not to complete and return their questionnaires before the deadline.

3.7.1 Informed Consent

Participants were given a statement explaining the purpose of the study, why it is being conducted, how the information they provide will be used, and a discussion of assurances and limitations of confidentiality. A copy of the Informed Consent to Participate form is provided in Appendix A.

3.8 Data Analysis

3.8.1 Significance, Power, Effect Size, and Sample Size

Significance criterion (α) for all statistical analyses was set to .05 (α = 0.05) to establish a 95% confidence interval and a 5% maximum risk allowed in the study for a Type I error (rejecting the null hypothesis when it should be retained). Previous research has shown differences in mean scores on several of the measures in the study (ATSPPHS, SSOSH, etc.) based upon such demographic factors as gender, previous experience of counseling, and race. A maximum of 20 t-tests of independent samples was performed to compare mean scores within the sample for this study. In addition, two Analysis of Variance procedures, and a multiple regression were utilized to analyze data in the study,
for a total of 23 statistical tests overall using data from the same sample. Therefore, a Bonferroni adjustment was necessary to reduce the likelihood of a Type I error. The adjustment was made by dividing the overall alpha level for the study ($\alpha = .05$) by the number of statistical tests performed for the study (23). This created an alpha level of .002 ($\alpha = .002$) for all statistical tests, and maintained an overall family-wise significance level of .05 ($\alpha = .05$).

Cohen (1988, 1992) suggests a statistical power of .80 as the acceptable and conventional level, since a smaller value tends to increase the likelihood of a Type II error (failure to reject the null hypothesis) and a statistical power larger than .80 may put an undue burden on the research design by requiring a sample size beyond available resources. For the purpose of this study, statistical power for all statistical analyses was set at .80. As a result, the likelihood of a Type II error in the statistical analysis of this study was 20% ($\beta = .20$).

Effect size represents the degree to which the null hypothesis can be expected to be false (Cohen, 1992). All statistical tests have their own indices of effect size, and Cohen (1988; 1992) has proposed operational definitions of small, medium, and large effect sizes for statistical tests. The requisite sample size for statistical analysis is determined in conjunction with significance, power, and effect size (Cohen, 1992). The settings for significance, power, and effect size, as well as the requisite sample sizes are outlined below:
| T-test of Independent Samples | Significance: $\alpha = .002$
|                             | Power: .80
|                             | Effect size: .50 to .80 (medium to large)
| Analysis of Variance         | Significance: $\alpha = .002$
| SOSSH by level of training   | Power: .80
| SSRPH by level of training   | Effect size: .25 (medium)
|                             | Sample size: 52 per IV (156 total)
| Multiple regression         | Significance: $\alpha = .002$
| **Predictor variables:**    | Power: .80
| Gender                      | Effect size: .35 (large)
| Previous experience of counseling | Sample size: 230
| SSRPH                        |                      
| SSOSH                        |                      
| DDI                          |                      
| **Dependent variable:**      |                     
| ATSPPH                       |                      

Table 3.1 Established significance, power, effect size, and sample size for the study

The proposed sample size for the multiple regression model was based upon the number of predictor variables in the model (5); the alpha level set for the statistical analysis ($\alpha=.002$); a statistical power setting of .80 (80%); and an effect size of .35. Based upon Cohen’s (1988) formula for sample size ($N = \text{statistical power} / \text{effect size}$) the
sample size for the regression model should be 230 participants or greater, therefore requiring a minimum of a 23% return rate from the mailing for this study.

3.9 Research Question One: Describing the Sample

What are the demographic characteristics of the survey respondents? What are their attitudes toward seeking professional psychological help; private and public stigma concerns about seeking help; likelihood of disclosing distressing information to others as measured by the instruments in the questionnaire (e.g. means, standard deviations for the instruments)? Are there differences in mean scores on the measures for the study (e.g. ATSPPH, attitudes toward seeking professional psychological help; SSOSH, self-stigma of seeking help; SSRPH, social stigma for receiving professional psychological help; DDI, (Distress Disclosure Index) comfort with disclosing distressing information) based upon independent variables (key demographic categories) of gender, previous counseling experience, and race? What perceived barriers to seeking psychological help did participants endorse, and at what level (e.g. not a barrier; somewhat a barrier; significant barrier)? Are there differences in participants’ number of endorsed barriers based upon the independent variables of gender, previous counseling, or race?

This portion of the study was analyzed using descriptive statistics, such as measures of central tendency, to draw a clear picture of who the respondents are to the survey. This will include an examination of the racial, gender, and age demographics of the participants; their previous experience of receiving counseling, if any; whether they have completed their counseling practicum; as well as their scores on the ATSPPH, SSOSH, SSRPH, and DDI. T-tests of independent samples were used to compare mean
scores between participants based on independent variables of gender, previous counseling experience, and race.

3.9.1 Demographic Questions

Participants were asked to report their gender, race, age, their degree sought (Masters, PhD, EdD, etc.), current year of training in their program (e.g. first year, second year, graduated/doctoral), and whether the student has ever sought help for an emotional or interpersonal problem from a professional. Participants will also be asked to provide ratings of various perceived barriers to help seeking.

Participants’ gender were recorded as a dichotomous, categorical variable, with valid responses being either “F” for “female” or “M” for male. Age was recorded as a continuous, interval variable. Previous participation in therapy was recorded as a categorical, dichotomous variable with “Y” (yes) indicating the participant has sought psychological help in the past, and “N” (no) indicating they have not. If participants have engaged in counseling, they were asked to give indicate the approximate length of time they have participated in counseling (e.g. three months or less; four to six months; seven to twelve months; more than a year).

The variable of race is intended to capture the participants’ personal identification of their racial and ethnic background. Methods used to assess racial/ethnic categories of survey participants are as diverse as the categories themselves (Atkinson & Gim, 1986; Cauce, Domenech-Rodriguez, Paradise, Cochran, Shea, Srebnik, & Baydar, 2002; Gonzalez, Prihoda, & Alegra, 2005). Participants were asked “What is your race?” and
given space to write in their response. Responses will then be grouped and categorized as part of the data entry process.

Participants’ ratings of perceived barriers to seeking psychological help (Stefl & Prosperi, 1985) were assessed using a 3 point Likert scale. Participants will specify whether the stated issue or situation (e.g. barriers such as cost, transportation, what others would think) is 1 = “is a significant barrier for me”; 2 = “somewhat of a barrier for me”; or 3 = “not a barrier for me”. Descriptive statistics such as percentages of barrier ratings were reported.

3.9.2 Analysis of Participant Scores on Instruments in the Study

Participants’ scores on instruments measuring such phenomena as social, or public, stigma (SSRPH, Komiya, Good, & Sherrod, 2000); private, or self-, stigma (SSOSH, Vogel, Wade, & Haake, 2006); and comfort levels with disclosing distressing information to others (DDI, Kahn & Hessling, 2001) were examined and interpreted. The internal reliability for each instrument was reported, as well as correlations between the scales. Group mean scores, as well as other measures of central tendency, and standard deviations (variability) were reported.

Scores on the instruments in the study will also be analyzed by examining mean differences between scores by demographic (e.g. independent variables of gender, previous experience of counseling, race) using t-tests of independent measures.
Research Question #1: Describe the Sample and Compare Means on Key Measures

<table>
<thead>
<tr>
<th>Describe:</th>
<th>Statistical Tests</th>
<th>Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td>Frequencies, percentages, Means, Standard Deviations, Range</td>
<td>Gender, Race, Year in Program, Concentration,</td>
</tr>
<tr>
<td>Describe Survey Instrument Responses</td>
<td>Means, Standard Deviations, Ranges</td>
<td>List instruments</td>
</tr>
<tr>
<td>Describe Perceived Barriers</td>
<td>Rankings, frequencies, percentages</td>
<td>Each of the 9 barriers</td>
</tr>
<tr>
<td>Compare mean scores on key measures in the study, based on participants’ gender, race, and previous experience in counseling</td>
<td>T-tests of independent measures</td>
<td>Independent Variables: Gender, Race, Previous experience in counseling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dependent Variables: ATSPPHS, SSOSH, SSRPH, DDI Number of endorsed barriers</td>
</tr>
</tbody>
</table>

Table 3.2: Summary of question one statistical analysis and variables

3.10 Research Question Two: Impact of Training on Stigma Concerns

Is there a difference in participants’ concern about the stigma of seeking psychological help based upon their level of counseling training?

\[ H_0 = \text{Variance in participants’ scores on the SSOSH (self stigma) and the SSRPH (social stigma) will be the same at different levels of the factor} \]
$H_1 = \text{Variance in participants’ scores on the SSOSH (self stigma) and SSRPH (social stigma) will be different at different levels of the factor, indicating that the further participants have progressed in training, the less concern they will have about the stigma of seeking help.}$

Participants’ concern about stigma was measured using the Self-Stigma of Seeking Help scale (SSOSH) and the Social Stigma for Receiving Psychological Help scale (SSRPH). The variance in participants’ scores on each of the two instruments were examined at different levels of training experience as determined by reported year of training (e.g. Item #: year in program, first year Masters, second year masters or more, graduated or doctoral student). The hypothesis for question number two assumes that as counseling students advance in their training, their concerns about stigma related to seeking professional psychological help will decrease.

The statistical tool of Analysis of Variance (ANOVA) was employed to answer this research question. The factor variable used in the analysis was year in program as an indication of the amount of training the participant has experienced at the point of being surveyed. The three levels of the factor are “first year Masters student,” “second year Masters student,” and “graduated Masters or Doctoral student.” Two ANOVA were conducted, one with SSOSH scores as the dependent variable, the other with SSRPH scores as the dependent variable. The two ANOVA will indicate if the variance in participants’ scores on the dependent variable (e.g. SSOSH (self stigma) score, or SSRPH (social stigma) score, respectively) differ at different levels of the factor (independent) variable (e.g. level of training).
There is a reasonable chance that participants may be unequally represented at different levels of the factor the sample, making comparison of group variances problematic. One means of correcting for this would be to randomly select equal numbers from each group at different levels of the factor. However, sample size is also a concern with regard to, among other things, power analysis. Each group represented in the ANOVA will have to include 52 participants (total sample size of at least 156 participants) in order to assure an effect size of .25.

3.10.1 Description of Statistical Analysis Techniques

The process of answering question two of the research study involves comparing groups formed by the categorical independent variable, or factor variable (e.g. year in program) based upon the amount of variance in the scores (e.g. dependent variable, SSOSH or SSRPH scores) within each group, and between the groups. Post hoc comparisons will also be conducted to determine which levels of the factor (independent variable) contribute most to the explanation of difference or variance in the dependent variables (SSOSH or SSRPH respectively).

The F statistic in ANOVA tests the null hypothesis that the variance in scores at different levels of the factor is due to chance or error alone. If the F-statistic is significantly larger than 1.00 (α = .002), the value of F indicates that the observed variance is larger than the variance attributable to error or chance. The larger F is, the greater the observed variance at different levels of the factor.

The role of the effect size measure, partial eta squared ($\eta^2$) in ANOVA is similar to that of R-square in multiple regression (which is the statistical tool used in Question #3
Partial $\eta^2$ returns a value interpreted as the amount of variance in the dependent variables accounted for by levels of the independent variable.

3.10.2 Post-hoc tests

In the event that the Analysis of Variance model was significant (e.g. not all means at each level of the factor were equal) the Tukey post-hoc test was selected to analyze results of the ANOVA in terms of which means vary among the factors in the model. The Tukey tends to be more conservative in rejecting the null hypothesis in the event of unequal comparison group sizes, a concern that was anticipated with regard to groupings by independent variables of the level of (i.e. year of) counseling training. Finally, the alpha level for each ANOVA was set to .002 ($\alpha = .002$), as with the t-tests of independent samples in question one, in order to further avoid a Type I error in the analysis of the statistical test results.

Table 3.3 outlines research question two, the statistical methods used to analyze the data, and the variables used in the analysis.
Research Question #2: Is there a difference in participants’ concern about the stigma of seeking psychological help based upon their level of counseling training?

<table>
<thead>
<tr>
<th>Question:</th>
<th>Statistical Tests</th>
<th>Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a difference in participants’ self stigma concerns based on year in counseling program?</td>
<td>Analysis of Variance (ANOVA) (post-hoc Tukey)</td>
<td>Independent Variable: Level in Program First year Masters Second year Masters Masters Grad or Doc&lt;sup&gt;a&lt;/sup&gt; Dependent Variable: Self stigma of Seeking Help</td>
</tr>
<tr>
<td>Is there a difference in participants’ social stigma concerns based on year in counseling program?</td>
<td>Analysis of Variance (ANOVA) (post-hoc Tukey)</td>
<td>Independent Variable: Level in Program First year Masters Second year Masters Masters Grad or Doc&lt;sup&gt;a&lt;/sup&gt; Dependent Variable: Social Stigma for Receiving Psychological Help</td>
</tr>
</tbody>
</table>

Table 3.3: Summary of question two statistical analysis and variables

Note: a. Masters graduate or doctoral student
3.11 Research Question Three: Factors Influencing Counseling Trainees’ Psychological Help Seeking Attitudes

What factors examined in the study might explain or predict counseling trainees' attitudes toward seeking professional psychological help?

H0 = None of the predictor variables (factors examined in the study) will be explanatory or predictive of the dependent variable (attitude toward seeking professional psychological help)

H1 = The predictor variables (e.g. self stigma, previous counseling, social stigma, gender, and distress disclosure), individually or in combination, will be explanatory and predictive of participants’ scores on the Attitudes Toward Seeking Professional Psychological Help scale (e.g. positive/negative attitudes toward seeking help).

Research question three was addressed utilizing the statistical technique of multiple regression, which is discussed in more detail below. The dependent variable was the participants’ aggregate scores on the Attitudes Toward Seeking Professional Psychological Help scale (ATSPPHS), short form, which returns scores ranging from 0 to 30 inclusive (Fischer & Farina, 1995). Predictor variables to be included in the regression model were the gender of the participant (either male or female); previous counseling experience; concerns about private or self stigma for seeking help (participants’ SSOSH scores); concerns about public stigma of seeking help (participants’ SSRPH scores); and level of comfort with disclosing distressing information to others (participants’ DDI scores).
3.11.1 *Description of Statistical Analysis Techniques*

The third research question was addressed using the statistical technique of multiple regression. Research question #3 is focused on examining what traits (gender), experiences (have or have not been in therapy), and beliefs (private and public stigma, distress disclosure) might influence participants’ attitudes toward seeking mental health services. Multiple regression can be used to explain the variance of a dependent (measured) variable based upon information available on two or more predictor variables. Predictor variables (gender, previous experience of counseling, score, SSOSH score, SSRPH score, and DDI score) were regressed against the dependent variable (participant’s score on the ATSPPH) in order to determine which personal characteristics, experiences, or beliefs contribute to or detract from a more positive level of attitude toward seeking professional psychological help (higher score on the ATSPPH). The resulting information from the statistical analysis showed to what degree any of the predictor variables account for or are predictive of the variance in participants' attitudes toward seeking professional psychological help.

The chosen method for entering the predictor variables into the regression model was simultaneous. This was done because there was little information in the existing research to dictate a sound theoretical basis for an order for entering the predictor variables into the regression model. Although previous studies on help seeking behavior and attitudes toward seeking professional psychological help have found that gender, previous experience of counseling as a client, public stigma against individuals who seek help for mental problems (Corrigan, River, Lundin, et al., 2000; Farber, 1999; Komiya,
Good, & Sherrod, 2001; Lang, 2005; Mohr, et al., 2008), as well as internal barriers such as Self (private) stigma, and personal comfort with disclosing distressing information to others (Dearing, et al., 2005; Kahn & Hessling, 2001; McCarthy, et al., 2010; Vogel, Wade, & Haake, 2006; Vogel & Wester, 2003), no studies currently exist that have examined the combined influence of these factors on attitudes toward psychological help seeking with a single sample. If levels of the predictor variables, in combination, explain variation in the dependent variable, the results of the multiple regression analysis will indicate the extent to which the proposed regression model (e.g. the combination of predictor variables and their unique contributions to levels of the dependent variable) is predictive or explanatory of participants’ attitudes toward seeking professional psychological help. Finally, predictor variables that did not achieve significance in the regression model (i.e. did not significantly contribute to the explanation of prediction of participants’ attitudes toward seeking psychological help) were removed from the regression model, and the multiple regression was recalculated to only include those predictor variables that significantly contributed to the model.

If the null hypothesis is supported in the results (e.g. none of the predictor variables is explanatory or predictive of scores on the dependent variable), the value of adjR² will be 0 (or close to it) (H₀: adjR² = 0). This would indicate in the sample the proportion of variance in the dependent variable (Y) explained or accounted for by the linear combination of the predictor variables (X₁, X₂, X₃,…) is zero (0). It would also indicate that all partial regression coefficients were equal to zero (H₀: B₁=B₂=B₃=B₄=B₅ =0). For the purposes of this study, results that supported the null hypothesis would
indicate none of the predictor variables used in the regression model were explanatory or predictive of the participants’ observed attitude toward seeking mental health services (aggregate score of the ATSPPH).

In the event that the null hypothesis is not supported, then \( \text{adj}R^2 \) will not be 0 (\( H_1: \text{adj}R^2 \neq 0 \)). Such results would indicate the predictor variables used in the regression model explain to some degree the variance observed in the dependent variable (ATSPPHS), and that the model, to some extent, is explanatory or predictive of the participants’ observed level of attitude toward seeking professional psychological help.

The beta coefficients indicate the relative importance of each of the predictor variables in predicting and explaining the value of the dependent variable. The betas were examined to determine how well and to what relative degree gender, perceptions of public (SSRPH) and self- (SSOSH) stigma, previous experience of counseling, and comfort with distress disclosure (DDI) predict and explain participants’ level of attitude toward seeking mental health services (ATSPPH).

The value of \( R^2 \) in the statistical results provides information on how powerful an explanation the regression model yields, or the “goodness of fit” of the model (Hair, Anderson, Tatham, & Black, 1998). This would indicate that the model overall (the predictor variables chosen, levels of error and multicollinearity, etc.) is a good means of explaining the variance of the dependent or measured variable. For example, an \( R^2 \) value of .768 shows that the linear combination of predictor variables in the model accounts for 76.8% of the variance in the dependent variable, indicating the model is a good fit, yielding a reasonably powerful explanation of the variance of the dependent variable.
R² tends to be biased and overestimates the population (Hair, et al., 1998). Therefore, adjusted R² was examined to determine the strength of the model given the number of predictor variables included in the regression equation and the sample size (shrinkage). Though the addition of a predictor variable to the model may increase R² (goodness of fit for the overall model), it may cause adjusted R² to go down if the additional variable has little explanatory value in the model (Hair, et al., 1998). Adjusted R² is a more realistic estimate of goodness of fit, and adjusts for bias.

Beta coefficients for each predictor variable indicate how much (by what percentage) a single unit change in one predictor variable would increase the level of the dependent variable (attitude toward seeking professional psychological help). Use of the beta coefficients standardizes, or establishes a common unit of measurement, across the predictor variables, making them a better indicator than the regression coefficients of the relative importance of each predictor variable to unit changes in the dependent variable (Hair, Anderson, Tatham, & Black, 1998). Beta coefficients can only be used as guides in analyzing the ability of the predictor variables to predict and explain levels of the dependent variable. Beta coefficients suggest the relative importance of the predictor variables to changes in the dependent variable. Hair, Anderson, Tatham, and Black (1998) offer the cautions in using beta coefficients in the analysis of the regression model, stating beta coefficients:

- Are to be used as a guide to the relative importance of the predictor variables only if collinearity for the model is minimal
- Must be interpreted in terms of their use relative to the other predictor variables, never as individual absolutes
- Levels of the predictor variables affect the beta coefficient values

The standard error of the estimate (how closely did the observed value of the dependent variable, or \( Y \), come to the predicted value of the dependent variable, or \( \hat{Y} \)) is represented by the value of \( s^2 \) (Hair, et al., 1998). It is a measure of the accuracy of the goodness of fit in predicting \( Y \) based upon the linear combination of the predictor variables. Another condition required to indicate the model is explanatory or predictive of the observed value of \( Y \) is that the predictor variables not be linearly related to one another, or, no perfect collinearity.

To test for multicollinearity, Tolerance and Variance Inflation Factor (VIF) values were examined (Hair, et al., 1998). Tolerance values for each predictor variable in the model should be near 1. If the Tolerance value is nearer to zero (0) this indicates that multicollinearity is a problem. The VIF statistic should be between zero (0) and ten (10), with a lower value (closer to zero) being preferred. If the VIF statistic exceeds ten (10) there is reason for concern. As the VIF increases, so does the variance, or the standard error of the partial regression coefficient (Hair, et al., 1998). High VIF values indicate that a particular predictor variable is a linear combination of the other predictor variables. If multicollinearity is indicated as a problem in the model, a principle component analysis might be done to combine related predictor variables (i.e. public stigma and self-stigma) into a smaller set of factors (principle components) (Hair, et al., 1998). These factors could then be entered as predictor variables in a multiple regression model.
Table 3.4 lists research question three and the statistical tests and variables used in the analysis.

<p>| Research Question #3: What factors examined in the study might explain or predict counseling trainees' attitudes toward seeking professional psychological help? |</p>
<table>
<thead>
<tr>
<th>Statistical Tests</th>
<th>Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple regression</td>
<td>Predictor Variables:</td>
</tr>
<tr>
<td></td>
<td>Gender</td>
</tr>
<tr>
<td></td>
<td>Previous counseling</td>
</tr>
<tr>
<td></td>
<td>Self stigma (SSOSH)</td>
</tr>
<tr>
<td></td>
<td>Social stigma (SSRPH)</td>
</tr>
<tr>
<td></td>
<td>Distress Disclosure (DDI)</td>
</tr>
<tr>
<td></td>
<td>Criterion Variable:</td>
</tr>
<tr>
<td></td>
<td>Attitudes Toward Seeking Professional</td>
</tr>
<tr>
<td></td>
<td>Psychological Help (ATSPPHS)</td>
</tr>
</tbody>
</table>

Table 3.4: Summary of question three statistical analysis and variables

3.12 Limitations of the Study

3.12.1 External Validity

External validity deals directly with the question of the generalizability of results of a study to a population, based upon a sample of that population. In other words, will the results of this study be applicable to counselor education students in the general
population? Campbell and Stanley (1963) suggest that the question of external validity is, in the final analysis, basically unanswerable. Yet, the goal of inferential statistics is to allow us to infer, or make assumptions, about a population based on data systematically obtained from a representative sample. To that end, Campbell and Stanley (1963) go on to suggest that research designs that account as much as possible for the greatest level of generalizability are the optimal designs.

There were no reactive or interaction effects as a threat to external validity. The questionnaire was administered only once to participants, therefore, there were no pretesting of study participants. Reactive effects of experimental arrangements are unlikely, since it is not likely participants have been exposed to this specific questionnaire in the past, outside of the setting in which the questionnaire was administered. It is possible that participants have been exposed to research regarding attitudes toward help seeking and issues of stigma directed at people with mental illness or those who seek mental health services. Concern over this exposure is minimal, however, since the purpose of the study is, in part, to examine how future counseling practitioners, with or without exposure to these constructs, think about the very topics and dynamics of seeking help, seeking psychological help themselves, and being labeled “mentally ill.” Interference due to multiple treatments is not a concern, since this questionnaire was administered to the participants only once.

3.12.2 Internal Validity

In the case of survey research, internal validity may be best discussed in terms of accuracy: does the questionnaire, as designed, collect and measure the constructs and
factors necessary to answer the proposed research questions? Campbell and Stanley (1963) discuss internal validity with regard to whether or not a treatment produces the desired results in an experimental design. Since this is survey, and not experimental research, we are interested most in insuring that the design of the survey (wording of questions; information solicited; instruments selected for inclusion; etc.) in fact elicits relevant data items. Questions of validity in the measurement of phenomena being researched may come down to the essential question: Are we measuring what we say we are measuring?

There was no effect for history, maturation, or testing, since the questionnaire was administered only once to participants. Effects of instrumentation are being controlled for in this study by establishing uniform wording of all items on the questionnaire, and establishing basis for the wording of items in the current research. In addition, all scoring was completed by the same researcher, with redundancy or checking provided by a single research assistant.

There is a concern regarding administration of the instrument as an effect on internal validity, since the questionnaire was self-administered. To ameliorate the possible effects of administration, detailed instructions were provided with the questionnaires. In addition, all participants will receive information by way of a cover sheet that will provide information about the study, its purpose, and the potential impact of their participation on the researcher, the counseling field, and themselves personally (e.g. informed consent).
Effects of statistical regression and selection are being controlled for by the random selection of participants from the population (student members of the American Counseling Association). Ultimately, participation in the study was a result of self selection by participants, which is a problem impacting the generalizability of the study, and is also consistent with existing research if this kind in the literature (Atkinson, & Gim, 1983; Atkinson, et al., 1989; Cepeda-Benito & Short, 1998; Constantine & Gainor, 2004; Constantine & Milville, 2006; Dearing, Maddux, & Tangney, 2005; Fischer & Cohen, 1972; Fischer & Farina, 1995; Fischer & Turner, 1970; Komiya, Good, & Sherrod, 2000; Leong & Zachar, 1999; McCarthy, Pfohl, & Bruno, 2010; Vogel Wade, & Haake, 2006).

3.13 Summary

This chapter has discussed the methodology and design for a study to be conducted with counselor education graduate students to investigate their attitudes and behaviors with regard to seeking mental health services. The overall design of the study is survey research. Counselor education students from the ACA student member database were randomly selected to participate in the study. Methods for selection and sampling, as well as recruitment have been discussed in detail. In addition, concerns relating to protocol for administering the questionnaires, provision of instructions for proper completion, and ethical issues such as informed consent have been addressed. Six research questions were proposed, and the statistical techniques for analysis of the data in order to answer those questions have been outlined.
Chapter Four

Data Analysis

4.1 Introduction

What follows is a discussion of the results of the analysis of the data collected for the study.

4.2 Data Collection

A mailing list of one thousand names and addresses, randomly selected from the student member database of the American Counseling Association, was used to recruit participants for the study. A questionnaire packet including an introductory letter; one questionnaire; two (2) Informed Consent to Participation forms (participants retain one, and return one); a self addressed, stamped envelope for return of the completed consent form and questionnaire; and a sticker, as a thank you, highlighting the Rogerian principles of “Empathy – Positive Regard – Authenticity” (see Appendix A) was mailed to each person in the sample.

Of the one thousand questionnaires mailed, seven questionnaires were returned by the United States Postal Service as undeliverable. Three hundred and ten (310) questionnaires were returned, of which 309 were completed resulting in a 31% return rate (309 out of 993 delivered). Heppner, Kivlighan, and Wampold (1992) suggest an
acceptable return rate ranges between 30% to 40%. Sixty-three respondents were enrolled in programs other than mental health, community/agency, school counseling and counselor education programs (e.g. psychology, rehabilitation counseling, marriage and family therapy, higher education) and so these were excluded from the statistical analysis. The following statistical analysis is based on a sample of 246 participants.

The American Counseling Association student member database includes graduate counseling trainees from throughout the United States. The sample for the study included individuals from 43 states in the United States, as well as the United States Military. States not represented in the sample were Arkansas, Delaware, Mississippi, Rhode Island, Vermont, West Virginia, and Wyoming. The states with the most respondents in the study are listed in Table 4.1.
### Table 4.1: States with most participants in the sample

<table>
<thead>
<tr>
<th>STATE</th>
<th>Frequency</th>
<th>Percentage of total responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida</td>
<td>20</td>
<td>8.1</td>
</tr>
<tr>
<td>Texas</td>
<td>18</td>
<td>7.3</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>16</td>
<td>6.5</td>
</tr>
<tr>
<td>Colorado</td>
<td>13</td>
<td>5.3</td>
</tr>
<tr>
<td>North Carolina</td>
<td>13</td>
<td>5.3</td>
</tr>
<tr>
<td>New Jersey</td>
<td>13</td>
<td>5.3</td>
</tr>
<tr>
<td>Virginia</td>
<td>13</td>
<td>5.3</td>
</tr>
<tr>
<td>Ohio</td>
<td>12</td>
<td>4.9</td>
</tr>
<tr>
<td>Illinois</td>
<td>11</td>
<td>4.5</td>
</tr>
<tr>
<td>Missouri</td>
<td>11</td>
<td>4.5</td>
</tr>
<tr>
<td>New York</td>
<td>9</td>
<td>3.7</td>
</tr>
<tr>
<td>Arizona</td>
<td>7</td>
<td>2.8</td>
</tr>
</tbody>
</table>

4.3 Analysis of Results for Research Question One

What are the demographic characteristics of the survey respondents? What are their attitudes toward seeking professional psychological help; private and public stigma concerns about seeking help; likelihood of disclosing distressing information to others as measured by the instruments in the questionnaire (e.g. means, standard deviations for the instruments)? Are there differences in mean scores on the measures for the study (e.g. ATSPPHS, attitudes toward seeking professional psychological help; SSOSH, self-stigma of seeking help; SSRPH, social stigma for receiving professional psychological help; DDI, Distress Disclosure Index, comfort with disclosing distressing information) based
upon independent variables (key demographic categories) of gender, previous counseling experience, and race? What perceived barriers to seeking psychological help did participants endorse, and at what levels (e.g. not a barrier; somewhat a barrier; significant barrier)? Are there differences in participants’ number of endorsed barriers based upon the independent variables of gender, previous counseling, or race?

4.3.1 Analysis of Demographic Data

The average age of participants in the study was approximately 36 years old (M = 35.59, Median = 31.00, sd = 11.509, min = 21, max = 67). Age for Masters level trainees only in the sample was also calculated and examined, and the average, median, and range of age remained similar for the smaller sample (M = 35.05, Median = 30.00, sd = 11.315, min = 21, max = 64). Female participants (84%) outnumbered male participants (16%). The racial makeup of the sample was largely White/Caucasian (82%). The 18% of participants who did not identify as white self-identified as Black and African American (11%), Latino/Hispanic (2%), Asian/Pacific Island (1%), Native American (.8%), and Biracial (3.2%). Table 4.2 lists the frequencies and percentages of participants’ response to the question “What is your race?” (Item 3).
<table>
<thead>
<tr>
<th>RACE</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White – Caucasian – European American</td>
<td>202</td>
<td>82.1</td>
</tr>
<tr>
<td>Black – African American – African – West Indian</td>
<td>26</td>
<td>10.6</td>
</tr>
<tr>
<td>Hispanic - Latino</td>
<td>6</td>
<td>2.4</td>
</tr>
<tr>
<td>Asian – Pacific Islander</td>
<td>3</td>
<td>1.2</td>
</tr>
<tr>
<td>Native American – Central American Indian</td>
<td>1</td>
<td>.4</td>
</tr>
<tr>
<td>Biracial – Black+White</td>
<td>2</td>
<td>.8</td>
</tr>
<tr>
<td>Biracial – American Indian+White</td>
<td>1</td>
<td>.4</td>
</tr>
<tr>
<td>Biracial – Asian+White</td>
<td>1</td>
<td>.4</td>
</tr>
<tr>
<td>Biracial – Hispanic/Latino+White</td>
<td>3</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>245</strong></td>
<td><strong>99.6</strong></td>
</tr>
</tbody>
</table>

Table 4.2: Reported race by participants, frequencies and percentages in the sample

Note: One participant in the sample did not report race.

Participants were asked to identify their concentration of study in their Counselor Education programs. Most participants identified as mental health counseling trainees (n = 133, 54.1%), followed by Community/Agency (n = 58, 23.6%), and School (n = 41, 16.7%). Doctoral trainees comprised 5.7% of the sample (n = 14) and identified their concentration of study as Counselor Education. Table 4.3 lists the frequencies and percentages of participants in each of the four concentrations of graduate study.
The majority of participants in the study had sought professional psychological help at some point in their lives. When asked “Have you ever attended counseling for an emotional, relationship, or psychological problem?” 79.7% (n = 196) of participants responded “yes”, while 20.3% (n = 50) responded “no.”

<table>
<thead>
<tr>
<th>Participants’ concentration of graduate study</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health counseling</td>
<td>133</td>
<td>54.1</td>
</tr>
<tr>
<td>Community or Agency counseling</td>
<td>58</td>
<td>23.6</td>
</tr>
<tr>
<td>School counseling</td>
<td>41</td>
<td>16.7</td>
</tr>
<tr>
<td>Counselor education (doctoral)</td>
<td>14</td>
<td>5.7</td>
</tr>
<tr>
<td>Total</td>
<td>246</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 4.3: Participants’ concentration of graduate study, frequencies and percentages

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has previous experience of counseling</td>
<td>196</td>
</tr>
<tr>
<td>Does not have previous experience of counseling</td>
<td>50</td>
</tr>
<tr>
<td>Total</td>
<td>246</td>
</tr>
</tbody>
</table>

Table 4.4: Participants’ previous experience of counseling as a client, frequencies and percentages
To further understand counseling trainees’ previous experience of counseling within the sample, previous counseling experience of participants was also examined by concentration of study. The results of a cross-tabulation of program concentration and previous experience of counseling showed that almost half of the participants who identified School Counseling as their concentration (43.9%) had no previous experience of counseling as a client. Participants who identified Counselor Education as their concentration (PhD) were the smallest group (n = 14), and had the highest rate of help seeking (92.9%). The full results of the cross-tabulation of concentration of graduate study and previous experience of counseling are listed in Table 4.5.
Table 4.5: Participants’ previous experience of counseling as a client, grouped by concentration of study, frequencies and percentages

<table>
<thead>
<tr>
<th>Concentration of Graduate Study</th>
<th>Previous counseling experience</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health counseling</td>
<td>Attended counseling</td>
<td>112</td>
<td>84.2</td>
</tr>
<tr>
<td></td>
<td>Has not attended counseling</td>
<td>21</td>
<td>15.8</td>
</tr>
<tr>
<td>School counseling</td>
<td>Attended counseling</td>
<td>23</td>
<td>56.1</td>
</tr>
<tr>
<td></td>
<td>Has not attended counseling</td>
<td>18</td>
<td>43.9</td>
</tr>
<tr>
<td>Community/Agency counseling</td>
<td>Attended counseling</td>
<td>48</td>
<td>82.8</td>
</tr>
<tr>
<td></td>
<td>Has not attended counseling</td>
<td>10</td>
<td>17.2</td>
</tr>
<tr>
<td>Counselor education</td>
<td>Attended counseling</td>
<td>13</td>
<td>92.9</td>
</tr>
<tr>
<td></td>
<td>Has not attended counseling</td>
<td>1</td>
<td>7.1</td>
</tr>
</tbody>
</table>

If participants indicated they had been to counseling in the past (e.g., previous experience) they were asked to indicate the length of time they had previously been in counseling to this point in their lives. Four ranges of time in months were offered as possible responses: zero to three months, four to six months, seven to twelve months, or longer than one year. A length of time in counseling of “no counseling” was coded for respondents who indicated they had no previous experience of counseling, and, thus, would have no length of time associated with being in counseling. The majority of participants had had more than one year of counseling (n = 77, 31.4%), followed by three months or less (n = 57, 23.3%), no counseling (n = 50, 20.4%), seven to twelve months (n = 50, 20.4%), zero to three months (n = 44, 18.2%), and four to six months (n = 26, 10.8%).
= 33, 13.5%), and four to six months (n = 28, 11.4%). The frequencies and percentages for participants’ length of time in counseling, including those who had never attended counseling, are shown in Table 4.6.

<table>
<thead>
<tr>
<th>Length of time in counseling</th>
<th>Frequency</th>
<th>Percentage</th>
<th>Cumulative Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No counseling</td>
<td>50</td>
<td>20.4</td>
<td>20.4</td>
</tr>
<tr>
<td>Has attended counseling 3 months or less</td>
<td>57</td>
<td>23.3</td>
<td>43.7</td>
</tr>
<tr>
<td>Has attended counseling 4-6 months</td>
<td>28</td>
<td>11.4</td>
<td>55.1</td>
</tr>
<tr>
<td>Has attended counseling 7-12 months</td>
<td>33</td>
<td>13.5</td>
<td>68.6</td>
</tr>
<tr>
<td>Has attended counseling longer than 1 year</td>
<td>77</td>
<td>31.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>245</td>
<td>99.6</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.6: Participants’ length of time spent in counseling, frequencies, percentages, and cumulative percentages

Note: One participant in the total sample did not report length of time in counseling

Masters students comprised the majority of respondents (n = 223, 92.1%), followed by PhD (n = 16, 6.6%), and EdD students (n = 2, 0.8%). Table 4.7 lists frequencies and percentages of participants by degree sought.
Table 4.7: Graduate degree sought or earned by participants

<table>
<thead>
<tr>
<th>Graduate degree sought or earned</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Masters</td>
<td>223</td>
<td>90.7</td>
</tr>
<tr>
<td>PhD</td>
<td>16</td>
<td>6.5</td>
</tr>
<tr>
<td>EdD</td>
<td>2</td>
<td>.8</td>
</tr>
<tr>
<td>Total</td>
<td>242</td>
<td>98.4</td>
</tr>
</tbody>
</table>

Note: Five participants in the total sample (n = 246) did not report graduate degree sought or earned.

The majority of participants were in their second year of Masters training (n = 135, 57.7%). Masters students who had graduated and doctoral students comprised the third level of training and were the second largest group of respondents (n = 73, 31.2%), and first year masters students were the smallest group (n = 26, 11.1%).

Table 4.8: Participants’ year of graduate training, frequencies and percentages

<table>
<thead>
<tr>
<th>Year of graduate training</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>First year Masters</td>
<td>26</td>
<td>10.6</td>
</tr>
<tr>
<td>Second year Masters</td>
<td>135</td>
<td>54.9</td>
</tr>
<tr>
<td>Masters graduate-Doctoral first year</td>
<td>73</td>
<td>29.7</td>
</tr>
<tr>
<td>Total</td>
<td>234</td>
<td>95.1</td>
</tr>
</tbody>
</table>

Note: Twelve participants in the total sample did not report year of training.
4.3.2 Participants’ Endorsement of Barriers to Help Seeking

The most frequently endorsed barrier to seeking psychological help was the cost of services (79.7%), followed by time taken from work or school (to go to counseling) (71.5%), fear of reaction from family and friends (27.3%), and fear of faculty reaction (26.9%). Table 4.9 lists the barriers from item 6 of the questionnaire and summarizes the endorsements given by participants.
<table>
<thead>
<tr>
<th>Type of Barrier</th>
<th>Barriers listed in Item 6</th>
<th>Not a barrier</th>
<th>Somewhat of a barrier</th>
<th>A significant barrier</th>
<th>Overall Percent Endorsed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Practical Affordability</strong></td>
<td>Cost of services</td>
<td>50 (20.3)</td>
<td>102 (41.5)</td>
<td>94 (38.2)</td>
<td>79.7%</td>
</tr>
<tr>
<td></td>
<td>Time taken from work and school</td>
<td>70 (28.5)</td>
<td>114 (46.3)</td>
<td>62 (25.2)</td>
<td>71.5%</td>
</tr>
<tr>
<td><strong>Emotional Acceptability</strong></td>
<td>Concerns about reaction from family &amp; friends</td>
<td>179 (72.8)</td>
<td>57 (23.2)</td>
<td>10 (4.1)</td>
<td>27.3%</td>
</tr>
<tr>
<td></td>
<td>Concerns about faculty reaction</td>
<td>180 (73.2)</td>
<td>57 (23.2)</td>
<td>9 (3.7)</td>
<td>26.9%</td>
</tr>
<tr>
<td></td>
<td>Being looked down upon</td>
<td>183 (74.4)</td>
<td>53 (21.5)</td>
<td>10 (4.1)</td>
<td>25.6%</td>
</tr>
<tr>
<td><strong>Practical Accessibility</strong></td>
<td>Knowing the location of services</td>
<td>183 (74.4)</td>
<td>54 (22.0)</td>
<td>9 (3.7)</td>
<td>24.5%</td>
</tr>
<tr>
<td></td>
<td>Knowing services are available</td>
<td>194 (78.9)</td>
<td>38 (15.4)</td>
<td>14 (5.7)</td>
<td>20.1%</td>
</tr>
<tr>
<td></td>
<td>Transportation</td>
<td>223 (90.7)</td>
<td>10 (4.1)</td>
<td>13 (5.3)</td>
<td>9.4%</td>
</tr>
<tr>
<td></td>
<td>Having someone to go with</td>
<td>236 (95.9)</td>
<td>9 (3.7)</td>
<td>1 (0.4)</td>
<td>4.1%</td>
</tr>
</tbody>
</table>

Table 4.9: Participants’ endorsement of barriers to help seeking, counts and percentages

Note: Percentages appear below count (number of participants in endorsed category) in parentheses.
4.3.3 Descriptive Statistical Analysis of Mean Scores on Instruments for the Study

Four measures were used in the study to assess participants’ attitudes toward seeking professional psychological help (ATSPPHS, Fischer & Farina, 1995); stigma concerns relating to the self stigma of seeking help (SSOSH, Vogel, Wade, & Haake, 2006); stigma concerns relating to social stigma for receiving psychological help (SSRPH, Komiya, Good, & Sherrod, 2000); and comfort with disclosing distressing information to others (DDI, Kahn & Hessling, 2001). The mean scores and standard deviations for the four key measures for the study are listed in Table 4.10. The correlation matrix and internal reliability statistics (Cronbach’s alpha, reported on the diagonal) for the measures used in the study are listed in Table 4.11.
<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Range of Possible Scores</th>
<th>Range of scores for the Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATSPPHS</td>
<td>24.22</td>
<td>3.451</td>
<td>0 – 30</td>
<td>13 – 30</td>
</tr>
<tr>
<td>SSOSH</td>
<td>7.87</td>
<td>5.779</td>
<td>0 – 40</td>
<td>0 – 28</td>
</tr>
<tr>
<td>SSRPH</td>
<td>3.83</td>
<td>2.842</td>
<td>0 - 15</td>
<td>0 – 11</td>
</tr>
<tr>
<td>DDI</td>
<td>24.82</td>
<td>7.080</td>
<td>0 - 36</td>
<td>2 - 36</td>
</tr>
</tbody>
</table>

Table 4.10: Means and standard deviations for participant scores on measures in the study

Note: n = 246; ATSPPHS – Attitudes Toward Seeking Professional Psychological Help-short form, SSOSH – Self Stigma of Seeking Help scale, SSRPH – Social Stigma for Receiving Psychological Help scale, DDI – Distress Disclosure Index

<table>
<thead>
<tr>
<th></th>
<th>ATSPPHS</th>
<th>SSOSH</th>
<th>SSRPH</th>
<th>DDI</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATSPPHS</td>
<td>.687a</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSOSH</td>
<td>-.463b</td>
<td>.796a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSRPH</td>
<td>-.342b</td>
<td>.491b</td>
<td>.766a</td>
<td></td>
</tr>
<tr>
<td>DDI</td>
<td>.191b</td>
<td>-.164b</td>
<td>-.071b</td>
<td>.907a</td>
</tr>
</tbody>
</table>

Table 4.11: Correlation matrix for scales in the study with internal reliability for each scale

Note: a. Cronbach’s alpha for each scale is reported on the diagonal; b. p < .05
4.3.4 Comparisons of Mean Scores Based on Certain Demographics.

Research on attitudes toward seeking psychological help and stigma concerns related to seeking that help consistently examines mean differences in scores of instruments measuring those phenomena (i.e. attitudes toward seeking professional psychological help, self stigma for receiving help, and social stigma for receiving psychological help) based upon groupings of gender, previous experience of counseling, and race. A series of t-tests of independent samples were run with gender (e.g. male or female), previous experience of counseling (e.g. yes or no), race (e.g. white or non-white), and program concentration (e.g. School or Mental Health/Community/Agency counseling) as the independent variables, and attitudes toward seeking psychological help (ATSPPHS), self stigma of seeking help (SSOSH), social stigma for receiving psychological help (SSRPH), comfort with distress disclosure (DDI), and total number of endorsed barriers (questionnaire item eight) as the dependent variables.

Additional mean comparisons were conducted in response to the findings regarding rates of help seeking within participants’ concentrations of study. Since School counseling trainees’ help seeking rates were much lower than Mental Health and Community/Agency trainees (see Tables 4.5 above), mean comparisons for scores on all four instruments in the study were conducted between School counseling and Mental Health/community/Agency counseling trainees. It was hypothesized that, if help seeking attitudes are related to actual help seeking behavior, then School counseling trainees’ may have significantly more negative attitudes toward help seeking than the other trainees, since their help seeking rates were so much lower.
Since doctoral level trainees represented such a small portion of the sample (n = 18, 7.3%), data from these respondents was not included for purposes of the statistical analysis of mean score comparisons (research question one), nor for the statistical analysis examining research questions two and three. The results of statistical analysis in the study from this point forward, then, will include only data obtained from Masters level trainees who responded to the survey. Finally, Levene’s test for assuming equal variances between groups for each t-test was analyzed. The following reported results are based on the appropriate assumptions for homogeneity of variance.

_T-tests of Independent Samples for the Dependent Variable of Attitudes Toward Seeking Professional Psychological Help._ Participants’ mean scores on the Attitudes Toward Seeking Professional Psychological Help scale differed significantly based upon their previous experience of counseling. Participants who had previously gone to counseling as clients (M = 24.96) expressed more positive attitudes toward seeking help than those without previous experience of counseling (M = 21.43; t = -6.888, p = .000, d = 1.035, power > .99). There was no significant mean difference in ATSPPHS scores based upon gender (t = -3.090, p = .003, d = .67, power = .96), race (t = -3.090, p = .003, d = .67, power = .22), or program concentration (t = 1.531, p = .127, d = .25, power = .33).

Table 4.12 lists results from the t-tests of independent measures conducted on the dependent variable of attitudes toward seeking professional psychological help (ATSPPHS) scores by gender, previous counseling, race, and program concentration.
<table>
<thead>
<tr>
<th>Dependent &amp; Independent Variables</th>
<th>Independent Variable Groups</th>
<th>N</th>
<th>Mean</th>
<th>Std Dev</th>
<th>t</th>
<th>Sig.</th>
<th>Effect size (Cohen’s d)</th>
<th>Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATSPPHS &amp; Gender</td>
<td>Female</td>
<td>191</td>
<td>24.59</td>
<td>3.157</td>
<td>-3.090</td>
<td>.003</td>
<td>.60</td>
<td>.96</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>37</td>
<td>22.35</td>
<td>4.185</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ATSPPHS &amp; Previous counseling</td>
<td>Counseling</td>
<td>181</td>
<td>24.96</td>
<td>3.107</td>
<td>-6.888</td>
<td>.000a</td>
<td>1.115</td>
<td>&gt; .99</td>
</tr>
<tr>
<td></td>
<td>No Counseling</td>
<td>47</td>
<td>21.43</td>
<td>3.222</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-white</td>
<td>40</td>
<td>23.65</td>
<td>3.725</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ATSPPHS &amp; Concentration</td>
<td>MHC Community Agency</td>
<td>188</td>
<td>24.39</td>
<td>3.316</td>
<td>1.531</td>
<td>.127</td>
<td>.25</td>
<td>.33</td>
</tr>
<tr>
<td></td>
<td>School</td>
<td>40</td>
<td>23.48</td>
<td>3.909</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.12: T-tests of independent samples comparing ATSPPHS scores using independent variables of gender, previous counseling, race, and program concentration

Note: ATSPPHS – Attitudes Toward Seeking Professional Psychological Help-short form

Note: a. significant at $\alpha = .002$, family-wise $\alpha = .05$
Figure 4.1 shows a scatter plot of participants’ scores on the ATSPPHS based upon their previous experience of counseling.

Figure 4.1: Participants’ attitudes toward seeking professional psychological help by previous counseling experience

Note: ATSPPHS – Attitudes Toward Seeking Professional Psychological Help scale, PRVCOUNS – previous experience of counseling

Note: Scores for the ATSPPHS can range from 0 to 30
T-tests of Independent Samples for the Dependent Variable of Self Stigma of Seeking Help. The only significant group mean difference in SSOSH (self or private stigma) scores was between participants who had previous experience of counseling and those who had no previous experience. Participants who had no previous experience of counseling expressed greater self (private) stigma concerns (n = 50, M = 11.12) than those who had previously attended counseling (n = 196, M = 7.04; t = 4.652, p = .000, effect size .71, power .95). There was no significant mean difference in SSOSH scores based upon gender, race, or program concentration.

Table 4.13 lists results from the t-tests of independent measures conducted on the dependent variable of self stigma of seeking help (SSOSH) scores by gender, previous counseling, and race.
<table>
<thead>
<tr>
<th>Dependent &amp; Independent Variables</th>
<th>Independent Variable Groups</th>
<th>N</th>
<th>Mean</th>
<th>Std Dev</th>
<th>t</th>
<th>Sig.</th>
<th>Effect size (Cohen’s $d$)</th>
<th>Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSOSH &amp; Gender</td>
<td>Female</td>
<td>191</td>
<td>7.75</td>
<td>5.709</td>
<td>.600</td>
<td>.549</td>
<td>.45</td>
<td>.09</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>37</td>
<td>8.38</td>
<td>6.224</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSOSH &amp; Previous counseling</td>
<td>Counseling</td>
<td>181</td>
<td>6.98</td>
<td>5.482</td>
<td>4.664</td>
<td>.000$^a$</td>
<td>.75</td>
<td>&gt;.99</td>
</tr>
<tr>
<td></td>
<td>No counseling</td>
<td>47</td>
<td>11.21</td>
<td>5.756</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSOSH &amp; Race</td>
<td>White</td>
<td>187</td>
<td>7.66</td>
<td>5.772</td>
<td>.929</td>
<td>.354</td>
<td>.16</td>
<td>.15</td>
</tr>
<tr>
<td></td>
<td>Non-white</td>
<td>40</td>
<td>8.60</td>
<td>5.852</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSOSH &amp; Concentration</td>
<td>MHC Community Agency</td>
<td>188</td>
<td>7.60</td>
<td>5.690</td>
<td>-1.442</td>
<td>.151</td>
<td>.20</td>
<td>.30</td>
</tr>
<tr>
<td></td>
<td>School</td>
<td>40</td>
<td>9.05</td>
<td>6.152</td>
<td></td>
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</tr>
</tbody>
</table>

Table 4.13: T-tests of independent samples comparing SSOSH scores using independent variables of gender, previous counseling, race, and program concentration

Note: SSOSH – Self Stigma of Seeking Help scale

Note: Note: a. significant at $\alpha = .002$, family-wise $\alpha = .05$
Figure 4.2 shows a scatter plot of participants’ scores on the self stigma scale (SSOSH). The plot illustrates the lower levels of self stigma concern for participants who had previous experience of counseling.

Figure 4.2: Participants’ self stigma of seeking help concerns by previous counseling experience

Note: SSOSH – Self Stigma of Seeking Help scale, PRVCOUNS – previous experience of counseling

Note: Scores for the SSOSH can range from 0 to 40
T-tests of Independent Samples for the Dependent Variables of Social Stigma for Receiving Psychological Help and Distress Disclosure. None of the mean scores for the Social Stigma for Receiving Psychological Help scale or the Distress Disclosure Index (e.g. comfort with disclosing distressing information to others) were significant based on any of the independent variables (e.g. demographics of gender, previous counseling experience, race, and program concentration). Table 4.14 lists the results of the t-tests run for the dependent variable of social stigma for receiving psychological help, and Table 4.15 lists the results for the dependent variable of comfort with disclosing distressing information.
<table>
<thead>
<tr>
<th>Dependent &amp; Independent Variables</th>
<th>Independent Variable Groups</th>
<th>N</th>
<th>Mean</th>
<th>Std Dev</th>
<th>t</th>
<th>Sig.</th>
<th>Effect size</th>
<th>Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSRPH &amp; Gender</td>
<td>Female</td>
<td>191</td>
<td>3.68</td>
<td>2.809</td>
<td>1.986</td>
<td>.048</td>
<td>.34</td>
<td>.51</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>37</td>
<td>4.70</td>
<td>3.143</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSRPH &amp; Previous counseling</td>
<td>Counseling</td>
<td>181</td>
<td>3.62</td>
<td>2.776</td>
<td>2.363</td>
<td>.019</td>
<td>.37</td>
<td>.65</td>
</tr>
<tr>
<td></td>
<td>No counseling</td>
<td>47</td>
<td>4.72</td>
<td>3.146</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSRPH &amp; Race</td>
<td>White</td>
<td>187</td>
<td>3.67</td>
<td>2.764</td>
<td>2.013</td>
<td>.045</td>
<td>.33</td>
<td>.52</td>
</tr>
<tr>
<td></td>
<td>Non-white</td>
<td>40</td>
<td>4.68</td>
<td>3.331</td>
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<td></td>
</tr>
<tr>
<td>SSRPH &amp; Concentration</td>
<td>MHC Community Agency</td>
<td>188</td>
<td>3.90</td>
<td>2.843</td>
<td>.595</td>
<td>.553</td>
<td>.10</td>
<td>.09</td>
</tr>
<tr>
<td></td>
<td>School</td>
<td>40</td>
<td>3.60</td>
<td>3.095</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.14: T-tests of independent samples comparing SSRPH (social stigma) scores using independent variables of gender, previous counseling, and race

Note: SSRPH – Social Stigma for Receiving Psychological Help scale

Note: None of the mean comparisons were significant (α = .002, family-wise α = .05)
<table>
<thead>
<tr>
<th>Dependent &amp; Independent Variables</th>
<th>Independent Variable Groups</th>
<th>N</th>
<th>Mean</th>
<th>Std Dev</th>
<th>t</th>
<th>Sig.</th>
<th>Effect size (Cohen’s $d$)</th>
<th>Power</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DDI &amp; Gender</strong></td>
<td>Female</td>
<td>191</td>
<td>25.03</td>
<td>7.062</td>
<td>-1.306</td>
<td>.193</td>
<td>.23</td>
<td>.26</td>
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<tr>
<td></td>
<td>Male</td>
<td>37</td>
<td>23.35</td>
<td>7.543</td>
<td></td>
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</tr>
<tr>
<td><strong>DDI &amp; Previous Counseling</strong></td>
<td>Counseling</td>
<td>181</td>
<td>22.79</td>
<td>6.956</td>
<td>-2.133</td>
<td>.034</td>
<td>.35</td>
<td>.57</td>
</tr>
<tr>
<td></td>
<td>No counseling</td>
<td>47</td>
<td>25.27</td>
<td>7.133</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DDI &amp; Race</strong></td>
<td>White</td>
<td>187</td>
<td>25.16</td>
<td>7.060</td>
<td>-1.551</td>
<td>.122</td>
<td>.27</td>
<td>.34</td>
</tr>
<tr>
<td></td>
<td>Non-white</td>
<td>40</td>
<td>23.25</td>
<td>7.110</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DDI &amp; Concentration</strong></td>
<td>MHC Community Agency</td>
<td>188</td>
<td>24.70</td>
<td>7.263</td>
<td>-.239</td>
<td>.812</td>
<td>.04</td>
<td>.056</td>
</tr>
<tr>
<td></td>
<td>Non-white</td>
<td>40</td>
<td>25.00</td>
<td>6.687</td>
<td></td>
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</tbody>
</table>

Table 4.15: T-tests of independent samples comparing DDI (distress disclosure) scores using independent variables of gender, previous counseling, and race

Note: DDI – Distress Disclosure Index

Note: None of the mean comparisons were significant ($\alpha = .002$, family-wise $\alpha = .05$)
T-tests of Independent Measures for the Dependent Variable of Number of Endorsed Barriers to Help Seeking. The number of endorsed barriers to seeking psychological help (questionnaire, Item #6, e.g. how many of the ten listed barriers were endorsed as “somewhat of” or “a significant” barrier) was totaled and recorded for each participant. Four t-tests of independent measures were conducted to examine differences in the mean number of endorsed barriers for participants based upon gender, previous experience of counseling, race, and program concentration.

The results of the t-test of independent measures for the independent variable of previous counseling experience was significant (t = 3.243, p = .001, d = .51, power .90). There was no significance for mean differences in number of endorsed barriers based upon participants’ gender, race, or program concentration. Tables 4.16 lists the results of the t-tests of independent samples run for number of endorsed barriers using each of the four independent variables (e.g. gender, previous counseling experience, race, and program concentration) as the grouping variables.
<table>
<thead>
<tr>
<th>Dependent &amp; Independent Variables</th>
<th>Independent Variable Groups</th>
<th>N</th>
<th>Mean</th>
<th>Std Dev</th>
<th>t</th>
<th>Sig.</th>
<th>Effect size (Cohen’s $d$)</th>
<th>Power</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of endorsed barriers &amp; Gender</strong></td>
<td>Female</td>
<td>191</td>
<td>2.9581</td>
<td>1.69778</td>
<td>1.265</td>
<td>.213</td>
<td>.25</td>
<td>.34</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>37</td>
<td>3.4595</td>
<td>2.29243</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of endorsed barriers &amp; Previous counseling</strong></td>
<td>Counseling</td>
<td>181</td>
<td>2.8453</td>
<td>1.72187</td>
<td>3.243</td>
<td>.001&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.51</td>
<td>.90</td>
</tr>
<tr>
<td></td>
<td>No counseling</td>
<td>47</td>
<td>3.7872</td>
<td>1.96642</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of endorsed barriers &amp; Race</strong></td>
<td>White</td>
<td>187</td>
<td>3.0160</td>
<td>1.82714</td>
<td>.423</td>
<td>.673</td>
<td>.07</td>
<td>.07</td>
</tr>
<tr>
<td></td>
<td>Non-white</td>
<td>40</td>
<td>3.1500</td>
<td>1.77663</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of endorsed barriers &amp; Concentration</strong></td>
<td>MHC Community Agency</td>
<td>188</td>
<td>2.915</td>
<td>1.70974</td>
<td>-1.956</td>
<td>.056</td>
<td>.36</td>
<td>.62</td>
</tr>
<tr>
<td></td>
<td>School</td>
<td>40</td>
<td>3.625</td>
<td>2.15653</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.16: T-tests of independent samples comparing participants’ number of endorsed barriers using independent variables of gender, previous counseling, race, and program concentration

Note: Number of endorsed barriers – total number of barriers in Item #6 that were endorsed as “somewhat” or “a significant” barrier

Note: a. significant at $\alpha = .002$, family-wise $\alpha = .05$
4.4 Data Analysis of Results for Research Question Two

Are there differences in participants’ stigma concerns associated with seeking psychological help based upon their level of graduate training in counseling?

H₀ = There will be no difference in participants’ scores on either the SSOSH or the SSRPH

H₁ = There will be a difference in the variance of scores based upon level of the factor variable, and levels of the factor variable will explain variance in stigma scores.

4.4.1 Results: Research Question 2

Two Analysis of Variance tests were run, one with SSOSH (Self-Stigma of Seeking Help) scores as the dependent variable, and another with SSRPH (Social Stigma for Receiving Psychological Help) scores as the dependent variable. The independent variable of Year of Training was used in the analysis, with levels of 1ˢᵗ year Masters student, 2ⁿᵈ year Masters student, or Graduated Masters/Doctoral student. The ANOVA was conducted on a sample of 234 participants, because twelve participants of the 246 in the overall sample did not indicate their year of training.

The first ANOVA was conducted on participants’ SSOSH scores (self/private stigma) scores using their level of graduate training as the independent variable. The ANOVA model was not significant (F = .872, p = .419) indicating that the amount of variance in self stigma scores due to error was larger than the amount of variance due to levels of the factor (e.g. level of training).

A second ANOVA was conducted to determine if participants’ SSRPH (social/public stigma) scores differ based upon their level of graduate training. The
ANOVA model was not significant (F = .477, p = .621), indicating that the amount of variance in social stigma scores due to error was larger than the amount of variance due to levels of the factor (e.g. level of training).

4.5 Data Analysis of Results for Research Question Three

What factors might explain or predict counseling trainees' attitudes toward seeking professional psychological help?

H₀ = None of the predictor variables (factors examined in the study) will be explanatory or predictive of the dependent variable (attitude toward seeking professional psychological help)

H₁ = The predictor variables (e.g. self stigma, previous counseling, social stigma, gender, and distress disclosure), individually or in combination, will be explanatory and predictive of participants’ scores on the Attitudes Toward Seeking Professional Psychological Help scale (e.g. positive/negative attitudes toward seeking help).

Table 4.17 lists the means and standard deviations for the dependent variable (ATSPPHS) and the other scales in the study used as three of the five predictor variables (e.g. SSOSH, SSRPH, and DDI). Participants’ gender (male or female) and whether or not they had previous experience of counseling as a client (yes or no) were also entered into the regression model as predictor variables.
### Table 4.17: Means and standard deviations for dependent and predictor variables in the regression model

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes Toward Seeking Professional</td>
<td>24.22</td>
<td>3.444</td>
</tr>
<tr>
<td>Psychological Help Scale – Short form(^a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self Stigma of Seeking Help(^b)</td>
<td>7.87</td>
<td>5.763</td>
</tr>
<tr>
<td>Social Stigma for Receiving Psychological Help(^b)</td>
<td>3.85</td>
<td>2.855</td>
</tr>
<tr>
<td>Distress Disclosure Index(^b)</td>
<td>24.80</td>
<td>7.068</td>
</tr>
</tbody>
</table>

*Note: a. dependent variable; b. predictor variable; ATSPPHS – Attitudes Toward Seeking Professional Psychological Help short form; SSOSH – Self Stigma of Seeking Help; SSRPH – Social Stigma for Receiving Help; DDI – Distress Disclosure Index*

The five predictor variables were entered simultaneously into the regression model. Results for the predictor variables of social stigma concerns (SSRPH scores) and comfort with disclosing distressing information (DDI scores) indicated that neither variable contributed significantly to the regression model (SSRPH, \(t = -2.008, p = .046\); DDI, \(t = 1.509, p = .133\)). In addition, collinearity statistics indicated an interaction between predictor variables of self stigma (SSOSH scores) and social stigma (SSRPH scores). Given that SSRPH and DDI scores did not add significantly to the regression, and multicolinearity concerns regarding SSOSH and SSRPH scores, SSRPH (social stigma) scores and DDI (distress disclosure) scores were removed from the model.

The multiple regression was then run again with using only participants’ gender, previous counseling experience, and self stigma concerns as predictor variables. The model was significant, and accounted 32.1% of the variance in participants’ ATSPPHS
scores (adjusted $R^2 = .321, \Delta R^2 = .333, \Delta F = 36.769, \ p = .000$). Self stigma concerns (SSOSH scores) about seeking psychological help accounted for the largest unique relationship to participants’ attitudes toward seeking that help ($\Delta R^2 = .211$, part correlation $= -.354$). Previous experience of counseling was second in accounting for the largest amount of variance of attitude scores ($\Delta R^2 = .086, \beta = .278$, part correlation $= .262, t = 4.798, \ p = .000$), followed by gender ($\Delta R^2 = .032, \beta = .182$, part correlation $= .180, t = 3.290, \ p = .001$). The Durbin-Watson statistic returned a value of 1.834, giving a strong indication that the assumptions of the model were met.

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Adjusted $R^2$</th>
<th>$\Delta R^2$</th>
<th>Standard $\beta$</th>
<th>t</th>
<th>Sig.</th>
<th>Part correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSOSH</td>
<td>.211</td>
<td>-.370</td>
<td>-6.465</td>
<td>.000(^a)</td>
<td>-.354</td>
<td></td>
</tr>
<tr>
<td>Previous counseling</td>
<td>.086</td>
<td>.278</td>
<td>4.798</td>
<td>.000(^a)</td>
<td>.262</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>.032</td>
<td>.182</td>
<td>3.290</td>
<td>.001(^a)</td>
<td>.180</td>
<td></td>
</tr>
<tr>
<td>Model</td>
<td>.321</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.18: Results of multiple regression analysis

Note: Dependent variable is ATSPPHS – Attitudes Toward Seeking Professional Psychological Help-short form; Predictor variables are SSOSH – Self Stigma of Seeking Help scale, Previous experience of counseling, Gender

Note: a. significant at $\alpha = .002$, family-wise $\alpha = .05$
Beta values for Self stigma ($\beta = -.370, t = -6.465, p = .000$), previous experience of counseling ($\beta = .278, t = 4.798, p = .000$), and gender ($\beta = .165, t = 3.035, p < .01$) were significant. Figure 4.3 shows the relationship between participants’ self stigma concerns (e.g. SSOSH scores) and attitudes toward seeking psychological help, and Figure 4.4 shows the relationship between previous counseling experience and help seeking attitudes.
Figure 4.3: Scatter plot of the partial regression, relationship between self stigma concern and attitudes toward seeking professional psychological help

Note: ATSPPHS – Attitudes Toward Seeking Professional Psychological Help scale, SSOSH – Self Stigma of Seeking Help scale
Figure 4.4: Scatter plot of the partial regression, relationship between previous experience of counseling and attitudes toward seeking professional psychological help

Note: ATSPPHS – Attitudes Toward Seeking Professional Psychological Help scale, PRVCOUNS – previous counseling experience

Diagnostic data for multicollinearity indicated that Tolerance for all predictor variables in the model stayed well above 0.20, with lowest Tolerance returned for previous experience of counseling (.891). VIF statistics for predictor variables ranged
from 1.123 to 1.026. Table 4.20 lists the correlations between the predictor variables in the regression model.

<table>
<thead>
<tr>
<th></th>
<th>SSOSH</th>
<th>Previous Counseling</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSOSH</td>
<td>---</td>
<td>.282</td>
<td>-.008</td>
</tr>
<tr>
<td>Previous Counseling</td>
<td>.282</td>
<td>---</td>
<td>-.183</td>
</tr>
<tr>
<td>Gender</td>
<td>-.008</td>
<td>-.183</td>
<td>---</td>
</tr>
</tbody>
</table>

Table 4.19: Correlations between predictor variables.

Case wise diagnostics were run in conjunction with the multiple regression analysis. One (1) score was reported as an extreme value within the distribution of sample scores. One individual score reported as an extreme value was determined to be within the acceptable level of error, given the level of acceptable error set for statistical analysis within the study ($\alpha = .002$ for a family wise alpha level of .05).

Graphs of the tests for normality of the residuals are displayed in Figure 4.5 and Figure 4.6.
Figure 4.5: Standardized residuals for the dependent variable ATSPPHS

Note: ATSPPHS – Attitudes Toward Seeking Professional Psychological Help
4.6 Summary

This chapter was a report of the results of the statistical analysis conducted to respond to the research questions posed by the study. There were both significant and non-significant results from the analysis.

Participants’ concerns about the stigma for seeking psychological help (self stigma scores, and social stigma scores) did not vary significantly based upon their level.
of graduate training. Also, mean comparisons of attitudes toward seeking help, stigma concerns, and number of endorsed barriers were not significantly different based upon participants’ race.

Significant results from mean comparisons were obtained based upon previous counseling experience (yes or no) for participants’ attitudes toward seeking professional psychological help, self stigma concerns for seeking help, and their total number of endorsed barriers to seeking help. Mean differences based upon gender were also significant for participants’ attitudes toward seeking help.

Results of the regression model were also significant, indicating that the combination of self stigma concerns for seeking help, previous experience of counseling, and gender combined to explain 32% of the variance in participants’ attitudes toward seeking professional psychological help. Self stigma concerns and previous experience of counseling as a client accounted for most of the variance in attitudes toward seeking professional psychological help (29%).
Chapter Five

Discussion

5.1 Purpose of the study

The purpose of the current study was to expand the research on counseling trainees’ psychological help seeking. Little research exists (2 studies) on counseling trainees’ psychological help seeking (Dearing, et al, 2005; Farber, 1999; McCarthy, et al., 2010). In an effort to expand on this previous research, the current study sought to determine what factors influence counseling trainees’ attitudes and behaviors in seeking psychological help. Also an effort was made to expand existing research to further identify counseling trainees’ perceived barriers to help seeking and how those might influence psychological help seeking attitudes and behavior. There is also limited research examining the impact of stigma on trainees’ help seeking (Dearing, et al, 2005; Farber, 1999; McCarthy, et al., 2010). Based upon research that has examined the impact of stigma on help seeking attitudes and behavior with counseling trainees and other populations, counseling trainees’ perceptions of public and private stigma concerning help seeking was assessed and analyzed.
5.2 Data Collection and Demographics

A random sample of 1,000 student members of the American Counseling Association (ACA) was surveyed. Responses from 310 of the surveyed counseling trainees (e.g. student members of ACA) were analyzed to examine participants’ help seeking attitudes, behaviors, stigma concerns, and perceived barriers to seeking psychological help.

Counseling trainees who responded to the survey were mostly female (84%) and white (82.1%), with an average age of 36 years. The majority reported having some previous experience of counseling (79.7%). Notably, help seeking rates for this sample were comparable to those reported in one of the previous two studies examining help seeking rates and attitudes in those training to be counselors/therapists (74%, Dearing, Maddux, & Tangney, 2005), and greater than those reported in McCarthy, Pfohl, and Bruno’s (2010) study conducted with community and school counseling trainees (44%). These findings suggest that counseling trainees in this sample sought psychological help at a rate two to four times more than the general population, and comparably to help seeking rates in other counseling disciplines. Discrepancies between the current study and McCarthy et. al. (2010) may be related to the fact that the latter was based on a small convenience sample from one counseling program in New York State, whereas the current study, while self-selected, was larger, and more diverse, at least by region.

The majority of respondents examined in the study were enrolled in mental health (54.1%) or community/agency concentrations (23.6%), followed by school counseling (16.7%) and doctoral students enrolled in counselor education programs (5.7%). Another
interesting finding emerged when help seeking rates were identified within major concentrations of graduate study (e.g. mental health, community/agency, school, and counselor education/doctorate). Help seeking rates among students in the school counseling concentration (56.1%) were lower than those in the other concentrations (e.g. mental health, 84.2%; community/agency, 82.8%; counselor education/doctoral, 92.9%).

Most of the participants were pursuing a Masters degree (90.7%). The majority of respondents in the study were in their second year of training (54.0%) or later (29.7%; e.g. masters graduate or doctoral). One reason for the low number of first year masters students in the sample (10.6%) might be that students may not know about the ACA until they begin their graduate programs, when they may be encouraged to join the professional organization as a student member. The American Counseling Association offers student members access to affordable group liability insurance, and many counseling trainees take advantage of this as they prepare for their field experiences in practicum (end of their first year) and internship (second year of training).

Counseling trainees who responded to the survey held more positive attitudes toward seeking help ($M = 24.22$, $SD = 3.451$) than indicated in research on the general public ($17.27$, Fischer & Farina, 1995). Participants also expressed less concern about the stigma of seeking help (self stigma, $M = 7.87$, $SD = 5.779$; social stigma $M = 3.83$, $SD = 2.842$) than the general public (self stigma, $M = 27.2$, $SD = 7.20$, Vogel, Wade, & Haake, 2006; social stigma, $M = 5.79$, $SD = 3.06$, Komiya, Good, & Sherrod, 2000).
5.3 Participants’ Endorsed Barriers to Help Seeking

Over three quarters of the students surveyed in this study indicated that they felt the affordability of seeking psychological help was a barrier for them. Cost of services was cited as somewhat of a barrier by 41.5% of participants, and as a significant barrier by 38.2% (total 79.7%). Time was the second most highly endorsed barrier, with 46.3% of participants citing it as somewhat of a barrier, and 25.2% indicating it was a significant barrier for them.

Even though participants seemed to place value on seeking psychological help (e.g. they reported having sought counseling and held positive attitudes toward doing so) they were still sensitive to the cost in both money and time that seeking counseling required. This finding is also consistent with the findings in the Dearing et al., (2005) and McCarthy et al., (2010) studies. Participants in those studies also highly endorsed money, lack of insurance, and time as significant barriers to their psychological help seeking.

The findings are interesting, since many graduate students pay for student health insurance and there are typically some counseling services made available to college and university students on their campuses. Graduate students who do have student health insurance would typically be entitled to a certain number of counseling sessions per semester or academic year (e.g. 10 sessions). At the same time, many graduate students are considered “nontraditional” students. These graduate students may be returning to college to make a career change, working full time, and attending class in the evening or on weekends. Some larger colleges and universities offer assistantships that subsidize graduate students so they can focus on their studies full time, while working part time,
though these appointments may be more rare for Masters level students such as those who comprise the majority of this sample.

Some other factors that may contribute to the salience of perceived barriers of affordability of psychological help for counseling graduate students may be that they are

- on campus during hours when counseling services are not available (evening or weekend classes)
- placed as interns or practicum students at campus counseling centers, and therefore do not wish to seek psychological help there
- “opting out” of their student health insurance because they have coverage through their employer or their spouse’s employer (i.e. therefore co pays and costs may be higher)
- enrolled as a part time student and, while eligible for financial aid, may not be eligible for student health insurance
- working full time and maintaining a family and personal life, in addition to attending graduate school

The next type of barrier most frequently endorsed by participants was barriers of acceptability. Fear about what relatives and friends might think (were it known the participant was seeking help) was endorsed by 27.3% of participants as somewhat of (23.2%) or a significant (4.1%) barrier to help seeking. Participants (26.9%) also endorsed what faculty might think as either somewhat of (23.2%) or a significant (3.7%) barrier. Finally, participants (25.6%) endorsed fear of being looked down on as either somewhat of (21.5%) or a significant (4.1%) barrier to their help seeking.
Participants’ concerns about barriers of acceptability of seeking counseling were on average endorsed by only a third as many as endorsed affordability of seeking counseling. This may be further evidence that, for counseling trainees who participated in this study, concern about how they will pay and find the time for counseling significantly outweighed their concerns related to acceptability and stigma for receiving help. These findings are also consistent with Dearing, et al (2005) and McCarthy, et al., (2010). In Dearing, et al’s 2005 study, cost of services and time needed to go for counseling had the highest level of endorsement as barriers to help seeking for the counseling psychology students who participated in the study. Acceptability concerns of what friends, family, or faculty might think were not highly endorsed as barriers (e.g. less than moderately important, Dearing, et al., 2005). In the McCarthy, et al. (2010) study, time was cited as the most significant barrier to help seeking, followed by cost and insurance. Interestingly, in the McCarthy et al., study, which was conducted with counselor education trainees at a small private college in New York State, stigma from professors was the fourth highest rated barrier, which is also consistent with the findings in the current study.

5.4 Statistically Significant Findings

What follows is a discussion of the statistically significant findings for each of the research questions in the study.

5.4.1 Research Question One

In addition to exploring the demographic characteristics of the sample (discussed above), question one involved an examination of the differences between the mean scores on the instruments based upon certain of those demographic characteristics, specifically,
gender, previous counseling experience as a client, and race. These differences were analyzed statistically using t-tests of independent measures. A total of 15 t-tests were run, three each (for gender, previous counseling experience, and race) on the Attitudes Toward Seeking Professional Psychological Help scale, the Self Stigma of Seeking Help scale, the Social Stigma for Receiving Psychological Help scale, the Distress Disclosure Index, and total number of endorsed barriers to help seeking.

To better insure against a Type I error (rejecting the null hypothesis when it is true) and inflation of the critical region, a Bonferroni adjustment was made to establish the alpha level for each of the t-tests of independent samples. The standard alpha level of 0.05 was divided by the number of statistical tests to be performed (23), establishing an alpha level of 0.002 (\(\alpha = .002\)) for each test, thus insuring a family-wise rate of acceptable error at 0.05.

Regarding the comparisons of Attitudes Toward Seeking Professional Psychological Help scores, interestingly, the findings for gender in the current study differ from that of numerous previous studies on help seeking, in that there was no significant difference in help seeking attitudes based upon gender. While female participants (\(M = 24.59\)) had more positive attitudes toward seeking help than male participants (\(M = 22.35\)) the difference was not significant at the \(\alpha = .002\) level (\(t = -3.090, p = .003, d = .67, \text{power} = .96\)). Tests of effect size indicated that the effect of gender on attitudes toward seeking help (or, the degree to which the hypothesis that means between females and male were equal is false) was moderate to large (Cohen, 1988). Post hoc power (.96) indicated a strong likelihood that the observed phenomenon
(e.g., there is a difference in attitudes toward help seeking between males and females) exists (Cohen, 1988). It is likely that a small sample size, particularly the smaller number of male participants, may have impacted that mean comparison, and that, given larger or more equal samples between the two groups, an effect for gender may have been observed.

Male participants in the current study reported more positive attitudes than those typically found in males within the general population ($M = 15.46$, Fischer & Farina, 1995). However, in one study focusing on psychological help seeking in males (Pederson & Vogel, 2007), participants’ (from a convenience sample of undergraduates enrolled in an introductory psychology course at a large Midwestern university) expressed attitudes toward seeking psychological help ($M = 22.6$) were as positive as those expressed by male counseling trainees in the current study ($M = 22.35$). The overall results seem to indicate that male participants in this study, all of whom were training to be counselors, may tend to have more positive attitudes about seeking psychological help than men in the general population, yet still do not express as positive attitudes as those of their female counterparts in the current study.

The most significant differences regarding help seeking attitudes ($t = -6.643$, $p = .000, d = 0.97$, power > .99), the self stigma of seeking help ($t = 4.652$, $p = .000, d = 0.71$, power = 0.95), and endorsement of perceived barriers to seeking help ($t = 3.182$, $p = .002, d = 0.50$, power = 0.574) arose between participants who had previously experienced counseling as a client and those who had not. Participants in this study who reported no previous experience of counseling indicated more negative attitudes toward
seeking psychological help, expressed more concern about how seeking psychological help would impact their self image and self esteem, and endorsed more barriers to seeking psychological help as relevant to their decisions about seeking that help.

These findings may suggest support for the influence of the “contact factor” in counseling trainees’ attitudes and stigma concerns related to psychological help seeking. The “contact factor” centers around the notion that once an individual has made contact with a person or situation that is unfamiliar, threatening, or stigmatized, but is in fact no real threat to them (i.e. it is the fear of the unknown that is most salient) the individual tends to form more positive attitudes toward that person or situation. Once counseling trainees have tried counseling themselves as clients, they may like it (e.g. feel more comfortable, assuage fears or hesitancies, find it productive and instructive), and therefore be more likely to seek psychological help in the future.

5.4.2 Research Question Three

What factors might explain or predict counseling trainees' attitudes toward seeking professional psychological help?

Multiple regression was used to answer question three, with attitudes toward seeking professional psychological help as the dependent variable, and participants’ gender, previous experience of counseling, level of self stigma concern, level of social stigma concern, and comfort with disclosing distressing information as the independent or predictor variables. The regression model was able to explain 32% (adjusted $R^2 = .319$) of the variance of participants’ attitudes toward seeking help (ATSPPHS scores). Self
(private) stigma accounted for the greatest variance in participants’ help seeking attitudes (13.4%).

Both self stigma ($\Delta R^2 = .211$, $\beta = -.370$) and previous experience of counseling ($\Delta R^2 = .086$, $\beta = .278$) each had significant unique contributions to the variance in help seeking attitudes. Interestingly, these are influences on help seeking attitudes that can be changed. While traits like gender and the judgments or reactions of others (social stigma) are relatively difficult to change, a person’s self–image and their direct experience with engaging in counseling can be changed. In fact, counseling itself represents the possibility of personal change through education, experience, and introspection.

The significant role of self-stigma concerns in influencing attitudes toward seeking help is worth noting for other reasons as well. Results of the current study may indicate that counseling trainees in the study, while holding positive attitudes toward help seeking and having low stigma concerns, are nevertheless influenced by the stigma concerns they do have (e.g. self stigma, or how will seeking help effect how they view and feel about themselves). It is possible that counseling trainees struggle with integrating their need for psychological help, and seeking out that help, with their own emerging identity of counselor and expert helper. Those expressing less positive attitudes toward seeking psychological help may hold them simply because they have never been a client, and therefore have no experiential basis on which to fully ground their positive feelings about help seeking. As in previous research on psychological help seeking attitudes and behavior, the results of the current study still do not solve the mystery of which comes first, a more positive attitude or help seeking. Research has shown a strong
relationship between positive attitudes and psychological help seeking behavior. A causal relationship has not been established, and it is still unknown whether creating more positive attitudes in people toward seeking psychological help will lead them to seek help more often when they need it, or if, by seeking and experiencing psychological help, people’s attitudes about doing so also improve.

Research has shown that attitudes do not necessarily predict behavior, and that behavior is not always congruent with a person’s attitudes or feelings. Certainly, the power of a situation (e.g. emotional or psychological distress, impaired functioning) may enjoin a person to take action, even in ways that may be uncustomary or incongruent. Although expressing low stigma concern, those expressed concerns were nevertheless shown to be influential on participants’ help seeking attitudes. It is possible that, even though counseling trainees may be worried about what their help seeking may say about them – particularly in their own minds – and these concerns have some negative influence on their help seeking attitudes, they seek psychological help anyway. It may be that the confluence of help seeking attitudes, self stigma concerns, and integration of personal and professional identities create ambivalence in counseling trainees around psychological help seeking. This ambivalence might be addressed as part of their developmental processes in training. Counselor educators, using this information from the current study, can intentionally address the integration of personal psychological help seeking with their counseling trainees as part of their training and professional development. Also, counseling trainees can be encouraged to engage in personal
counseling, not only for personal problems, but also in order to address essential aspects of their professional identities as counselors.

These results may indicate that part of the process of effective field experience may be best accomplished by placing trainees in both chairs – the chair of the counselor, and the chair of the client. Participating in a personal counseling experience may provide trainees with a more integrated and comprehensive understanding of the counseling process. While many counseling trainees may practice counseling skills using one another as “practice clients,” it does not have the same effect as engaging in the counseling process with a fully trained professional in a therapeutic environment. Counseling trainees may improve their abilities to create an effective working alliance once they have been able to build it from both sides of the therapeutic equation. Such an intentional and reflective process may also provide opportunities to enhance trainees’ capacities for empathy in the therapeutic relationship. Medical schools sometimes include a “patient experience” to improve bedside manner in medical students and interns. The medical student becomes the patient, and undergoes treatment in an environment as close to an actual patient experience as possible. Engaging in personal therapy could augment counselor training in a similar manner.

5.5 Statistically Non-Significant Findings

5.5.1 Research Question One

None of the t-tests of independent samples for race were significant for any of the dependent variables (attitudes toward seeking help, self stigma of seeking help, social stigma for receiving psychological help, distress disclosure, or number of endorsed
barriers). In this sample of counseling trainees, there were no significant mean differences in attitudes, stigma concerns, comfort with disclosing distress, or perceived barriers to help as a result of racial or ethnic differences. These findings are consistent with the literature on help seeking attitudes in showing that racial difference does not tend to account for significant differences in attitudes toward seeking psychological help or help seeking behavior (Delphin & Rollock, 1995; Duncan, 2003; Milville & Constantine, 2006). However, individuals who reported a racial or ethnic background other than white represented a small percentage of the sample (16%). The limitation of lack of racial diversity in the sample is further discussed below in section 5.6, Limitations of the Study.

Also, none of the mean comparisons for the Distress Disclosure Index were significant. This might suggest that counseling trainees in this sample shared a comfort level with disclosing distressing information to others, perhaps because, as counselors in training, they are prepared for hearing and being exposed to others distress in the therapeutic process. Also, since the majority of participants had been to counseling at some point prior to the study, they had already experienced the act of disclosing their own distress and other personal information to another individual or individuals.

There were no mean differences for race, previous counseling, gender, or program concentration with regard to concerns about the social stigma of help seeking (SSRPH scores). It may be that the salience of stigma as an internal experience (e.g. self or private stigma) is much greater for counseling trainees than trepidation about the reactions of others. Also, trainees typically discuss and explore the social stigma of
psychological help seeking and mental health diagnoses (e.g. labeling) in their coursework. Part of becoming an effective practitioner involves deepening trainees’ understanding of the impact of social stigma on their clients. Their training concerning public perception of people with mental illness increases their awareness of, and perhaps their resistance to, negative perceptions on the part of others regarding psychological help seeking.

5.5.2 Research Question Two

Is there a difference in participants’ concern about the stigma of seeking psychological help based upon their level of counseling training?

It was hypothesized that the more training a counseling student had completed the lower their stigma concerns would be. While the results did not support this hypothesis, it is notable that participants expressed stigma concerns on the whole were low. It may be that participants, being individuals who had chosen to enter the field of counseling, naturally held fewer concerns about the stigma of seeking the kind of help they were motivated to provide. Those in the sample who had previously experienced counseling may have already addressed and reduced their stigma concerns prior to entering training. These findings may also suggest a reexamination of the specific ways in which social and self stigma concerns relating to psychological help seeking are addressed with counseling trainees. A more intentional pedagogical practice that assists counseling trainees in integrating how stigma impacts their clients and themselves as help seekers may result in further reducing the impact of such stigma. It may also better prepare counseling trainees to address these stigma issues with their clients.
5.6 Limitations of the Study

The current study is limited by the fact that collected sample was obtained through the self selection of participants. Also, the nature of the questionnaire (i.e. measurement) was self report, and therefore results relied on participants to answer questions with openness and honesty. Given these limitations, the current study does differ from the majority of published studies in this topic area in that participants self selected from a randomized, national sample and not from an initial convenience sample from one or two colleges or universities.

Another limitation of the study arises from the lack of racial and gender diversity in the sample. The sample for the current study was comprised mostly of individuals who identified their race/ethnicity as white (82%), and were female (84%). Demographic data for the membership of the American Counseling Association, reported as of October of 2010, show that 83% of members identify as white, and 73% of members are female. It may be argued that the current sample is somewhat representative of the membership of ACA as a whole, given the comparable rates of white and female participants in the current study.

5.7 Suggestions for Future Research

Barriers of time and money continue to emerge as significant to counseling trainees with regard to psychological help seeking. Since college campuses typically provide counseling for students, it would be interesting to further explore the exact nature of these barriers to counseling trainees. Accessing counseling services on campus may not be an option to counseling trainees who are completing their internships at campus
counseling centers. Even the act of seeking a referral for services from a site supervisor or faculty member may illicit stigma concerns in a counseling trainee. Studies examining the policies and procedures for referral of counseling trainees for psychological help may help Counselor Educators better understand the specific and unique needs of their trainees when it comes to their psychological help seeking. Also, an assessment of what services are available to counseling trainees at colleges and universities, when these services operate, and the cost of such services may provide a baseline for understanding why barriers of cost and time appear to be such obstacles to psychological help seeking for counseling trainees.

A survey of counselor training programs throughout the United States might determine

- trainees’ awareness of and access to counseling services
- trainees use or non-use of student health insurance
- establishment of appropriate referrals and resources for trainees who may wish to seek counseling
  - are referral policies and procedures in programs
  - formalized through department or campus infrastructure
  - informal systems through advisors and other faculty

A continued examination of the influence of stigma on help seeking attitudes in counseling trainees (and the general population) may lead to research that increases our understanding of this relationship in specific ways. It may be fruitful to further examine counseling trainees’ attitudes toward help seeking and help seeking behavior by
expanding the examination of factors to include anticipated risks (some of which are related to stigma) and benefits of counseling. The regression model in question three explained 32% of the variance in attitudes toward seeking help. Other studies have explained more variance with the inclusion of scales weighing the risk and benefits of seeking help in addition to stigma concerns (Vogel, Wade, & Haake, 2006). Indeed, counseling trainees’ perception of the risks and benefits of seeking counseling may differ from that of the general population, as perceptions of stigma seem to. There may also be aspects to perceived risks and benefits of seeking counseling that have yet to be determined for counseling trainees, some of which may be unique to their development as professionals. How counseling trainees think about the risks and benefits of seeking psychological help has yet to be examined. By understanding the interaction of attitudes, stigma, risks and benefits, and help seeking behaviors, future research may lead to effective, targeted interventions that may increase the frequency of help seeking for counseling trainees and others who need or could benefit from psychological help.

Further research with school counseling trainees may also provide a better understanding of their help seeking attitudes and behavior. School counseling trainees in the study sought psychological help less often than mental health, or community/agency counseling trainees. It could be interesting to further examine school counseling trainees’ help seeking behavior as well as their attitudes toward seeking psychological help to see if their attitudes differ significantly from their mental health and community/agency counseling counterparts. School counseling trainees comprised only 16.7% of the sample for the current study, and only 14% of ACA members identify school counseling as their
specialty area (ACA, 2010). One explanation for the relatively small sample of school counseling respondents might be that more school counseling trainees would seek student membership in the American School Counseling Association, which provides comprehensive professional services.

More research is needed in this area of counselor development, both for those training to be counselors, and those currently practicing. Little has been studied or is known about the help seeking attitudes and behaviors of individuals who are training to become professional counselors. The current study suggests that counseling trainees may have unique needs relative to receiving counseling services. In addition, counseling trainees may experience unique practical and emotional barriers to seeking psychological help. It is important to better understand these needs and barriers if counselor educators are to be informed and empowered to assist their trainees in this critical area of personal and professional growth.

Many questions remain unanswered concerning the help seeking attitudes, needs, and barriers to help seeking in counseling trainees who did not respond, or did not have an opportunity to respond, to this or other similar studies. The 31% of surveyed counseling trainees who responded to the current study may have been motivated to do so because of their positive attitudes and experiences with receiving psychological help. Those counseling trainees who have more negative attitudes, who may have had a negative experience in therapy, or for whom seeking psychological help had less relevance may not have been motivated to participate in the current study. Future research that focuses on reaching that population of counseling trainees could add
valuable information that could inform counselor preparation programs and benefit future counselors.

5.8 Conclusion

As counselors, current and future, we value what we do and its power to help people create positive change in their lives. One compelling reason for our passion for the counseling process may be our direct experience of its benefits. We are committed to the process of counseling and our behavior and attitudes reflect that commitment. Counselors seek out counseling, both to help solve our own problems, and in an effort to achieve personal growth and the benefits that accompany that process.

Some of the results of the study offer assurance that counseling trainees have positive attitudes about psychological help seeking, low concern for stigma related to seeking that help, and do in fact seek help at a high rate. The current study also raises questions about those trainees who may not have sought help, since their attitudes may not be as positive, their stigma concerns may be higher, and they may perceive more barriers to seeking help.

If counseling trainees themselves struggle with these issues, and, based on this research, they seem to do so to some degree, then it may be incumbent upon counselor educators to intentionally address issues of personal attitudes about help seeking and help seeking behaviors with their trainees. Certainly, discussions related to professional burn out and counselor self care are a uniform part of counselor preparation curricula. There is research in professional journals and texts used in the preparation of counseling trainees that warn against the effects of burn out and offer suggestions for self care as prevention.
against professional pitfalls such as compassion fatigue and vicarious trauma. Yet even with adequate education regarding these issues, professional burn out continues to be a problem in the helping professions.

The results of the current study may suggest new ways of engaging in this conversation with counselor trainees about their own attitudes about help seeking and their help seeking behavior. The results of the current study suggest that counseling trainees may benefit from an examination of their concerns about how their own help seeking help may reflect on their self image as well as their professional role. Counselor educators could assist counselor trainees in their exploration of how seeking psychological help, when needed, relates to the articulations of their personal and professional identities. It may also benefit counseling trainees to explore the barriers of affordability, acceptability, accessibility and availability of counseling services, not only as they apply to their clients, but also as they apply to themselves.

Counseling trainees are influenced by many of the same practical and emotional barriers to help seeking that impact the general public, and their present and future clients. They are also influenced by concerns about what others may think of them, and, most importantly, what they may think of themselves were they to seek psychological help. Understanding their own situation and position with regard to these help seeking influences may add a layer of complexity to their development, better preparing them for their professional roles as counselors, and their continued personal growth as a parallel process.
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Appendix A: Survey Packet for the Study

The following pages contain the materials included in the survey packet that was sent to 1,000 randomly selected student members of the American Counseling Association in August, 2010. Included in the packet was an introductory letter, two (2) Informed Consent to Participate forms, the questionnaire, and a thank you in the form of a sticker highlighting the core principles of the therapeutic alliance proposed by Carl Rogers, Empathy, Positive Regard, and Authenticity. A return addressed, stamped envelope was also sent in the packet, but an example was not included in this appendix.
Hello!

My name is Anne Pfohl, and I am a counseling student in the Counselor Education program at Ohio State University. I am interested in exploring, and, hopefully, strengthening our knowledge and efforts to provide the best training possible to current and future counseling trainees, based on evidence supported by research. Enclosed you will find a questionnaire as part of a research study I am conducting in order to complete my Ph.D. The questionnaire should take you approximately 15 minutes to complete, and you can return it in the postage-paid envelope.

At this time in our profession, we know very little about how participation in counseling may enhance trainees’ developmental experiences, or how trainees view or participate in seeking professional psychological help for themselves. Specifically, I am interested in learning more about how counseling trainees perceive their own needs for personal counseling. This study intends to focus on the factors (attitudes, perceptions of stigma, costs and benefits) that influence counseling trainees’ decisions to seek professional psychological help for themselves. I am curious about such questions as do we seek counseling while we are training to be counselors; and what barriers to or concerns about seeking professional help are most important to us?

My hunch is we share a passion about counseling, or we wouldn’t have invested so much effort, time, and money in becoming qualified to serve in our profession. As professional helpers, we are trained to consider our own health and well-being as a critical element in our effectiveness as professionals. Your participation in this study, I hope, will benefit our profession by providing information to counselors and counselor educators in an area of our professional development that has not been extensively studied.

Your survey packet contains the questionnaire, informed consent forms, and a postage-paid return envelope. Please read the Informed Consent thoroughly, and, if you elect to participate, complete the questionnaire per the instructions provided (about 15 minutes), and return your signed Informed Consent, and the completed questionnaire in the stamped return envelope provided.
Please accept the enclosed sticker as my thank you for your time and consideration. Your participation is greatly appreciated.

All my best,
Anne

[Signature]
The Ohio State University Consent to Participate in Research

Study Title: Factors Influencing Psychological Help Seeking Attitudes and Behaviors in Counselor Education Trainees

Researcher: Darcy Haag Granello, PhD, Principal Investigator
Anne Hartley Pfohl, MSEd, Co-Investigator

Sponsor: None

This is a consent form for research participation. It contains important information about this study and what to expect if you decide to participate.

Your participation is voluntary.
Please consider the information carefully. Feel free to ask questions before making your decision whether or not to participate. If you decide to participate, you will be asked to sign this form and you can retain a copy of the form for your records.

Purpose:
The purpose of the current study is three-fold:
5. Determine what factors influence counseling trainees’ attitudes and behaviors in seeking professional psychological help
6. Identify perceived barriers to help seeking and how those might influence attitude and behavior
7. Determine if counseling trainees hold perceptions of public and private stigma concerning seeking mental health services that may influence their help seeking attitudes and behaviors

Procedures/Tasks:

Your participation in this study will require you to
1. Read and sign this consent form, and return it with your completed questionnaire (retain the second copy of this consent for your records)
2. Complete the questionnaire
3. Place the signed consent form and completed questionnaire in the stamped, addressed envelope provided and place it in the mail
Duration: approx. 15 minutes

You may choose to stop completing the questionnaire at any time. If you decide to stop participating in the study, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled. Your decision will not affect any future relationship you may have with The Ohio State University.

Risks and Benefits:

There are no direct benefits to you for your participation in this study. The subject of the research is related to counselor training, a process in which you are actively engaged, and therefore it may be of some interest to you. One potential benefit may lie in the use of the findings of this study to inform future counselor training and preparation methods. Again, this possibility presents no direct benefit to you, but may have potential to benefit future trainees.

The research may assist in identifying typical barriers to help seeking for counseling trainees, thereby enabling educators to address those barriers (emotional and practical) to assist trainees by greater normalization of psychological help seeking, benefitting them as persons, practitioners, and their future clients, creating a more healthy and accepting environment for seeking counseling services.

The findings of the study also have the potential to foster improvement to counselor preparation in areas of stigma sensitivity, client advocacy, public education about mental health (again, counselors as advocates), lessening emotional and practical barriers to seeking psychological help, increasing counselor effectiveness by encouraging trainees to seek psychological help for their personal growth and benefit, and as part of their comprehensive training as a practitioner through experience in the client’s chair.

There will be no physical, legal, or economic risks or harms to you as a participant. Possible risk or discomfort may lie in the recollection of why you may have sought psychological help in the past.

Confidentiality:

Efforts will be made to keep your study-related information confidential. However, there may be circumstances where this information must be released. For example, personal information regarding your participation in this study may be disclosed if required by state law. Also, your records may be reviewed by the following groups (as applicable to the research):
• Office for Human Research Protections or other federal, state, or international regulatory agencies;
• The Ohio State University Institutional Review Board or Office of Responsible Research Practices;
• The sponsor, if any, or agency (including the Food and Drug Administration for FDA-regulated research) supporting the study.

Incentives:

There are no financial benefits or incentives being offered for your participation in this study. A small thank you in the form of a sticker with a phrase related to counseling is included with the questionnaire. It is yours to keep, whether or not you choose to participate in the study.

Participant Rights:

You may refuse to participate in this study without penalty or loss of benefits to which you are otherwise entitled. If you are a student or employee at Ohio State, your decision will not affect your grades or employment status.

If you choose to participate in the study, you may discontinue participation at any time without penalty or loss of benefits. By signing this form, you do not give up any personal legal rights you may have as a participant in this study.

An Institutional Review Board responsible for human subjects research at The Ohio State University reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of participants in research.

Contacts and Questions:

For questions, concerns, or complaints about the study you may contact Anne Hartley Pfohl, at pfohl.1@osu.edu or 1-716-560-2036.

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-800-678-6251.

If you are harmed or upset as a result of participating in this study and feel in need of assistance, you may contact your campus counseling center or Anne Hartley Pfohl, at pfohl.1@osu.edu or 1-716-560-2036 for assistance in obtaining a referral to an appropriate resource.
Signing the consent form

I have read (or someone has read to me) this form and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. I voluntarily agree to participate in this study.

I am not giving up any legal rights by signing this form. I will be given a copy of this form.

<table>
<thead>
<tr>
<th>Printed name of subject</th>
<th>Signature of subject</th>
<th>AM/PM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Date and time</td>
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</table>

<table>
<thead>
<tr>
<th>Printed name of person authorized to consent for subject (when applicable)</th>
<th>Signature of person authorized to consent for subject (when applicable)</th>
<th>AM/PM</th>
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</thead>
<tbody>
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<td>Date and time</td>
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<tr>
<th>Relationship to the subject</th>
<th>Date and time</th>
</tr>
</thead>
</table>

Investigator/Research Staff

I have explained the research to the participant or his/her representative before requesting the signature(s) above. There are no blanks in this document. A copy of this form has been given to the participant or his/her representative.

Anne Hartley Pfohl

<table>
<thead>
<tr>
<th>Printed name of person obtaining consent</th>
<th>Signature of person obtaining consent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8/13/2010, 9:00 am</td>
</tr>
<tr>
<td></td>
<td>Date and time</td>
</tr>
</tbody>
</table>
Graduate Student Survey

Please respond to every item on the questionnaire.

Please answer the following questions by circling the appropriate answer, or by filling in the blank, as indicated.

1. Gender         Male     Female

2. Age            ______

3. What is your race?  __________________________________________

4. Which degree and concentration are you pursuing in your program (circle one in each column):

   Mental Health Counseling       Masters       Current student (First year)
   School Counseling              PhD          Current student (2nd year or more)
   Community/Agency Counseling    EdD          Graduated
   Social Work                    PsyD
   Psychology                     Other ________
   Other _______________________

5. Have you ever gone to see a professional (psychologist, counselor, social worker, and so forth) for counseling related to emotional, relationship, or psychological difficulties you were having?

   _____ Yes    _____ No

5a. If you answered “Yes” to #5, approximately how long did and/or have you participated in counseling as a client thus far in your lifetime? (mark the time frame that may best apply to you)

   _____ 3 months or less   _____ 4 to 6 months   _____ 7 mo. to 1 year   _____ longer than a year

6. Assume for a moment you were to need counseling for a relationship, emotional, or psychological problem. Please use numbers from the scale below to rate to what degree each of the following concerns could possibly be a barrier for you at this time were you to enter counseling or therapy.

   1 = Significant barrier for me   2 = Somewhat a barrier for me   3 = Not a barrier for me

   _____ Not knowing services are available   _____ Fear of what relatives, friends might think
   _____ Not knowing where services are located   _____ Fear of what faculty might think
   _____ No transportation   _____ Cost of services (i.e. money, insurance)
   _____ No one to go with   _____ Have to take time off from work/school/family
   _____ Fear of being looked down on   _____ Other _______________________

Please turn to the back of this page and continue responding to items on Page 2.................
INSTRUCTIONS

The term professional refers to individuals who have been trained to provide counseling and deal with emotional, relationship, and psychological problems (e.g., psychologists, psychiatrists, counselors, social workers, and family physicians). The terms psychological problems refers to reasons one might visit a professional. Similar terms include mental health concerns, emotional problems, relationship problems, mental troubles, and personal difficulties.

Please respond to each item in a way that expresses your genuine opinions and feelings, and not simply those which you have been trained to or think you ought to express. The validity of the study depends on your responses being authentic, frank, and open.

For each item, indicate whether you (0) disagree, (1) somewhat disagree, (2) somewhat agree, or (3) agree.

<table>
<thead>
<tr>
<th>Item</th>
<th>Disagree</th>
<th>1</th>
<th>2</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When I feel upset, I usually confide in my friends</td>
<td>[0]</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. I prefer not to talk about my problems</td>
<td>[0]</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. When something unpleasant happens to me, I often look for someone to talk to</td>
<td>[0]</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. I typically don’t discuss things that upset me</td>
<td>[0]</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. When I feel depressed or sad, I tend to keep those feelings to myself</td>
<td>[0]</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. I try to find people to talk with about my problems</td>
<td>[0]</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. When I am in a bad mood, I talk about it with my friends</td>
<td>[0]</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. If I have a bad day, the last thing I want to do is talk about it</td>
<td>[0]</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. I rarely look for people to talk with when I am having a problem</td>
<td>[0]</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. When I’m distressed I don’t tell anyone</td>
<td>[0]</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. I usually seek out someone to talk to when I am in a bad mood</td>
<td>[0]</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. I am willing to tell others my distressing thoughts</td>
<td>[0]</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Seeing a professional for emotional or interpersonal problems carries social stigma</td>
<td>[0]</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. It is a sign of personal weakness or inadequacy to see a professional for emotional or interpersonal problems</td>
<td>[0]</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. People will see a person in a less favorable way if they come to know that he/she has seen a therapist</td>
<td>[0]</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. It is advisable for a person to hide from people that he/she has seen a therapist</td>
<td>[0]</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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For each item below, indicate whether you (0) disagree, (1) somewhat disagree, (2) somewhat agree, or (3) agree.
<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>32. My view of myself would not change just because I made the choice to see a therapist.</td>
<td>[0 1 2 3 4]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. It would make me feel inferior to ask a therapist for help.</td>
<td>[0 1 2 3 4]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. I would feel okay about myself if I made the choice to seek professional help.</td>
<td>[0 1 2 3 4]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. If I went to a therapist, I would be less satisfied with myself.</td>
<td>[0 1 2 3 4]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. My self-confidence would remain the same if I sought help for a problem I could not solve.</td>
<td>[0 1 2 3 4]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. I would feel worse about myself if I could not solve my own problems.</td>
<td>[0 1 2 3 4]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please be sure you have responded to every item on the questionnaire, and

Thank you for your participation
Figure A1: Thank you to potential participants included in mailing