2016

Distress Among Psychologists: Prevalence, Barriers, and Remedies for Accessing Mental Health Care

Kimberly Patterson-Hyatt
Antioch University Seattle

Follow this and additional works at: http://aura.antioch.edu/etds

Part of the Clinical Psychology Commons, and the Public Health Commons

DISTRESS AMONG PSYCHOLOGISTS: PREVALENCE, BARRIERS,

AND REMEDIES FOR ACCESSING MENTAL HEALTH CARE

A Dissertation

Presented to the Faculty of

Antioch University Seattle

Seattle, WA

In partial fulfillment

of the Requirements of the Degree

Doctor of Psychology

By

Kimberly G. Patterson-Hyatt

August 2016

DISTRESS AMONG PSYCHOLOGISTS: PREVALENCE, BARRIERS,

AND REMEDIES FOR ACCESSING MENTAL HEALTH CARE

This dissertation, by Kimberly G. Patterson-Hyatt, has been approved by the committee members signed below who recommend that it be accepted by the faculty of the Antioch University Seattle at Seattle, WA in partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY

Dissertation Committee:

_____
Mark Russell, Ph.D., ABPP
Chairperson

_____
Bill Heusler, Psy.D.

_____
Colin Ward, Ph.D.

_____
Date

ABSTRACT

DISTRESS AMONG PSYCHOLOGISTS: PREVALENCE, BARRIERS,

AND REMEDIES FOR ACCESSING MENTAL HEALTH CARE

Kimberly G. Patterson-Hyatt

Antioch University Seattle

Seattle, WA

This study completed a critical review of psychologists' mental health by developing a conceptual analysis based on the current empirical literature of the mental health needs of clinical psychologists. Distress among psychologists was explored by examining the following domains: (a) examining the prevalence of mental illness and psychological distress that exist among them, (b) examining the barriers they encounter to seeking treatment when experiencing this distress, and (c) reviewing current interventions and integrating remedies for access to mental health care that best meets psychologists' needs. Results included several themes within each domain shaping a contextual picture of some of the challenges faced by psychologists and gaps that need to still be further addressed. The following five themes were found within the domain of lifetime prevalence of mental illness and psychological distress among psychologists: psychiatric disorders reported reaching at approximately 81%, substance use (primarily ethanol) vacillating from 1% to 70%, psychological distress ranging from 10% to 74%, impairment varying from 4.6% to 63%, as well as burnout and compassion fatigue found stretching to 80%. There dominant barriers in place that created obstacles for psychologists to access appropriate and effective mental health services, which included: limited insight, education and prevention strategies lacking, keeping distress secretive, institutions of psychology being unsupportive to the distressed psychologists, utilizing reactive interventions versus preventative ones, lacking

evidence-based research on psychologists' distress along with interventions that remediate stress, an unsupportive and avoidant culture when dealing with psychological distress, and limited psychotherapy resources. There are at least six suggestions identified for intervening with psychologists facing barriers to accessing care, which included: educating and increasing awareness, improving systemic influences, utilizing self-care, developing a culture of support, increasing empirical research, and utilizing personal therapy and treatment programs. Inconsistencies were found in the literature, which harness poor integration between prevalence, barriers, and interventions. Particular areas discussed included: empirical research, personal therapy, ranges in prevalence, shame, and self-care. Limitations of the study and areas for further research were discussed.

The electronic version of this dissertation is at AURA: Antioch University Repository and Archive, http://aura.antioch.edu/ and OhioLINK ETD Center, https://etd.ohiolink.edu.

Keywords: mental illness, psychological distress, psychologists, treatment, barriers, remedies, interventions, psychiatric disorders, substance use, burnout, compassion fatigue, systems, education, self-care, personal therapy, denial.

Dedication

"Healers are spiritual warriors who have found the courage to defeat the darkness of their souls. Awakening and rising from the depths of their deepest fears, like a Phoenix rising from the ashes. Reborn with wisdom and strength that creates a light that shines bright enough to help, encourage, and inspire others out of their own darkness."

(Melanie Koulouris)

For the psychologists who have discovered their strength on their own path of healing and share their light with others.

Acknowledgments

To start, I would like to give special thanks to those keeping the faith in others that struggle to do so for themselves; for those that believed in me, when I did not believe in myself. I am who I am today because of you. My mentors, my teachers, my supervisors, my friends, my family, and my partner have carried me through the many peaks and valleys that have eventually led me to this point and keep my fuel running high. Special thanks, Dr. Tien and Dr. Russell, for your guidance, patience, and commitment. You have played a substantial part to my personal development and professional achievements, as well as reminding me and showing me how to stand strong in the face of difficulty. A special thanks to my teachers and committee members who remained patient and committed to my academic growth, while encouraging me to be inquisitive and critical. Thank you to my supervisors that remained dedicated, sacrificed their time, and shared their wisdom with me. My friends, family, and partner who have forced me to personally grow, reminded me of my resilience, and helped me stay grounded both outside and within my professional goals. I am grateful for you all. For better or for worse, I would have been someone doing something completely different without you, for I am merely a reflection of what you see.

Table of Contents   Page

Chapter I: Introduction

Statement of the Problem

Unlike other professions, psychology has developed an aura of invulnerability to psychological distress, as well as disorders, and these assumptions of immunity foster high expectations for personal efficacy (Wood, Klein, Cross, Lammers, & Elliott, 1985). Psychologists, similar to the general public, are vulnerable to psychiatric disorders and other various impairments (Nachshoni et al., 2008). For decades, it has been known that this can also create obstacles for psychologists in recognizing personal psychological difficulties (Wood et al., 1985). Good, Khairallah, and Mintz (2009) recognized in their research that "despite [psychologists'] extensive training, knowledge from research, and insight from therapy, mental health professionals are not immune to the multitude of human biomedical and psychosocial ailments" (p. 21).

In addition to psychologists having comparable mental health problems to the general public, their professional demands contribute to their impairment due to the unique risk factors they face (Good et al., 2009). Similarly, Skorina (1982) agreed that psychologists are particularly vulnerable due to the high expectations placed on them within the profession for personal and professional resiliency, as well as self-healing skills. Despite the discourse regarding professional expectations, Bearse, McMinn, Seegobin, and Free (2013) proposed that clinical psychologists' work does predispose them to experience certain problems such as burnout, vicarious traumatization, compassion fatigue, and countertransference, creating a strong potential to take a toll on those practicing in the field of mental health. In the literature, researchers have suggested the need for the field to increase the understanding of mental illness, psychological distress, and impairment among clinical psychologists to help in the prevention or care of mental

health-related impairment (Nachshoni et al., 2008; Skorina, 1982; Smith & Moss, 2009; Wood et al., 1985).

Since the early 1970s, the psychological profession has developed awareness to psychologists' mental health problems (Mausner & Steppacher, 1973), yet important interventions have not been made as even now, decades later, researchers have continued to emphasize that mental health professionals in a variety of roles are often required to provide a high degree of care to clients over a time, which results in physical and psychological distress (Ray, Wong, White, & Heaslip, 2013). Despite the psychiatric services clinical psychologists are receiving, there is limited information about the mental health status of these psychologists and treatment options that are appropriate for them. Clinical psychologists are experiencing psychological turmoil that is impacting both their professional and personal lives (Nachshoni et al., 2008; Newell & MacNeil, 2010; Wood et al., 1985); recommendations for reducing this turmoil need to be adequately addressed. More information is needed about psychologists' impairments, in order to convince those in the psychological profession that there is an unmet need to facilitate the appropriate interventions (Nathan, 1982, as cited in Laliotis & Grayson, 1985). Smith and Moss (2009) argued that psychologists are an underserved population who facilitate healing in others and are also susceptible to mental illness, yet lack the appropriate services for their own mental health. Newell and MacNeil (2010) too have argued within their research the need to comprehensively understand the complexity of phenomena within psychological distress among clinical professionals in efforts to identify, prevent, and minimize their effects. While researchers have investigated the prevalence of mental illness and psychological distress among psychologists (Nachshoni et al., 2008; Newell & MacNeil, 2010; Smith & Moss, 2009) and, often separately, the barriers they face in seeking mental health

treatment (Bearse et al., 2013), no researchers have looked at the systemic integrated remedies that psychologists need in order to access the appropriate mental health treatment for their noted distress and barriers.

There has been a great effort to reduce the barriers to the general public of seeking mental health treatments (American Psychological Association, 2006), but in comparison, little has been done to address the mental health needs of psychologists. For example, many clinical psychologists seek personal therapy and find it beneficial, but there are still factors that impede their participation (Bearse et al., 2013). Without integrated insight into the various types of psychological distress that psychologists face and the barriers to receiving care, they encounter continued suffering, declines in mental health, increased isolation, and increased resistance to treatment. This then becomes a social justice issue, as it is a blind spot in our professional social justice activities and advocacy. When mental health treatment options are developed and easily available, psychologists can avoid having to provide their own diagnosis and treatment during mental distress (Bearse et al., 2013; Nachshoni et al., 2008; Smith & Moss, 2009). The purpose of this conceptual-analytic investigation was to critically and systemically analyze the scholarly literature that examines the prevalence of mental illness among psychologists and the barriers they face to mental health treatment, as well as to develop remedies for them to access the appropriate mental health care for their highlighted concerns and improve their quality of life.

Psychologists' psychological distress is a worthy topic for research, practice, and training (Bearse et al., 2013). Psychologists are people, and as people, their level of mental health functioning fluctuates continuously in accordance with the many demands of their lives (Good et al., 2009). The intention of this study was to strengthen the psychology profession's identity by helping to support psychologists' mental health. Offering integrated information about the

prevalence of psychologists' mental illness and psychological distress (Elliott & Guy, 1993; Gilroy, Carroll, & Murra, 2002; Good et al., 2009; Nachshoni et al., 2008; Newell & MacNeil, 2010) and barriers to treatment (Bearse et al., 2013), as well as developing remedies to access mental health care, will significantly contribute to this population. These remedies include supporting the elimination of mental health isolation, highlighting susceptible disorders among this population, normalizing obstacles psychologists may face in accessing treatment, and finally, giving helpful methods to mediate the problem. This research will also help psychologists to highlight professional hazards and better prepare psychologists for their career by heightening their awareness of the potential mental health risks (Bearse et al., 2013; Newell & MacNeil, 2010) as well as giving them empirically based interventions.

Importance of the Study

For over three decades, researchers have expressed the urgent need for those within the profession of psychology to deal more effectively with psychiatric problems experienced by psychologists (Skorina, 1982). For example, Skorina (1982) primarily examined the challenge psychologists were facing with alcoholism, as well as impairment, and presented that very little was being done to truly understand the prevalence of this disorder among psychologists. Researchers such as Skorina (1982), Pope and Tabachnick (1994), and Nachshoni et al. (2008) have advocated for psychologists who are managing various disorders to be supported and helped by individuals in the field. Unfortunately, psychologists do very little to become aware of and respond to the needs of their distressed colleagues as compared to those within other professions studied (Skorina, Bissell, & de Soto, 1990). Skorina et al. (1990) supported the argument that despite psychologists' clinical training, they are still unable to identify early warning signs of psychiatric problems they are experiencing without the assistance of another

professional. This finding has also been supported in Smith and Moss's (2009) research regarding psychologists' impairment, what it is, and how it can be prevented. Distressed and professionally impaired psychologists in clinical practice can adversely affect the clinical process when their mental health needs go unmanaged (Sherman & Thelen, 1998).

Smith and Moss (2009) also delivered a persuasive plea for leaders in the profession of psychology to develop adequate attention to the issues of mental health and distress experienced among psychologists. Smith and Moss critiqued the limited resources given to psychologists who are impaired and the treatment available to them. The researchers also evaluated psychologists' current ability to identify impairment among their colleagues. Smith and Moss stated that remedies should include the need for the American Psychological Association to mandate mental health coverage as part of accreditation, third-party insurance, and national uniformity in mental health facilities. Smith and Moss proposed increased research into interventions that educate psychologists about risks, signs, and effects of impairment, as well as research on the effectiveness of colleague assistance programs. More than a decade prior, Orr (1997) directed those who lead the profession on a national level to fund, define, and develop policies toward practitioner illness that are compassionate, fair, and firm. Orr suggested that leaders develop a better understanding of unethical acts as they relate to illness and clarify the management of such notions.

The research community is calling for the establishment and maintenance of mental health interventions for psychologists in need and has continued to struggle to meet these needs appropriately (Laliotis & Grayson, 1985; Smith & Moss, 2009). Kutz (1986) stated that further defining and understanding impairment among practitioners could address concerns for public welfare regarding psychologists' impairment. Kutz stressed the relevance of this topic. An

increased understanding of impairment will help to delineate performance problems, diminish mental health problems, and develop the appropriate interventions to remove the barriers in place for psychologists. Kutz noted that this delineation would also help to distinguish between persons who have provided inadequate professional services and those who have not, but are at greater risk to do so. Furthermore, psychological associations and the state boards of examiners' concern for the public welfare would benefit from building these frameworks into the codes of ethics, as the ethical guidelines can then be clearer in deciding factors such as these (Kutz, 1986). Perhaps with focalized awareness and treatment remedies around the specific mental health challenges faced by psychologists, they may then be avoided. The present research highlighted what psychiatric illnesses psychologists may be facing in isolation, critically analyzed the various barriers they are facing to manage their mental health problems, and sought to synthesize and create a systematic change regarding the remedies psychologists can have to accessing mental health treatment.

Method Review With Guided Theoretical Framework

Thematic analysis was the theoretical framework used to examine the body of literature for this study. This framework was chosen because it provides the best opportunity for the researcher to ask the most pertinent questions about the topic (Howitt & Cramer, 2007). According to Braun and Clarke (2008), thematic analysis is a step-by-step procedure widely used to analyze data in a flexible and in-depth manner. Additional advantages to using thematic analysis include its theoretical flexibility and suitability to conceptualizing the various perceptions. This is done by examining patterns of meaning across data sets through a rigorous process of familiarization, data coding, and theme development (Braun & Clarke, 2008). In this particular study, the data sets were the domains listed below.

In the current study, the researcher sought to answer the research questions through examining patterns of meaning across these various data set domains:

- What does the combined research indicate regarding prevalence of mental illness and psychological distress among clinical psychologists?

- What has research attributed as barriers psychologists face to accessing mental health treatment?

- What new insights can be gained regarding remedies for psychologists in accessing appropriate mental health care?

These questions were formulated into three research categories: (a) to identify what prevalence of mental illness and psychological distress exists among clinical psychologists; (b) to identify barriers psychologists are facing to access mental health care, as well as what happens when psychologists do access mental health care; and (c) to identify relevant remedies for clinical psychologists to have better access mental health care relevant to their needs. Within these categories, the researcher examined other relevant information such as defining terms (e.g., mental illness, psychological distress), examining treatments that have been found more effective than others for this population, and making professional comparisons (e.g., social workers, psychiatrists, other mental health practitioners, and the general public) within the mental health field in an effort to develop a well-rounded analysis of the presenting problem. Thematic analysis allowed the researcher to identify various commonalities within each domain and subdomain, which allowed for the construction of meaning making to be found out of the research question.

Theoretical Framework

Thematic analysis also allows a researcher to intimately familiarize himself or herself with the various research of theoretical domains, conduct a detailed analysis of the data sets that have been collected and outlined, and integrate important themes that speak to the mental health needs of clinical psychologists (Fereday & Muir-Cochrane, 2006). In this study, the researcher performed a critical systematic review and conceptual analysis of the available empirical and theoretical literature through coding and theme development as directed by the content of the data and research question. Research domains are listed in the method review; the researcher used Braun and Clarke's (2008) six-phase thematic analysis of inclusionary and exclusionary methods to determine appropriate documents for review and the lens from which data collections were taken.

Purpose of the Study

The purpose of the study was to undertake a critical review and create a conceptual analysis of the empirical literature on the mental health needs of clinical psychologists by (a) examining the prevalence of mental illness and psychological distress that exist among them, (b) examining the barriers they encounter to seeking treatment when experiencing this distress, and (c) reviewing current interventions and integrating remedies for access to mental health care that best meets psychologists' needs. The assumptions brought to this work proposed the idea that clinical psychologists are facing mental health challenges and the associated barriers, and that these challenges are not being appropriately or holistically addressed within the mental health profession (Bearse et al., 2013).

Research Questions

The goal of this dissertation project was to determine the prevalence of mental health challenges in psychologists, complete an analysis and synthesis of the existing literature relevant to what barriers clinical psychologists are facing to maintain their mental health, and gain new insights that enhance what clinical solutions are available for them to access the appropriate mental health treatment. In the current study, the researcher sought to answer, "What does the collaborative research indicate regarding prevalence of mental illness among clinical psychologists?" "What has research attributed as barriers they face to accessing mental health treatment?" and "What new insights can be gained regarding remedies available for clinical psychologists in accessing the appropriate mental health care?"

Chapter II: Review of the Literature

The following sections provide definitions of important terms, as well as a preliminary discussion about the prevalence of mental illness across the United States including the general population and other mental health professionals and how that mirrors what psychologists are experiencing. A discussion of some of the mental distress psychologists have reported experiencing, as well as other risk factors that have been noted as relevant when examining psychologists' mental health, is explored. The researcher then explored the barriers psychologists are facing that are noted in the research, followed by an identification of the gaps that will be filled with this research. In addition to clinical psychologists, other mental health professionals have been included in this literature review regarding prevalence and barriers to treatment, in order to more thoroughly investigate the missing gaps applicable to clinical psychologists. Furthermore, each major domain offers additional research findings on the topic.

Mental Illness and Psychological Distress

Defining mental illness and psychological distress. In order to understand the prevalence of mental health suffering among clinical psychologists, it is important to begin to understand mental illness and psychological distress, as well as cognize the front-runners in the profession that influence these elements of mental health. Since the 1950s, the seven editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) have been a commonly used tool in the United States and throughout the psychological community for understanding prevalence rates and classifying psychological distress. For decades, this manual has been a main tool for mental health practitioners to define and understand psychological disparities (American Psychiatric Association [APA], 2013a) in Western culture. Due to the manual's nature to build from previous editions, such as the *DSM-5,*

DSM-IV-TR, DSM-IV, DSM-III-R, DSM-III, DSM-II, and *DSM-I,* as well as its recognition as the cornerstone to identifying mental disorders reliably in the broad scientific community (APA, 2013a), the researcher utilized all editions of the *DSM* as they arose in the literature on the pervasiveness of mental illness and psychological stress among clinical psychologists and other mental health practitioners. According to the American Psychiatric Association (2013a), as the science of mental disorders continues to evolve, so does the *DSM*. It is a living document, which is an adaptable tool that most universally fills the need for clinicians and researchers to have a clear and concise description of each mental disorder, thus being desirable for this research. Additionally, as with previous editions, the *DSM-5* has organized mental disorders with explicit diagnostic criteria as well as dimensional measures that cross diagnostic boundaries with information about diagnosis, risk factors, associated features, research advances, and various expressions of the disorder (APA, 2013a), allowing for more analysis of psychological distress impairment without diagnosis. The *DSM-5*'s diagnostic criteria for mental illness identifies symptoms, behaviors, cognitive function, personality traits, physical signs, syndromes, combinations, and duration, as do many of the surveying tools used in the research that was examined for this dissertation.

The *DSM* delineates whether one meets criteria for a disorder by differentiating from normal life and transient responses from stress to criteria that meets clinical significance. It summarizes characteristic syndromes of signs and symptoms that point to an underlying disorder with a characteristic developmental history, biological and environmental risk factors, neuropsychological and physiological correlates, and typical clinical course (APA, 2013a). The American Psychiatric Association (2013a) defined a mental disorder as

> a syndrome characterized by clinically significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a dysfunction in the

psychological, biological, or developmental processes underlying mental functioning . . . are usually associated with significant distress or disability in social, occupational, or other important activities. (p. 20)

Clinical practice and research from the *DSM* is pulled from diverse empirically based sources in Western scientific culture and therefore suits the topic of research for this project. Common critiques of use for the *DSM* include its inability to indicate the etiology of mental illness and psychopathological commonalities (APA, 2013a). For this research study, the lack of etiological findings minimally impacted the conceptual analysis of barriers psychologists face to accessing treatment, as well as the remedies to help. While this may be one of the limitations of the study, it should not greatly impact the results for psychologists, as the philosophy of the profession is represented in the *DSM* and conforms to Western psychological practices.

The World Health Organization's ([WHO], 2010) *International Statistical Classification of Diseases and Related Mental Health Problems,* 10th revision manual (*ICD-10*), is another standard diagnostic tool for epidemiology and clinical purpose to monitor the incidence and prevalence of disease and health problems. The *ICD-10* systematically analyzes, interprets, and compares mortality and morbidity and translates the information internationally (WHO, 2010). The *ICD-10* was originally developed to classify causes as well as documentation of death and later was expanded to include diagnosis in morbidity (WHO, 2010). The WHO (1992) identifies mental disorders as inherently a disease and illness and implies that there is

an existence of a clinical recognizable set of symptoms or behavior associated in most cases with distress and with interference with personal functions. Social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder as defined here. (p. 11)

The Centers for Disease Control and Prevention ([CDC], 2011) is another organization that monitors prevalence of mental illness and psychological distress due to their concerns of it being a significant public health problem. Similarly to the *DSM* (APA, 2013a), the CDC

describes mental illness as sustained abnormal alterations of cognition, affect, and behavior that are correlated with distress and impaired functioning. The CDC stated that mental illness is a type of impairment that disrupts daily functioning and social and occupational roles and causes premature death (APA, 2013a). In 1992, the American Psychiatric Association defined impairment as the presence of an illness that renders the professional incapable of maintaining acceptable practice standards; impairment includes affective disorders, psychoactive substance use disorders, and personality disorders, as well as geriatric and neurological conditions. Impairment is a relevant component to examining the mental health of clinical psychologists, as it is a form of psychological distress that causes similar suffering as that of mental illnesses and can lead to increased levels of severity (Kutz, 1986). Orr (1997) defined impairment as the presence of an illness or illnesses and added that impairments are likely to render the professional psychologists incapable of maintaining acceptable practice standards. Professional impairment is an imperative concern for both the profession of psychology and the public it seeks to serve (Good, Thoreson, & Shaughnessy, 1995), as well as important to the sanctity of the psychologists' mental health. The prevalence of mental illness, psychological distress, and impairments associated with clinical psychologists is in significant need of examination and intervention due to the various barriers placed in front of them for seeking the appropriate mental health care (APA, 2006; Barnett & Cooper, 2009; Bearse et al., 2013; Good et al., 1995; Kutz, 1986; Linnerooth, Mrdjenovich, & Moore; 2011; Orr, 1997; Thomas, 2005).

There are other lenses in which psychological distress can present itself among psychologists and mental health practitioners. Table 1 shows preliminary data to this investigation that begin to depict the various types of distress, mental illness, and impairment that are described in the literature.

Table 1

Defining Mental Illness and Psychological Distress Data Set

Defining Mental Illness and Psychological Distress Data Set				
Researchers	Method	Sample Size	Sample	Findings
Freudenberger (1974)	Theoretical Review	No Sample	Literature	Originally coined burnout as carrying symptoms of emotional and physical exhaustion of staff members for alternative health care institutions.
Farber & Heifetz (1982)	Mixed Methods: semi-structured interview, coded, and chi-squared analysis	N=60	Psychotherapists including: psychiatrists (n=24), psychologists (n=21), social workers (n=15)	Stated burnout includes emotional frustrations that lead to psychosomatic symptoms, such as exhaustion, insomnia, headaches, and increased interpersonal conflict.
Laliotis & Grayson (1985)	Review & Quantitative Survey	N=50	State examining boards of psychology	Defined impairment as the "interference in professional functioning due to chemical dependency, mental illness, or personal conflict" (p. 85).
Orr (1997)	Review	No Sample	Literature	Defined the impaired among psychologists' as "presence of an illness or illnesses that render or are very likely to render the professional incapable of maintaining acceptable practice standards" (p. 293).
Baird & Kracen (2006)	Synthesis	No Sample	Literature	Defined vicarious traumatization as "harmful changes that occur in professionals' views of themselves, others, and the world, as a result of exposure to the graphic and/or traumatic

				material of their clients" (p. 181). Secondary trauma stress was defined as "a set of psychological symptoms that mimic post-traumatic stress disorder, but is required through exposure to persons suffering the effects of trauma" (p. 181).
Smith & Moss (2009)	Review	No Sample	Literature	Argued the delineation between distress and impairment as being confusing. Defined the impaired professional as a practitioner who is ill, but not malevolent, deceitful, or inexperienced.
Newell & MacNeil (2010)	Theoretical review	No Sample	Literature based on direct social work services	Examined as well as defined professional burnout as "a state of physical, emotional, psychological, and spiritual exhaustion from chronic exposure to populations that are vulnerable or suffering" (p. 58), vicarious trauma as a process of change resulting from repetitive empathetic engagement with client's trauma, secondary traumatic stress as normal behaviors and emotions consequential to knowing traumatizing information experienced by a client and the stress resulting in making attempts to help the client, compassion fatigue as "the overall experience of emotional and physical fatigue that . . . due to the chronic use of empathy when treating patients who are suffering in some way" (p. 61).

Showalter (2010)	Theoretical review	No Sample	Literature	Explored compassion fatigue as stated it being the cost/stress of caring and how it weighs on the professional caregiver physically, mentally, and emotionally. Cumulative stress leads to "fatigue . . . having persistent thoughts and images related to the problem of others; and developing physical symptoms (headaches, gastrointestinal disorders, muscle tightness, sleep disturbance, anger/tearfulness), and depression" (p. 240).

Kutz (1986) argued that impairment needed clearer delineation or defining, but at that time, the

psychological community grappled with understanding impairment as the mixing of diagnostic

categories and specific problem behaviors that described deterioration and diminishment from a

previously higher level of functioning to a lesser degree.

Prevalence of mental illness and psychological distress.

Defining prevalence. According to the National Institute of Mental Health ([NIMH],

2015c), prevalence is "the proportion of a population who have (or had) a specific

characteristic(s) in a given time period" (para. 1) and is estimated or calculated based on

information about the entire population of interest. Lifetime prevalence, "the proportion of a

population who, at some point in life up to the time of the assessment, has ever had a

characteristic" (NIMH, 2015c, para. 4), was used for this study. Characteristics for this study

should be understood as mental health disorders, psychological distress, and other mental health

morbidities. Furthermore, prevalence measures the characteristics that determine a population's

likelihood of having known characteristics of mental illness and psychological distress (New York State Department of Health, 1999).

Known prevalence of mental illness among the general population. The general public has received great attention regarding lifetime prevalence rates and age of onset distributions of *DSM* disorders (Kessler et al., 2005). Robins, Locke, and Regier (1991) studied American psychiatric disorders from an epidemiologic catchment area (ECA) framework that included 20,000 participants. The sample size was based on probable prevalence rates of specific disorders found in previous studies. According to Robins et al., ECA studies present more comprehensive prevalence rates of mental disorders in the United States and serve to fill the void that was identified during the late 1970s by the President of the Commission on Mental Health for research and accessing consequent services. Epidemiological studies were used to define characteristics of illness as part of a total research, clinical service, and prevention strategy, and were developed to improve the knowledge about the frequency of psychiatric disorders, which include identifying underserved portions of the populations. Robins et al. reported that by the early 1990s, 32% of American adults experience one or more psychiatric disorders at some point in their lives and 20% are actively dealing with one. They reported this number as being 13% higher than the President's Commission's estimate on mental health in 1978. They reported the most common disorder in America to be phobias (14.3%), but following not too far behind, alcohol abuse/dependence was seen to be making its mark on society (13.8%). After that, generalized anxiety (8.5%), drug abuse/dependence (6.4%), and dysthymia (3.3%) trailed behind.

Prevalence of psychiatric disorders has been increasing throughout the years in the United States and it is believed that most of the population will experience some kind of

psychiatric disorder during their lifetime (Kessler et al., 1994). According to Kessler et al. (2005), approximately half of Americans meet criteria for *DSM-IV* (APA, 2013a) disorders at some point in their life, with their first onset typically occurring during childhood or adolescence; the researchers based this finding on a sample size of 9,282 participants. Kessler et al. (2005) also argued that projections of future risk could be estimated by survey data to understand why some of these prevalence rates are transferable to specialized populations, such as psychologists. This is relevant as the clinical community trials can offer insights to the potential *DSM* diagnoses that psychologists are experiencing similar to the general public and other professions, as substantially more research has been completed on these sample groups.

Kessler et al. (2005) utilized the National Comorbidity Survey Replication (NCS-R), which is a stratified multistage probability sample that included face-to-face interviews with a non-institutionalized civilian population, using the *DSM-III-R* diagnostic tool. It asked descriptive information about mental health functioning and was distributed across the United States between February 2001 and April 2003 and received a 70.9% response rate ($N = 8,098$). The most prevalent lifetime disorders noted included major depressive disorder (16.6%), alcohol abuse (13.2%), specific phobia (12.5%), and social phobia (12.1%). Anxiety disorders were the most predominant class (28%), then impulse-control disorders (24.8%), mood disorders (20.8%), and substance use disorders (14.6%). According to Kessler et al. (2005), lifetime prevalence of any mental illness was 46.6% and participants with two or more diagnoses represented 27.7%. Participants with three or more diagnoses represented 17.3% of the population.

According to the National Alliance on Mental Illness ([NAMI], 2015) in the United States, the prevalence of mental illness found over the course of one's lifetime is a common report among the general public. They base their reports on the framework of prevalence, which

they described as an estimation of randomly selected sampling expressed as a percentage. Similarly to previous studies, NAMI (2015) found that approximately 26% of American adults experience a diagnosable mental disorder in a given year. Prior to Kessler et al.'s research in 2005, Kessler et al. conducted another study in 1994 that then utilized a survey and structured interview for 15-to-54-year-old non-institutionalized civilians in the United States using the Composite International Diagnostic Interview to evaluate the prevalence of mental illness. They found that nearly 50% of the respondents reported at least one lifetime disorder, while 30% reported experiencing a psychiatric disorder within the last 12 months. The most common disorders reported were depressive episodes, alcohol dependence, social phobia, and simple phobia; it is noted that this study was using the *DSM-III-R* to determine diagnoses (Kessler et al., 1994).

Comparatively speaking, anxiety disorders are the most prevalent mental health disorder among the general public in the United States (Anxiety and Depression Association of America, 2015) versus the reported mood disorders among psychologists (Nachshoni et al., 2008). The Anxiety and Depression Association of America reported mental illness affecting approximately 40 million adults, equaling about 18% of the population. There are at least 13 different types of anxiety disorders (APA, 2000), which can develop during every phase of one's life span (LaFreniere, 2009). According to the *DSM-IV*, many individuals with generalized anxiety disorder report being anxious their whole lives (APA, 2000). Kessler et al. (2005) argued that mood disorders such as depression are not very different from generalized anxiety and in fact are merely different manifestations of a single underlying internalizing syndrome.

The National Institute of Mental Health (NIMH), a component of the U.S. Department of Health and Human Services, published an assortment of empirically based educational resources

for mental health and disorders. Within this material, NIMH (2015a, 2015b) reported suicide being the tenth leading cause of death for all ages in the United States, causing an estimated $34.6 billion in combined medical and work loss costs. These data sets are transferrable to subpopulations, such as practitioners in the psychology profession (Creswell, 1994), thus creating an urgency and due diligence to increase mental health options for practitioners. Similarities were seen, while some differences of psychiatric disorders between the general public and psychologists were noted.

Prevalence of mental illness and psychological distress among psychologists and mental health practitioners.

Mental illness. Nachshoni et al. (2008) found similar psychiatric disorders being reported among psychologists. They surveyed 63 Israeli psychologists and 65 social workers working at a military mental health hospital and asked them to indicate whether they noticed the symptomology for Axis I or II from the *DSM-IV* within themselves at any time in their lives; those surveyed were also asked to indicate the severity of the disorders (Nachshoni et al., 2008). They utilized a Likert scale to determine their functional impairment; they distinguished functional impairment as not applying to their professional capability. There were specific differences between psychologists and social workers indicated with regard to mood, social phobias, eating, and psychotic disorders (Nachshoni et al., 2008). Nachshoni et al. found that a greater portion of psychologists than social workers reported mood (68% versus 46%), anxiety (36% versus 48%), and eating (49% versus 25%) disorders. The eating disorders were more prominent among women than men and intensity was rated somewhat higher for women regarding mood, eating, and sleep disorders. Psychotic disorders were only reported among social workers. Nachshoni et al. reported that psychologists rated greater intensity of mood

disorders and paranoia. Psychologists described themselves with more prominent features of diverse Axis I and II disorders than social workers, despite not being diagnosed with a formal psychiatric disorder. These disorders included mood (especially depression and anxiety), obsessive compulsive, social phobia, eating, paranoia, narcissism, avoidant, and dependent disorders.

Nachshoni et al. (2008) found that approximately 81% of Israeli military psychologists and social workers perceived themselves to have some *DSM-IV* symptomology with minimal severity, and approximately 70% believed themselves to have both Axis I and II traits. The intensity and prominence of these disorders were not correlated with race. The researchers' rationale for using self-describers was based on the qualifications of the participants; they posited that psychologists and social workers were more capable of analyzing and treating psychiatric disorders, therefore were able to do a valid self-evaluation for meeting the symptomology for Axis I or II from the *DSM-IV*. Nonetheless, the prevalence rates of mental illness reported were similar to the research conducted on the general public (Kessler et al., 2005; Nachshoni et al., 2008). Nachshoni et al. discussed concerns with the validity of the participants' reports, as there were no check systems in place to determine surety to reported diagnoses. Nonetheless, highlighted self-perceived psychopathologies among clinical psychologists were noted (Nachshoni et al., 2008), giving insight to the types of mental health struggles psychologists may be facing in their private and public lives. The authors still fell short of explicitly demonstrating the barriers psychologists are facing to accessing treatment and how the prevalence noted could be remediated with appropriate services.

Though Nachshoni et al. (2008) utilized self-describing reports of perceived mental illness, nor did they measure formal diagnostic methods, similar to Kessler et al. (1994).

Nachshoni et al. also reported not expecting prevalence rates of mental illness symptomology among psychologists to mirror that of the general population. They argued that this could have been a result of psychologists inaccurately reporting Axis I or II traits. They also speculated that psychologists treating particular disorders, such as depression, anxiety, and suicide increase their ability to see similar symptoms within themselves, as well as with ongoing reminders in treatment; this can be one explanation to the mirroring of disorders between psychologists and the general public or the patients they are treating (Nachshoni et al., 2008).

Pope and Tabachnick (1994) investigated 476 psychologists' self-reported prevalence rates of mental health problems and psychological distress, as well as their beliefs about them. Their research indicated that 20% of the participants reported holding onto shaming secrets about themselves, mostly regarding sexual challenges; 61% reported experiencing symptoms of clinical depression; 29% reported suicidal feelings, and of those, 4% attempted suicide. Despite not having an objective evaluator to determine prevalence, severity, and risks of false reporting, the researchers still demonstrated psychological distress among psychologists. Fortunately, Pope and Tabachnick were able to identify thematic reports regarding shame and secrecy among the profession as it relates to possible mental illness. Thus, analyzing prevalence rates of *DSM* diagnoses and distress among psychologists and the barriers psychologists have experienced when seeking mental health treatment can improve the understanding of the limited opportunities they have to access mental health care.

Gilroy et al. (2002) found evidence after sampling 425 random psychologists that they are at risk for depression and found that approximately 62% of the participants identified themselves as depressed. Women reported more frequent states and higher levels of depression (60%) than men (40%). Women who did not report experiencing depression did not significantly

differ from those who were reporting depression, based on the following variables: number of children, type of employment setting, income, and number of years in clinical practice. Significant differences among women and men between depressed and non-depressed respondents included that the number of client contact hours reported per week were higher among the depressed respondents. Approximately 62% to 73% of depressed psychologists sought treatment, with no significant difference based on gender. Psychologists who self-identified with being depressed indicated the major reason for not seeking treatment was due to confidentiality concerns. Of those who did seek services, decision-making factors to seek treatment included the reputation of the therapist, educational background and training, no conflict of interest recognized, and the congruence of theoretical orientation. Gilroy et al. encouraged future researchers to investigate larger sample sizes, understanding the impacts of stress-related work events and links between depressive symptoms and psychologists' clinical work. Although their sample size was small, Gilroy et al.'s research begins to indicate the possibility of professional hazards for psychologists, placing them as an at-risk population.

Trauma. There is a plethora of information of the negative impacts trauma has on mental health practitioners (Elliott & Guy, 1993; Freudenberger, 1974; McCann & Pearlman, 1990; Nachshoni et al., 2008; Newell & MacNeil, 2010; Pearlman & Saakvitne, 1995). Pearlman and Saakvitne (1995) theoretically explored trauma among treating therapists. They found that therapists exhibiting challenges with vicarious trauma and secondary traumatic stress disorders developing as a result of working with clients exploring their own trauma. They defined vicarious traumatization as a "transformation in the therapist's inner experience resulting from empathic engagement with clients' material" (Pearlman & Saakvitne, 1995, p. 122). The researchers argued that these effects cause cumulative and permanent effects in a therapist's

professional and personal life, creating profound disruptions in the therapist's interpersonal world (Pearlman & Saakvitne, 1995). Newell and MacNeil (2010) also theoretically examined the sensitivities of trauma, stress, and burnout among mental health workers. In their study, Newell and MacNeil (2010) found that as a great deal of work practice is spent addressing crisis situations and helping clients deal with trauma, it also places psychologists in substantial risk for traumatic response within themselves. Newell and MacNeil (2010) defined secondary traumatic stress as normal behaviors and emotions consequential to knowing traumatizing information experienced by a client and the stress resulting in making attempts to help the client. The prevalence of trauma among mental health practitioners has been known for decades (Elliott & Guy, 1993; Freudenberger, 1974; Nachshoni et al., 2008).

Pearlman and Saakvitne (1995) argued that trauma shows in symptoms, such as decreased tolerance to affect, identity disruption, disruption in connections with self and others, as well as interruptions with ego and memory. Additionally, the therapist may become socially withdrawn, have perceived alienation, and loss of pleasure in common forms of entertainment; this creates an imbalance of needs that may surface in the therapeutic relationship or in other intimate relationships (Pearlman & Saakvitne, 1995). Similarly, McCann, Sakheim, and Abrahamson (1988) argued that trauma and victimization are simply psychological responses that affect therapists' emotional, cognitive, behavioral, biological, and interpersonal dynamics. Elliott and Guy (1993) found that psychologists may have a higher than normal incidence of childhood trauma as compared to the general public. In their study, psychotherapists reported higher rates of physical and sexual abuse (43.3% versus 31%), parental alcoholism (21.9% versus 16.1%), and psychiatric hospitalization of a parent (8.1% versus 5.3%), as well as death of a family member (Elliott & Guy, 1993). Among 2,963 participants of diverse professional roles

versus 340 mental health professionals, Elliott and Guy found that as adults, psychotherapists experienced significantly more family dysfunction in terms of more conflict. They also have less cohesion, independence, moral emphasis, and achievement orientation in their families of origin than in other professions. This appears to be more profound among female psychotherapists. Furthermore, mental health professionals were no better at identifying a history of sexual abuse in their childhood than other professionals (Elliott & Guy, 1993). This finding suggests that etiology and exposure of psychological distresses may impact the prevalence rates among psychologists, as well as their need for mental health treatment; however, this does not make them keener to assess such distress, based on personal experiences. On the other hand, researchers proposed that although most of the conditions reported were at low severity, indicative of a threshold, it remains that there is a source of distress and need of intervention (Elliott & Guy, 1993; Nachshoni et al., 2008).

Substance use. Skorina et al. (1990) interviewed 70 abstinent alcoholic psychologists in an effort to understand and explore their experiences with seeking out mental health and substance treatment. Skorina et al. examined whether the experiences of psychologists closely resembled the general experience of those in other professions, including doctors, lawyers, and social workers ($N = 407$). According to Skorina et al., psychologists were mostly professionally active and spread out through different domains in the field. Skorina et al. conducted one-hour semi-structured interviews with 70 psychologists to identify benchmarks of alcoholism in their lives, self-described visibility or detection of alcoholism, and their recovery process. Similar to other professionals, psychologists experienced relatively advanced, visible signs of alcoholism, but sanctions were rare and almost never combined with effective interventions. Skorina et al.

noted that 70% of the psychologists received professional treatment for psychiatric distress and approximately half of them received in- and outpatient treatment.

Additionally, Skorina et al. (1990) found that psychologists sought personal therapy prior to inpatient treatment stays and were often diagnosed with social stressors or situational presenting problems, such as marital and parenting problems, but not substance-related disorders. Approximately 40% of the abstinent alcoholic psychologists were unable to see that they were experiencing psychiatric problems and were unwilling to share relevant information or the diagnosis with others (Skorina et al., 1990). Unlike the findings of researchers Bearse et al. (2013), Skorina et al. argued that psychologists' visible signs of mental illness were often neglected due to the stereotypes or stigmas affiliated with the psychological profession. The combination of psychologists struggling to identify mental illness within themselves and what they chose to share with others, in combination of experiencing similar prevalence rates to the general public, leads to maladaptive outcome of poor coping skills and obstacle ridden intervention strategies.

Suicide. Kleespies et al. (2011) researched the incidence, impact, and treatment of suicide among psychologists. They reviewed unpublished data from the National Institute of Occupational Safety and Health that investigated reported suicide among psychologists and the effects suicide had on interpersonal relationships including colleagues and students, as well as clients. Kleespies et al. linked their findings to current research on professional distress, occupational hazards, and impairment, as well as self-care, and found correlations between the data. Similarly, NIMH (2015a, 2015b) linked suicide and suicidal behaviors as unhealthy responses to stress.

The *Seattle Post-Intelligencer* reported an example indicating that correlations between psychopathology and suicide are also impacting the public (Rowe, 2007). Rowe (2007) recounted events in the life and death of a nationally renowned forensic psychologist, Stuart Greenberg, who committed suicide after undergoing a criminal investigation for voyeurism. Greenberg was reportedly having difficulty with sexual urges and feelings of extreme guilt leading to his suicide, though there was no reported history of mental illness or treatment received.

Another sad case includes Linnerooth, a military captain and clinical psychologist. In an interview by M. Thompson (2013), Linnerooth discussed that the demand and occupational hazards some psychologists have are way too great, leading to burnout; for example, he noted that the military provides only approximately 350 clinical psychologists to support the entire Army of about a half a million individuals (M. Thompson, 2013). Linnerooth et al. (2011) wrote, in another of his research findings: "Despite the resilience that may result from training and experience, it is reasonable to assume that professional burnout occurs at a relatively high rate among the vulnerable and overstretched population of clinical military psychologists" (p. 87). M. Thompson (2013) reported that Linnerooth was stricken by the demands of the profession and struggling with posttraumatic stress disorder (PTSD) and depression after his deployment; Linnerooth later committed suicide, leaving behind a wife and three small children, despite all of the research he completed on this topic.

As noted before, anxiety disorders are a risk factor for suicidality, and management of anxiety disorders is an important component in strategies to reduce population rates of suicide (Boden, Fergusson, & Horwood, 2007). In fact, estimates of the population's attributed risk suggest that anxiety disorders account for 7% to 10% of the suicidality in the United States

(Boden et al., 2007). Reports indicated that Linnerooth was engaged in Veterans Association mental health treatment, but needed more appropriate treatment resources to meet his needs as a military psychologist (M. Thompson, 2013). His wife reported that Linnerooth was being forced to use services that he referred his patients to and that they were not effectively working, nor did they provide him with the confidentiality he desired (M. Thompson, 2013).

Linnerooth and Greenberg are good examples, demonstrating how the prevalence of psychological stress and having limited mental health options brought two powerful men, who collaboratively helped hundreds of people to find mental health remedies, become unable to help themselves. There has been a heightened risk for suicide over the last few years for psychologists and there is a continued need to investigate the psychological challenges that psychologists are facing (Kleespies et al., 2011). It is important to make sure that the appropriate measures are being taken to ensure that useful interventions are in place, so that psychologists and other clinical providers have access to mental health treatment. The combined research indicates correlations between suicide and mental illness; this, without question, is impacting the psychological community. Unfortunately, self-reports of mental illness (Nachshoni et al., 2008), secretly held shame (Pope & Tabachnick, 1994), and suicide (Kleespies et al., 2011; Linnerooth et al., 2011; M. Thompson, 2013) are not the only mental health devastations psychologists are facing.

Psychological distress, compassion fatigue, burnout, and impairment. It is argued that psychologists' level of functioning changes on a continuum and those changes can be impacted by the professional demands causing impairment (Good et al., 2009). Psychologists who are engrossed in personal distress are at risk of impaired functioning due to this distress (Gilroy et al., 2002; Good et al., 2009; Sherman & Thelen, 1998). In 2009, Smith and Moss investigated

psychologists' self-reports on a variety of problems to their personal and professional functioning. They found that psychologists indicated self-descriptions of depression, substance abuse, and burnout symptoms. In their research, Smith and Moss examined the impairment that these symptoms caused in psychologists, which impacted both their personal and professional functioning. The impairment of psychologists and the reasons for it have been argued (Nachshoni et al., 2008), although it has become clear that occupational hazards and professional demands impact psychologists' psychological distress leading to concerns, such as burnout and stress (Farber & Heifetz, 1982; Linnerooth et al., 2011).

Psychologists are also at risk for burnout and compassion fatigue as a result of vicarious traumatization (Baird & Kracen, 2006; Bearse et al., 2013; McCann & Pearlman, 1990; McCann et al., 1988). Figley (2002) argued that psychotherapists' nature of work endorses the use of compassion, which creates a natural susceptibility to professional suffering. Figley found that with increased exposure to trauma, risks of compassion fatigue increase by 27% among mental health practitioners. Figley found the following behaviors to be common signs of compassion fatigue: feeling emotionally drained, chronic lack of self-care, compassion fatigue in professional conduct and personal lives, prolonged exposure to stress, a prolonged requirement to respond to the source of stress, not feeling a sense of satisfaction with work, traumatic recollections of client accounts, and life disruption. The researcher argued that the less a practitioner practices with empathy, the less susceptible they are to compassion fatigue (Figley, 2002).

Similarly, Sprang, Clark, and Whitt-Woosley (2007) examined compassion fatigue (CF) among mental health providers, but also looked at the relationship it has with compassion satisfaction (CS) and burnout. Sprang et al. found that female MHPs had higher levels of CF, and MHPs with specialized training in trauma work reported higher levels of CS. For MHPs,

discipline proved to be an important factor, with psychiatrists reporting higher levels of CF than their non-medical counterparts. When providers were compared using rural, urban, and rural with urban influence classifications, the most rural providers reported increased levels of burnout but could not be distinguished from their colleagues on the CF and CS subscales. (Sprang et al., 2007, p. 259)

In agreement, I. Thompson et al. (2014) found that more female psychologists reported CF and attributions to this appeared to be involved with lack of compassion satisfaction and feeling a lack of personal accomplishment. Ray et al. (2013) also examined compassion satisfaction (CS), compassion fatigue (CF), work life conditions, and burnout among frontline mental health care professionals, such as psychologists. In mental health workers, the researchers found higher levels of CS, lower levels of CF, and higher overall degree of fit.

Bearse et al. (2013) also identified burnout as an area of concern, but highlighted vicarious traumatization, compassion fatigue, and countertransference as being contributing risk factors for those practicing in the field of mental health. McCann and Pearlman (1990) believed burnout may be caused by working with clients disclosing trauma, with difficult to treat disorders, and requiring long-term therapy. Burnout was defined as emotional exhaustion, depersonalization, and decreased sense of accomplishment; distress and loss of empathy is commonly recognized as a result of practicing psychologists' exposure to graphic information (Bearse et al., 2013). Bearse et al. described this phenomenon in the context of countertransference, a situation that occurs in clinical dynamics that impacts psychologists' cognitive, affective, and behavioral responses to their patients based on the enactment of the patients and the impacts it leaves with the psychologists.

A significant proportion of psychologists are judged by their colleagues as impaired, and the majority of psychologists believe that impaired practitioners are a serious problem within the profession (Wood et al., 1985). It is clear that psychologists are vulnerable to the effects of

psychological distress, which can lead to burnout, vicarious traumatization, and impaired professional competence if left unchecked (Barnett & Cooper, 2009). Increased awareness of the impaired psychologists, such as prevalence of mental illness among this population, could decrease the residual effects psychological distress has in both psychologists' professional and personal lives (Smith & Moss, 2009). Smith and Moss (2009) argued that increasing awareness of impairment would also increase awareness of those barriers psychologists face to treatment options; they argued that more insight into appropriate treatment options is necessary and will promote their effectiveness professionally. Therefore, highlighting the specific psychopathologies and distress psychologists are experiencing as practitioners and the barriers they are facing can better inform those in the profession of psychology, both of the internal struggles they face and of psychological care available to psychologists.

Existing Literature on Barriers to Treatment

Defining barriers to mental health treatment. Barrier is generally defined as a type of obstacle that prevents or makes it difficult for something to occur (Barrier, 2015). Treatment barriers are not much different. Vogel, Wester, and Larson (2007) identified treatment barriers as inhibitions of help-seeking behaviors for individuals who could benefit from treatment; this idea includes individual inhibitions for seeking treatment or the inhibitions of the system offering mental health treatment. Vogel et al. focused primarily on the internal and social barriers, rather than a systemic examination of the problem, which was this researcher's focus. Thus, in the context of this research project, mental health treatment barriers are considered to be obstructions in the process that cause people in need of treatment to not be able to receive it for one reason or the other (Young, 2014).

The investigation of treatment services and treatment plans that fit the necessities of psychologists was a major component of analysis in this study, as it plays a large role in appropriately meeting psychologists' mental health needs. The National Alliance on Mental Illness (2015) defined mental health treatment as a way one can experience relief from their symptoms by actively participating in an individual treatment plan with numerous treatment services for mental illnesses being available. Understanding what treatment options are currently available and what barriers are preventing psychologists from accessing those treatment options will help to answer what remedies are necessary for psychologists to access mental health services.

Barriers.

Summary of various forms of barriers for general population and other professions. There is growing evidence of the importance of avoidance factors in a person not seeking professional help, despite experiencing psychological distress (Vogel et al., 2007). Vogel et al. (2007) identified five major inhibitive-seeking factors to a person avoiding psychological interventions, which included social stigma, treatment fears, fear of emotion, anticipated utility and risks, and self-disclosure. Similarly, Young (2014) agreed that despite the millions of dollars that are spent in offering mental health treatment to the public, people in need of services are still encountering obstacles in getting the care they are seeking. Young delineated these barriers as (a) refusal of treatment, (b) balancing life and treatment, (c) financial issues, (d) family support, (e) geographical barriers, and (f) finding the right treatment. Barriers to finding the right treatment may include obstacles from health insurance companies, the need for a treatment provider with multicultural competence, the search for a specialized treatment provider who can

treat a specific condition, and the search for a treatment provider with whom one is able to develop rapport (Young, 2014).

Mojtabai et al. (2011) examined the barriers to initiate and continue treatment of individuals with common mental disorders in the U.S. general population. Mojtabai et al. examined 5,962 respondents in the National Comorbidity Survey Replication with common *DSM-IV* disorders by asking about perceived need for treatment, as well as structural and evaluative barriers to initiation and continuation of treatment. Results from the Mojtabai et al. study indicated low perceived need (44.8%), a desire to handle the problem on one's own (72.6%), and dropping out of treatment (42.2%). Mojtabai et al. also found that attitudinal factors were much more relevant than structural barriers for initiating treatment (97.4% versus 22.2%) and continuing treatment (81.9% versus 31.8%). Reasons for not seeking treatment varied with severity of illness; for example, low perceived need was a more common reason for not seeking treatment among individuals with mild (57.0%) than moderate (39.3%) or severe (25.9%) disorders. Structural and attitudinal barriers were more common among respondents with more severe conditions (Mojtabai et al., 2011). Mojtabai et al. suggested that "efforts to increase treatment seeking and reduce treatment drop-out need to take these barriers into consideration as well as to recognize that barriers differ as a function of socio-demographic and clinical characteristics" (p. 1752). Finally, stigma with mental health treatment-seeking behaviors appears to be a barrier for the general public (Gulliver, Griffiths, & Christensen, 2010). Braquehais (2011) completed a review on the literature regarding barriers likely to cause physicians, such as psychiatrists, to not seek help when experiencing suicidal ideation. He found that the stigma of having a mental illness is greater among physicians than the general public. Braquehais also found that physicians often experience denial, causing a delay in seeking

treatment; that physicians try to intervene in isolation by self-medicating; that physicians suffer

isolation as well as personal suffering; and that physicians have easy access to lethal means for

self-harm.

Other barriers with education, support, and resources have surfaced in other mental health

professions (Kaslow, 1986; I. Thompson et al., 2014). I. Thompson et al. (2014) surveyed *(N =*

213) mental health counselors in diverse treating settings and examined personal and contextual

predictors of mental health counselors' compassion fatigue and burnout. They found that levels

of compassion fatigue and burnout are impacted by working conditions of an environment

impacts and the personal resources of the practitioner (e.g., types of coping strategies). The

perception of working conditions, such as coworker support and work atmosphere, was a

significant predictor of burnout. The researchers identified certain styles of coping that were

associated with burnout, which included substance use, denial, distraction, and self-blaming.

Some of these pitfalls arise because help-seeking therapists are more likely to denigrate their

therapists' knowledge and skills, be resistant to their interpretations, be more competitive with

their therapists, and be more confrontative with their therapists (Kaslow, 1986).

An examination of the political influences to treatment barriers is also relevant, revealing

how larger governing systems impact treatment options and obstacles (Kersting, 2004).

Depending on the type of psychological disorder or categorized distress given, parity laws

selectively and sparsely fund clinical treatment interventions (Kersting, 2004). For example,

substance use among psychologists has been a prevalent concern for decades; however, it is

treated, funded, and sourced differently than other disorders within the mental health profession,

creating significant barriers to access helpful treatment methods (Skorina et al., 1990). By 2004,

psychologists in Missouri made strides in passing a comprehensive health parity law that covers

mental illness similar to physical illness; however, substance abuse treatment was not covered (Kersting, 2004). Additionally, Missouri was one of only four states at that time that expanded their already limited mental health parity laws to cover most mental health diagnoses, as many psychological distresses are not covered by third-party insurance (Kersting, 2004).

Since Kersting's 2004 research, growth in mental health coverage laws has improved (NAMI, 2016). Other states, such as Connecticut, Minnesota, Oregon, and Vermont, began offering comprehensive mental health parities. Canada's mental health system was facing similar problems. Mulvale and Hurley (2008) examined how private supplemental and public health insurance status affected the utilization of mental health treatment among the general public. Results from a Canadian Community Health Survey using multivariate regression ($N = 36,984$) indicated that private supplemental insurance increases the chances of a mental health treatment seeker to receive medications, such as anti-psychotics and mood stabilizers, due to their limited choices in covered provider services. It was argued that insurance coverage greatly impacts the likelihood of prescribed medications for mental illness treatment. It is important to note that most states in the United States by 2004 had not made progress in maintaining and improving practice opportunities for mental health parity, causing continued barriers for mental health practitioners to seek treatment and access services (Kersting, 2004).

The amount of funding provided to the public for mental health services drives the availability of services and eligibility of who can receive them (NAMI, 2014). NAMI (2014) argued that despite the scrutiny of inadequate service systems, seven states (Rhode Island, North Carolina, Louisiana, Nebraska, Michigan, and Alaska) cut mental health benefits for 2015 despite the noticeable need for services. It has been hopeful to see that in the last two years, 30 states, including D.C., have increased their mental health budgets allocated to services ranging

from strengthening mental health hospitals, crisis services, and outpatient treatment services. Despite the funding cuts, there is a new paradigm of delivering mental health care with innovative services, such as "integrated care, workforce recruitment, expanded treatment authority for allied professions, the use of peer support specialists and telehealth were reflected in state legislation enacted in 2014" (NAMI, 2014, p. 15) built into legislative bills. Further examination of parity changes will be a relevant component to whether this remediation has been effective for psychologists accessing mental health care or if barriers remain for them.

Preliminary Themes of the Various Forms of Barriers to Treatment for Psychologists

Psychologists and mental health therapists face a plethora of barriers when seeking mental health care (Bearse et al., 2013). These barriers include:

- the inability to find an acceptable psychotherapist (Bearse et al., 2013);

- difficulty making and having time for treatment (Bearse et al., 2013; Kaslow, 1986; Mahoney, 1997);

- financial strain/cost (Bearse et al., 2013; Mahoney, 1997; Mulvale & Hurley, 2008) and difficulties with third-party endorsement (Orr, 1997);

- the emphasis for mental health practitioners to self-identify psychological distress within themselves and among their colleagues and the problems that coincide with this (Firmin et al., 2012; O'Connor, n.d.; Skorina et al., 1990);

- historical perceptions and stereotypes of clinicians (Firmin et al., 2012; Gilroy et al., 2002; Linnerooth et al., 2011);

- coping with ethical complaints that may be asserted as a result of their impairment (Thomas, 2005);

- focus of harm avoidance is geared toward the client, therefore neglecting the psychological needs of the psychologists (O'Connor, 2001; Thomas, 2005);

- the codes of conduct seem to generally rely on mental health clinicians to recognize their psychological distress and compromising impairment and seek mental health treatment (Zur, 2014); however, the combined research has already indicated that despite practitioners' knowledge of mental illness, they have difficulties recognizing it within themselves (Boden et al., 2007; Kleespies et al., 2011; Skorina et al., 1990; I. Thompson, Amatea, & Thompson, 2014);

- colleague assistance programs, noted as unaccommodating for psychologists (Linnerooth et al., 2011) with poor policy development (Orr, 1997), and not well maintained (Bearse et al., 2013; Laliotis & Grayson, 1985; O'Connor, 2001);

- lack of accessibility and developed colleague assistance programs (Barnett & Hillard, 2001);

- psychologists' and other mental health professionals' willingness to help their peers (Floyd, Myszka, & Orr, 1998; Good et al., 1995; Orr, 1997);

- mandates for training and accreditation (Wood et al., 1985);

- ethical codes and standards for psychologists (Zur, 2014); and

- other miscellaneous barriers (Dearing, Maddox, & Tangney, 2005; Fleischer & Wissler, 1985; Kersting, 2004; Norcross, Strausser-Kirtland, & Faltus, 1988).

While the preliminary finding of this review is limited and needs further critical analysis, the goal was to simply indicate the need to investigate the multiple and isolated concerns that the scholarly field is presenting. Examining the current literature on psychologists' untreated psychological distress will help to develop the appropriate remedies for psychologists to access

treatment, as well as serve to fill one of the deep and scary mental health gaps faced by the profession. A thorough examination of the themes uncovered will allow for a systematic review and conceptual analysis that offers an integration of the prevalence of mental illness among psychologists and informed remedies for their access to care.

Preliminary Understanding of Effective Treatment Interventions for Mental Illness and Psychological Distress: Designing the Framework

Since the 1980s, there have been questions of accountability and maintenance of professional competency within the field of psychology, leading to major efforts both from state and national services to create standards for effective professional interventions (Thoreson, Miller, & Krauskopf, 1989). Interventions for distressed psychologists have been inadequate (Bearse et al., 2013; Laliotis & Grayson, 1985; Thoreson et al., 1989). Unfortunately, researchers have fallen short by not intimately and systemically analyzing the mental health issues among psychologists, as well as the multitude of systemic barriers they are facing, to fill the gap in their research. Examining barriers from an integrated lens will better help to identify those gaps in the literature that prohibit the profession from developing effective mental health interventions for psychologists. Information such as this can give the psychological community opportunities that better prevent mental health impairment. In the present study, the researcher performed an integral and in-depth analysis of the multiple systems that play roles in the mental health of psychologists and their involvement in mental health services.

For example, Zur (2014) compared ethical codes among therapists regarding impairment as a type of proof that the practice of psychotherapy alone poses hazards to practitioners, as well as demonstrating that the focus of intervention is for the client, not practitioner. He began his argument by stating that the American Counseling Association (2014) reported that the

counselors themselves can monitor impairment and incapacitation for signs of impairment to their physical, emotional, and mental problems. Once this is determined, the counselor should refrain from providing professional services and caring for patients, thus transferring their patients to other counselors or developing a termination plan. The American Psychiatric Association's (2013b) principles of medical ethics with annotations are applicable for psychiatry, informing practitioners to uphold standards of professionals and offering special consideration to be given to them if mental illness jeopardizes their welfare and practices. Finally, the American Psychological Association (2010) addressed the ethical principles of psychologists and their code of conduct. It is noted as psychologists needing to refrain from conducting treatment when they know that their personal problems will prevent them from performing their work-related activities. When psychologists become aware of personal problems that are impacting their work, they should take measures to obtain consultation or assistance and limit their work-related duties. Based on the preliminary findings for this project, the codes of conduct seem to generally rely on mental health clinicians to recognize their psychological distress and compromising impairment and seek mental health treatment (Zur, 2014); however, the combined research has already indicated that despite practitioners' knowledge of mental illness, they have difficulties recognizing it within themselves (Boden et al., 2007; Kleespies et al., 2011; Skorina et al., 1990; I. Thompson et al., 2014).

Another area for examination is the roles psychologists may have in improving prevalence and barriers. Figley (2002) reviewed the literature examining compassion fatigue psychotherapists across professional divisions and examined concerns with chronic lack of self-care. Figley suggested that psychotherapists utilize self-care strategies to help prevent compassion fatigue, such as disengaging from sources of stress, seeking a sense of achievement

and satisfaction in professional demands, recognizing where the responsibilities end and begin

with client care, desensitizing to stressors as needed, decreasing exposure to stressors,

participating in stress management and self-soothing techniques, and finally, combining

exposure to stressors with relaxation. Another example of this was Grafanaki et al.'s (2005)

research on (N = 10) mental health professionals that included counselors and psychologists and

examined the experience and role of leisure in the life of counselors and psychologists. The

researchers emphasized that leisure is a vital aspect of self-care as it improved the practitioner's

mental health and ability to manage stress. They found the following themes relevant for

successful self-care practices: (a) attitude plays a significant role in experiencing quality leisure,

(b) quality leisure was found more helpful than the quantity of leisure, (c) leisure practices with

spirituality and nature were often reported, (d) leisure activities included relational connections

with others, (e) leisure promotes balance and integration, and (f) the types of leisure used are

reflective of the practitioner.

Working conditions of an environment impacts and the environmental culture as have

played a role in psychologists' vitality and wellness. I. Thompson et al. (2014) surveyed (N =

213) mental health counselors (MHC) in diverse treatment settings. They examined personal and

contextual predictors of mental health counselors' compassion fatigue (CF) and burnout and

recommended efforts to be made to ameliorate burnout through increasing peer and work

atmosphere support (I. Thompson et al., 2014). Suggestions included finding ways to monitor

their level so compassion satisfaction and utilizing supervisory relationships to assess for well-

being, perceived work stress, and personal resources for managing job-related stressors. They

found that a positive working environment decreased compassion fatigue and burnout. The

researchers also found that the longer the MHC worked in the field, the less CF and burnout was

reported. Counselors also need to monitor their levels of distress, and supervisors can help to assess in understanding states of well-being, work stressors, and the personal resources they have to manage it. Similarly, Figley (2002) agreed that when psychotherapists enhance social support in both numbers and variety of relationship and participate in support groups to enhance social support, they improve their mental wellness. Finally, Elliott and Guy (1993) surveyed 2,963 mental health practitioners, made up of 63% social workers, 17% psychologists, 17% psychiatric nurse practitioners, 3% psychiatrists) compared to other professions (e.g., accountants, attorneys, artists, engineers, chemists, and nurse practitioners). They examined trauma and adult functioning in practicing and non-practicing mental health professionals. 78% received treatment as adults and had remained in treatment an average of 167 hours, suggesting adulthood distress and willingness to examine causes of distress through personal therapy.

Finally, there is a need and a benefit for the empirical exploration of psychologists' psychiatric states and the barriers that stop them from receiving the services that meet their needs (Barnett & Hillard, 2001; Nachshoni et al., 2008; Pope & Tabachnick, 1994; Sherman & Thelen, 1998; Skorina et al., 1990; Smith & Moss, 2009), then giving relevant insight to various remediation or suggestions that may be helpful. Having exploratory research that takes an in-depth investigation of the prevalence rates of mental illness among psychologists and the barriers they face to mental health care will increase awareness of psychiatric distress, as well as help facilitate interventions that will potentially limit suffering and decrease impairment among psychologists. The findings of this research provide important information about a sample population that is under-represented in the research as it relates to psychiatric challenges. Research that clearly identifies mental health prevalence and the barriers psychologists face in mental health treatment will help to identify areas for development of more appropriate remedies

for care access. This will ultimately help to provide a more accurate understanding of obstacles and the effectiveness of interventions. Not having empirical evidence to validate the integration of psychiatric problems among psychologists and offer clinical solutions may further create impairment by increasing isolation and de-normalization of the existence of mental illness and various obstacles in their lives (Nachshoni et al., 2008).

Chapter III: Methodology

Overview of Purpose and Research Questions

A systematic review and conceptual analysis of the available literature was performed in this study. The researcher sought to answer, "What does the combined research indicate regarding prevalence of mental illness and psychological distress among clinical psychologists?" "What has research attributed as barriers psychologists face to accessing mental health treatment?" and "What new insights can be gained regarding remedies for psychologists in accessing appropriate mental health care?" These questions were formulated into three research objectives: (a) to identify what prevalence of mental illness exists among psychologists, (b) to identify barriers they are facing to accessing mental health care, and (c) to identify variables studied as a relevant component to finding remedies for psychologists accessing mental health care.

Plan of Action

This chapter presents the plan of action that was used in this study. These plans included (a) a description of the method that was used to critically analyze the theoretical and empirical literature, (b) a description of materials and the process that was used to organize the literature review, (c) a discussion of the limitations of the study, and (d) a discussion of ethical considerations.

Description of materials used. Appropriate documents were identified through a comprehensive search of a variety of online databases, including PsychINFO, EBSCO, OhioLINK, ProQuest, and PubMed, as well as the Psychology and Behavioral Sciences Collection. Recently published books and periodicals on psychologists' mental health and treatment and the use of the thematic approach also served as resources in the identification of

pertinent literature. Finally, online sites that provide demographic, mental health, and professional information on psychologists, such as the website of the American Psychological Association, were also utilized as resources for conceptual analysis.

Relevant documents were identified through searches of combinations of the following keywords: "psychologists," "mental health," "prevalence," "barriers," "treatment," "mental illness," "remedies," "access," "diagnoses," "suicide," "burnout," "compassion fatigue," and "services." The literature was further narrowed by publications meeting specific criteria for inclusion; this helped to decrease the number of non-relevant documents. The inclusion criteria for this study was comprised of (a) theoretical papers and empirical studies, professional journal articles, books, book chapters, and dissertations; (b) websites that speak to the mental health of psychologists, associating treatments, and professional frameworks; and (c) documents that assess mental health as defined by the *Diagnostic Statistical Manuals I through 5* (APA, 1952, 1968, 1974, 1980, 1987, 1994, 2000, 2013a). Documents were similarly disqualified if they met specific criteria for exclusion. The exclusion criteria for the current study included (a) documents not available in English and (b) documents not specifically focused on psychologists as the participant or subject of analysis. Research was terminated when redundancy of literature occurred and no new data was uncovered.

Description of methodology. Using a theoretical framework to structure one's study offers constructs to form hypotheses and helps to specify the relationships among the variables proposed (Creswell, 1994). Furthermore, a systematic view helps to better discuss the singularities of what remedies exist for psychologists to better access mental health care. Thematic analysis also allows the researcher to interpret the information and themes in the context of the conceptual framework and still contribute to the development of answering the

project's research questions.

According to Guest, MacQueen, and Namey (2012), thematic analysis is a highly involved and interpretive theoretical framework that "moves beyond counting explicit words or phrases and focuses on identifying and describing both implicit and explicit ideas within the data" (p. 10). Boyatzis (1998) agreed that thematic analysis enables researchers to use a variety of information in a systemic manner that increases accuracy in understanding the material. This process allows for the researcher to develop themes from coded information in the text (Guest et al., 2012). Defining relevant terms is helpful, as terminology in qualitative analysis can be defined differently. Data are defined as textual representations of the information and themes are units of meaning that of observed in the data by the analyst (Guest et al., 2012). A code is a description of a theme or component of a theme, while coding is the process by which the analyst links these codes to specific data (Guest et al., 2012). The overall plan proposed by the researcher included conducting a literature review, summarizing the findings from each domain from a thematic lens of analysis.

The central propositions for thematic analysis that were adapted to the researcher's project were adapted from Braun and Clarke's (2008) six-phase thematic analytic work. Braun and Clarke's work discussed (a) familiarization with the data, including comprehensively reading and understanding the documents to a place of topic immersion; (b) coding important features of the data that might be relevant to answering the research questions; (c) searching for themes by examining codes and collated data to identify significant broader patterns of meaning; (d) reviewing themes that include the possibility of splitting, combining, and discarding various features found; (e) developing a detailed analysis of each theme, defining and naming for scope and focus what themes will occur; and (f) writing up the analytic narrative and data extracts, as

well as contextualizing the analysis in relation to the existing literature.

As mentioned earlier, thematic analysis as described by Braun and Clarke (2008) and Guest et al. (2012) was adapted to meet the needs of this unique research project. Because a system analysis was completed on the literature versus interviews, some coding and developing themes were pre-identified, such as (a) the prevalence of mental illness exists among psychologists, (b) the barriers they are facing to accessing mental health care, and (c) the variables studied as a relevant component to finding remedies for psychologists accessing mental health care. Further themes were found and pre-identified within the dissertation and in descriptive charts instead of the use of codebooks. Codebooks provide a textual compendium of codes that include a description of how the codes are related to each other (Guest et al., 2012). Boyatzis (1998) referred to this as "sensing themes in life" (p. 1) or recognizing a codable moment. Similar to this project, Boyatzis proposed that thematic analysis often has overlapping and alternative uses, such as a way of seeing, a way of making sense of seemingly unrelated material, a way of analyzing information, and a way of systemically organizing information.

Conclusions were compared across domains/themes to formulate a more comprehensive understanding of the potential mental health issues that psychologists encounter, including the barriers they face to receiving treatment and what remedies will allow for them to access mental health care as a whole. Although Braun and Clarke (2008) argued that thematic analysis has important phases to follow, they also identified that these phases are not linear but require back-and-forth movement, blending various stages together. The research objectives were considered in a final concluding examination.

Limitations of study. The research is interpretive in nature and therefore created limitations within the findings. According to Guest et al. (2012), reliability is of greater concern

with thematic analysis than in some other research designs, because more interpretation goes into defining the data. Guba and Lincoln (1994) proposed that in interpretive inquiries similar to this research, credibility replaces internal validity, dependability replaces reliability, confirmability replaces objectivity, and transferability replaces external validity. Guba and Lincoln suggested that credibility will be improved by continued scholarly commitment and persistence to understanding literature offered on the topic, as well as peer debriefing and chair/member checks. Dependability of the data, which is concerned with the stability of data over time and enhanced by the evolution of the research inquiry (Guba & Lincoln, 1994), was determined through a thematic framework and was interpreted based on its theoretical lens. In order to obtain objectivity within the research and data analysis, as well as transferability of the conceptual analysis obtained, the raw data and process used were included in this writing for review with a detailed description of the context, methodology, and data analysis procedures. Audit and research trails are provided to enhance confirmability. According to Guba and Lincoln, the traditional means of judging the quality or rigor of a research inquiry includes some subjectivity, as it is interpretive in nature. However, there were multiple measures in place that will allow for sound methodology and data analysis procedures.

According to Braun and Clarke (2008), the use of thematic analysis in psychology has advantages for data analysis and synthesis due to its theoretical flexibility and diversity of use among other analyzed frameworks to answer different types of research questions. Risks are also somewhat offset by only having one researcher as the analyst, as it helps to decrease mistakes made with word-based analysis that goes into defining and identifying themes (Guest et al., 2012). Maintaining rigor and strategies, such as the ones discussed in the description of methodology, also helps to achieve reliability in the analytic process (Guest et al., 2012).

Reliability checks (Guest et al., 2012) along with the combination of ethical guidelines allows for the basis of quality assurance for the study, as it is another source of accountability for the analyst to have at the forefront of their research (American Psychological Association, 2010).

      Ethical considerations. There were important ethical principles and guidelines for the researcher's conduct throughout this project. The guiding ethical principles considered were the American Psychological Association (2014) general principles of (a) beneficence and nonmaleficence, (b) fidelity and responsibility, (c) integrity, and (d) justice. Additionally, the American Psychological Association's (2014) Standard 8 on research and publication was upheld by (a) obtaining institutional approval, (b) reporting accurate research results, (c) not plagiarizing material, (d) distributing publication credit as deserved, (e) not withholding research data for verification, and (f) giving the appropriate respect and proprietary rights to the reviewers. For further clarification, Kazdin (2002) discussed the authorship credit as being another important component to scholarly research. The researcher applied Kazdin's guidelines for determining who gets credit for research; Kazdin argued that those with less experience are expected to make a more substantial professional contribution and therefore will get credit for authorship. The researcher is in agreement that the conceptual analysis and clinical application of the research project was of scholarly importance, deserving of authorship and contribution.

Chapter IV: Results

This chapter presents themes discovered in the pre-identified domains: the prevalence of mental illness among psychologists, barriers they are facing to accessing mental health care, and variables studied as a relevant component to finding remedies for psychologists accessing mental health care. The chapter has been organized in a way that shows how themes were identified and supported. Each domain is presented in a separate section that begins with an introduction, followed by the identified theme's title, and below that, a data-set table highlighting the data collected and analyzed to support the stated theme. Below the table, a final compartmentalized data analysis states the findings. Following the completion of the domains' analyses is a synthesis statement, bringing together the themes. A final section brings the compartmentalized domains' themes together in efforts to theorize what new insights can be gained regarding remedies for psychologists in accessing appropriate mental health care.

Combined Research on Prevalence of Mental Illness and Psychological Distress Among Psychologists

Prevalence of mental illness and psychological distress among psychologists was found. In this section, themes of mental illness and psychological distress among psychologists are shown, as well as a final synthesis bringing together the themes of this domain.

Theme 1: Psychiatric Disorders. The data set in Table 2 represents what the literature states regarding the prevalence of reported psychiatric disorders among psychologists.

Table 2

Prevalence of Mental Illness and Psychological Distress, Psychiatric Disorders Data Set

Prevalence of Mental Illness and Psychological Distress, Psychiatric Disorders Data Set Theme 1: Psychiatric Disorders				
Researchers	Methods	Sample Size	Sample	Purpose and Findings
Mausner & Steppacher (1973)	Epidem. Study; a death list acquired from APA that included information to obtain a death certificate	*N*=573	APA members, fellows, & associates who died between 1960–1969 who were under 65 years	A total of 58 deaths among APA members under the age of 65 years was identified. Of these, 50 deaths were classified as suicide: 34 males and 16 females. The rate of suicide among male psychologists was comparable to the general public; however, suicide rates among female psychologists were three times greater.
Wood et al. (1985)	Survey	*N*=157	Academic and Clinical Psychologists	Licensed psychologists offered their opinions about the prevalence of personal distress and professional impairment among psychologists. They reported believing that impaired psychologists are a serious problem and that significant proportions were impaired. Attributions of psychological distress led to depression (60%).
Thoreson et al. (1989)	Survey: Psychologist Health Questionnaire (PHQ)	*N*=379	Psychologists from Midwestern state psychological association	Examined the prevalence and treatment considerations for distressed psychologists. Indicated high levels of adjustment, satisfaction, and good health, approximately 10% of sample reported distress across the following dimensions: depression (11%), loneliness (9%), relationships dissatisfaction (11%), recurrent physical illness (10%), and recognition of drinking problems (8%).

Phillips (1999)	Quantitative Review	*N*=820	APA members, fellows, & associates who died between 1981–1990 who were under 65 years	Examined suicide rates for psychologists from 1981–1990 and found suicide rates among psychologists to be at or below that of the general public: 7.8 versus 24.9 per 100,000. Suicide was listed as a manner of death for 42 psychologists' death certificates, 14 women and 28 men. Most common methods included: gunshot (29%), drug overdose or poisoning (24%), asphyxia by hanging (14%), and carbon monoxide poisoning (12%).
Gilroy et al. (2002)	Survey using Likert scale	*N*=425	Members of the APA Counseling Association Division (17)	Practicing psychologists identified depression/dysthymia as the most frequently acknowledged diagnosis. Felt their emotional distress gave them empathy to their patients but also increased their sense of isolation from their colleagues and lessened their energy and ability to concentrate in their relationships with their clients. Approximately 62% of the participants identified themselves as depressed. Women reported more frequent states and higher levels of depression (60%) than men (40%). Significant differences among women and men between depressed and non-depressed respondents included that the number of client contact hours reported per week was higher among the depressed respondents. Approximately 62%–73% of depressed psychologists sought treatment, with no significant difference based on gender.
Good et al. (2009)	Theoretical	No Sample	Literature	The researchers examined wellness and impairment among psychologists. They discussed factors influencing psychologists' level of functioning, such as psychologists' impairment, depression, and suicide.
Nachshoni et al. (2008)	Survey	*N*=128	63 Psychologists (P) & 65 Social Workers (SW)	Identified psychiatric disorders among psychologists. A greater portion of Ps than SWs reported mood (68% versus 46%), anxiety (36% versus 48%), and eating (49%

				versus 25%) disorders. The eating disorders were more prominent among women than men and intensity was rated somewhat higher for women regarding mood, eating, and sleep disorders. Psychotic disorders were only reported among SWs. Ps rated greater intensity of mood disorders and paranoia. Ps were describing themselves with more prominent features of diverse Axis I and II disorders than SWs, despite not being diagnosed with a formal psychiatric disorder. These disorders included mood (especially depression and anxiety), obsessive compulsive, social phobia, eating, paranoia, narcissism, avoidant, and dependent disorders. Approximately 81% of Israeli military Ps and SWs believed they had some DSM-IV symptomology with minimal severity, and approximately 70% believed themselves to have both Axis I and II traits.
Pope & Tabachnick (1994)	Survey	*N*=476	Psychologists randomly selected from APA Divisions	Their research indicated that 20% of the participants reported holding onto shaming secrets about themselves, mostly regarding sexual challenges; 61% reported experiencing symptoms of clinical depression; 29% reported suicidal feelings, and of those, 4% attempted suicide.
Smith & Moss (2009)	Review	No Sample	Literature	Psychologists indicated self-descriptions of depression.
Bridgeman & Galper (2010)	Survey	*N*=658	Psychologists from APA membership database	Psychologists reported feeling worried about anxiety (51%) and experiencing suicidal ideation (18%). Of that 18%, 43% of psychologists did not tell anyone.
Practice Central (2010)	Review Survey	No Sample	Literature	Psychologists are at risk of disregarding their own stress levels until it becomes damaging to their health and practice. For example, 14% of psychologists who reported suicidal ideation did not tell anyone about their mental health concerns;

				this included their therapist.
Kleespies et al. (2011)	Literature Review & Semi-structured interview	*N*=14	Unpublished data from the National Institute of Occupational Safety and Health & CPA members	Examined suicide among psychologists; its impact, incidence, and suggestions for preventions and intervention. They argued, "psychologists are at risk for mental health problems, such as depression, anxiety, substance abuse, and suicidality" (p. 245). They also investigated reported suicide among psychologists and the effects suicide had on interpersonal relationships including colleagues and students, as well as clients. More than 50% of colleagues identified symptoms of depression and substance abuse among their deceased colleagues.

Analysis of Theme 1: Psychiatric Disorders. There is a portion of psychologists who identified with having a diagnosable psychiatric disorder (81%) within the continuum spectrum of severity, and approximately 70% believed they also presented with personality-disordered traits over the course of their lifetime. This portion size and severity varied; however, severity was frequently reported as mild to moderate. The following psychiatric concerns were noted: substance abuse (predominantly alcohol) ranging from 8% to 50%, mood (68%), reported depression reaching from 11% to 62%, anxiety stretching from 36% to 51%, eating disorders (49%), paranoia, social phobia, sexual dysfunction/challenges (20%), narcissism, and avoidant, obsessive compulsive, and dependent disorders. Another noticeable psychiatric concern highlighted the rate of suicide and suicidal ideation found among psychologists. Male psychologists' ideations were found to be similar to males in the general public; however, female psychologists have a three times greater risks than females in the general population. In comparison to male and female psychologists, females have higher symptomology and severity of symptoms. Within a psychologists' sample pool, male psychologists are more likely to

successfully commit suicide than female psychologists. Psychologists reported suicidal ideation varying from 14% to 29% and attempted suicides were noted at 4%. Other prominent psychiatric concerns reported among psychologists were depressive-type disorders that included symptoms such as isolation and loneliness (9%), mood dysregulation, relationship dissatisfaction (11%), somatic illness (10%), and hopelessness/helplessness.

Theme 2: Substance Use. The data set in Table 3 represents the demonstration in the professional literature that substance use and abuse is a dominant feature found among prevalence rates of mental health concerns for psychologists.

Table 3

Prevalence of Mental Illness and Psychological Distress, Substance Use Data Set

Prevalence of Mental Illness and Psychological Distress, Substance Use Data Set Theme 2: Substance Use				
Researchers	Methods	Sample Size	Sample	Purpose and Findings
Wood et al. (1985)	Survey	*N*=157	Academic and Clinical Psychologists	Licensed psychologists offered their opinions about the prevalence of personal distress and professional impairment among psychologists. They reported believing that impaired psychologists are a serious problem and that significant proportions were impaired. Attributions of psychological distress led to substance use (52%).

Skorina (1982)	Theoretical	No Sample	Literature Review	Discussed the urgent need for the profession to effectively address impaired psychologists due to alcoholism.
Guy et al. (1989)	Randomized anonymous survey using a multiple discriminant analysis	*N*=318	Psychologists who are members belonging to APA divisions: 12 (clinical), 29 (psychotherapy), and 42 (independent-practitioners)	Examined personal distress and therapeutic effectiveness among practicing psychologists. 1% of psychologists reported drug abuse.
Thoreson et al. (1989)	Survey: Psychologist Health Questionnaire (PHQ)	*N*=379	Psychologists from Midwestern state psychological association	Examined the prevalence and treatment considerations for distressed psychologists. Found that approximately 10% of sample reported distress across recognition of drinking problems (8%).
Skorina et al. (1990)	Semi-structured interviews	*N*=70	International Doctors in AA and Psychologists Helping Psychologists. All professional active: 41% in clinical or counseling, 23% in academic settings, and other in fields such as school and industrial. They identified as abstinent alcoholic psychologists.	Examined routes to recovery for alcoholic psychologists. Psychologists experienced relatively advanced, visible signs of alcoholism, but sanctions were rare and almost never combined with effective interventions. 70% of the psychologists received professional treatment for psychiatric distress and approximately half of them received in- and outpatient treatment. Psychologists sought personal therapy prior to these treatment stays and were often diagnosed with social stressors or situational presenting problems, such as marital and parenting problems. Approximately 40% of the abstinent alcoholic psychologists were unable to see that they were experiencing

				psychiatric problems and were unwilling to share relevant information or the diagnosis with others.
Elliott & Guy (1993)	Survey	*N*=2,963	(63% social workers, 17% psychologists, 17% psychiatric nurse practitioners, 3% psychiatrists) compared to other professions (e.g., accountants, attorneys, artists, engineers, chemists, nurse practitioners, etc.)	Examined trauma and adult functioning in practicing and non-practicing mental health psychologists. Approximately 7% of sample reported a history of substance abuse, which was no significant difference from the other professions compared.
Good et al. (1995)	Descriptive Survey	*N*=393	APA Counseling Psychology Division 17 members	Surveyed counseling psychologists examining their past and current substance use, identification and confrontation of impaired psychologists, life satisfaction, work stress, and psychological distress. Their research found that 16% of psychologists reported using alcohol daily. Previous use included cigarettes and marijuana (38%), and 7%–14% had previously used tranquilizers, hallucinogens, opiates, and cocaine. 40%–62% of psychologists had identified a history of substance abuse in their colleagues. 28%–43% identified a colleague having a current substance abuse problem. 10% reported being confronted on their own substance use behaviors and of that, 17% of these individuals sought help (totaling 2% of

				entire sample).
Floyd et al. (1998)	Survey	*N*=633	Psychologists	Researchers sought to identify the percentage of psychologists who are or were impaired by either a psychological condition or substance use and give examples of such impairment. Psychologists estimated that 9%–13% were impaired as a result of substance use. 75% of psychologists agreed that the following characteristics are evidence of impairment: alcohol on breath during working hours, frequent intoxications at social functions, erratic mood swings, excessive use of sick time, complaints about professional performance, and gossip.
Smith & Moss (2009)	Review	No Sample	Literature	Psychologists indicated self-descriptions of substance abuse. They found the 1980s to have some of the highest reports of substance use among psychologists. By the 1990s, psychologists reported problems with substance use to be the lowest rated personal problem reported.
Kleespies et al. (2011)	Literature Review & Semi-structured interview	*N*=14	Unpublished data from the National Institute of Occupational Safety and Health & CPA members	Examined suicide among psychologists: its impact, incidence, and suggestions for preventions and intervention. They argued, "psychologists are at risk for mental health problems, such as […] substance abuse" (p. 245) as well as other psychiatric problems. More than 50% of colleagues identified symptoms of depression and substance abuse among their colleagues who had deceased from suicide.

Analysis of Theme 2: Substance Use. There has been a fluctuation in the last three decades of reported lifetime substance use rates among psychologists, vacillating from 1% to 70%. Identified substances included cannabis and cigarettes (38%), tranquilizers (ranging from 7% to 14%), hallucinogens, opiates, ethanol, and cocaine. It remains clear that there is a risk involved with psychologists' maladaptive uses of ethanol, with reported rates ranging from 1% to 70%. Of these, 16% reported using alcohol daily. Psychologists have indicated concerns regarding not only their use, but also their colleagues' use; this identified problem ranged from 28% to 62%, either historically or with present concern. Other psychological symptoms associated were identified as affecting the ways that they function both professionally (9%) and within their personal lives. Psychologists' recovery was dependent on self-diagnosis. Psychologists have not only experienced psychiatric problems with or without visible signs, but approximately 40% were also unable to identify psychiatric distress and/or receive effective outside treatment and interventions that were effective.

Theme 3: Psychological Distress. The data set in Table 4 represents the demonstration in the professional literature on psychological distress as a prevalent concern among psychologists.

Table 4

Prevalence of Mental Illness and Psychological Distress, Psychological Distress Data Set

Prevalence of Mental Illness and Psychological Distress, Psychological Distress Data Set Theme 3: Psychological Distress				
Researchers	Methods	Sample Size	Sample	Purpose and Findings

Wood et al. (1985)	Survey	*N*=157	Academic and Clinical Psychologists	Licensed psychologists offered their opinions about the prevalence of personal distress and professional impairment among psychologists. They reported believing that impaired psychologists are a serious problem and that significant proportions were impaired. Attributions of psychological distress led to depression (60%), substance use (52%), and sexual overtures (32.3%).
Guy et al. (1989)	Randomized anonymous survey using a multiple discriminant analysis	*N*=318	Psychologists who are members belonging to APA divisions: 12 (clinical), 29 (psychotherapy), and 42 (independent-practitioners)	Examined personal distress and therapeutic effectiveness among practicing psychologists. 74.3 % of psychologists reported experiencing "personal distress" within three years and of those, 36.0% indicated that it negatively impacted their ability to give quality patient care. 4.6% admitted that it resulted in inadequate treatment. Factors associated with personal distress included: job = 32.9%, illness in the family = 23.2%, marital problems = 15.9%, midlife crisis = 15.7%, personal physical illness = 3.1%, legal problems = 6.6%, other = 10.9%, personal mental illness = 3.1%, and drug abuse = 1.0%.
Thoreson et al. (1989)	Survey: Psychologist Health Questionnaire (PHQ)	*N*=379	Psychologists from Midwestern state psychological association	Examined the prevalence and treatment considerations for distressed psychologists. Found that approximately 10% of sample reported distress across the following dimensions: loneliness (9%), relationships dissatisfaction (11%), and recurrent physical illness (10%).
Elliott & Guy (1993)	Survey	*N*=2963	(63% social workers, 17% psychologists, 17% psychiatric nurse	Examined trauma and adult functioning in practicing and non-practicing mental health professionals. Compared to other professionals, mental health

			practitioners, 3% psychiatrists) compared to other professions (e.g., accountants, attorneys, artists, engineers, chemists, nurse practitioners, etc.)	professionals reported higher levels of any trauma (66.5% vs. 49%), physical abuse (27.5% vs. 6%), sexual molestation (19.7% vs. 31%), parental alcoholism (7% vs. 16%), hospitalization of a parent for mental illness (4.2% vs. 5.3%), and death of a parent or sibling (11.4% vs. 7.5%). There was no significant difference between other professions and mental health professions regarding current interpersonal difficulties. 78% received treatment as adults and had remained in treatment an average of 167 hours, suggesting adulthood distress and willingness to examine causes of distress.
Mahoney (1997)	Survey	N=155	Psychotherapy practitioners	Focused on psychotherapists discussing their personal problems. Reported problems among psychologist to include: emotional exhaustion (42.6%), intimate relationships (37.7%), and chronic fatigue (33.3%). Other problems were surrounded by their job: severity of caseload (37.9%), therapeutic effectiveness (42.2%), and disillusionment of work (42.5%). Finally somatic complaints were reported: insufficient/unsatisfactory sleep (43.5%), gastrointestinal problems (17.6%), headaches (11.8%), and cold episodes (7.4%).
Baird & Kracen (2006)	Research Synthesis	No Sample	Literature	Researched the contributors to the development of vicarious traumatization (VT) and secondary trauma stress (STS). VT was defined as "harmful changes that occur in professionals' views of themselves, other, and the world, as a result of exposure to the

				graphic and/or traumatic material of their clients. . . . STS refers to a set of psychological symptoms that mimic PTSD, but acquire through exposure to the graphic traumatic material of their clients" (p. 181). The researchers found the following variables linked to the susceptibility to VT and STS: having a personal history of trauma, increased exposure to VT and STS, perceived coping style, and access to treatment material.
Bridgeman & Galper (2010)	Survey	*N*=658	Psychologists from APA Membership database	Psychologists reported feeling overly challenged work-life balance (72%), family issues (61%), physical health concerns (50%), and intimate relationship issues (41%). 49% reported their issues were all in the past, 51% reported they were current challenges. Economic distress and constraints was the 6th ranked barrier for psychologists (33%). Psychologists expressed economic uncertainty diminishing well-being.
Sherman & Thelen (1998)	Survey	*N*=522	Practicing psychologists	Examined the nature and extent of distress (and impairment), as well as the cognitive component of subjective well-being and the relation to satisfaction with personal and professional domains in life. There were high correlations between distress and professional impairment among psychologists in clinical practice from: life events (24%), debt (21%), relational problems (21%), change in employment (21%), change in financial status (21%), familial problems (19%), and death/injury to a friend/family member (12%), personal injury (11%), minor law violation (10%), and other. There were high correlations between distress and

	professional impairment due to life events and work factors, with relationship problems and working with difficult clients to be particularly troublesome.

Analysis of Theme 3: Psychological Distress. Both psychologists and their peers have identified psychological distress as a lifetime prevalent feature among this population, reaching from 10% to 74%. The types of correlations of psychological distress have been reported as: relational problems (oscillating from 11%–61%), job-related concerns (varying from 21%–72%), mental illness (3%), life span adjustment and events (16%–24%), personal and family physical illness (ranging from 4%–50%), diverse problems (varying from 7%–44%), legal problems (7%–10%), isolation (9%), financial (21%–33%), somatic complaints (ranging from 7%–43%), having a personal history with trauma and/or childhood trauma fluctuating from 4%–67%, exposure to others with trauma, and other unidentified problems (11%). Attributions of psychological distress led to depression (60%), substance use (52%), emotional exhaustion (43%), and sexual overtures (32.3%). The reported psychological distress affected their professional lives (36%), including patient care. The identified psychological distress has caused psychologists to seek out support services, such as personal therapy.

Theme 4: Burnout and Compassion Fatigue. The data set in Table 5 represents the demonstration in the professional literature that burnout and compassion fatigue are prevalent concerns among psychologists.

Table 5

Prevalence of Mental Illness and Psychological Distress, Burnout and Compassion Fatigue Data Set

Prevalence of Mental Illness and Psychological Distress, Burnout Data Set
Theme 4: Burnout and Compassion Fatigue

Researchers	Methods	Sample Size	Sample	Purpose and Findings
Farber & Heifetz (1982)	Mixed Methods: semi-structured interview, coded. And chi-squared analysis	N=60	Psychotherapists: psychiatrists (n=24), psychologists (n=21), social workers (n=15)	Focused on the phenomenon of therapist burnout. Their research found that 57% of therapists attributed the occurrence of burnout to the non-reciprocated attentiveness, giving, and responsibility demanded by the therapeutic relationship. Other factors included overwork (22%), difficulty of dealing with patient problems (20.4%), discouragement with the slow process of therapy (18.5%), the tendency of therapy to raise personal issues among therapists (13%), the passivity of therapeutic work (13%), and the isolation of the work (11.1%). Therapists reported feeling particularly burned out during winter months (40.8%) and a smaller amount in spring (16.3%) and summer (14.3%).
Freudenberger (1986)	Theoretical	No Sample	Literature	Reviewed literature on the symptoms and causes of burnout among psychologists. The research attributed burnout to the levels of dedication and commitment psychologists make to the profession. He reported that particularly

				vulnerable psychologists are those who work in free clinics, community settings, crisis-related intervention programs, group homes, and those who have high demand jobs. The researcher reported signs, such as difficulty in holding feelings, ease to anger, paranoia, omnipotence, high-risk behaviors, overconfidence, substance use, rigidity, cynicism, shows depressive-like symptoms, lacking work productivity, and increased hours at job.
Rupert & Morgan (2005)	Survey	*N*=571	Professional psychologists	The researchers argued that psychologists are at significant risk for burnout and examined the relationship between work setting and burnout. Their research found that female psychologists working in agency-employment settings are more likely to experience stress and burnout due to the less control they have over their work activities and having to deal with managed-care challenges. Male psychologists reported experiencing higher levels of emotional exhaustion in group independent practices. Emotional exhaustion was attributed to personal accomplishments and work satisfaction, as well as hours worked, pay, control over work activities, over-involvement with clients, paperwork, managed care, and difficulty of clients.
Rupert et al. (2009)	Survey	*N*=497	Psychologists	Researchers emphasized that burnout is multidimensional and other important risk factors to consider include: psychologists who feel in less control at work activities, work

				longer hours, spend more time doing administrative paperwork, see few direct pay clients, and deal with more negative client behaviors.
Smith & Moss (2009)	Review	No Sample	Literature	Psychologists indicated self-descriptions of burnout as a reaction to occupational demands, which included: negative client behaviors, paperwork, administrative duties, and non-work-related demands, such as relationship problems, financial strain, and secondary trauma.
Rupert et al. (2009)	Survey	N=497	Psychologists	Burnout is experienced differently based on gender and correlated to work environments. For example, women appear to be a greater risk for emotional exhaustion in agency settings and men appear to be a greater risk in group independent practice settings. Their research also found that conflict between work and family domains contribute to burnout. Higher work-family conflict and family-work conflict were associated with a lower sense of personal accomplishment, greater emotional exhaustion, and depersonalization of clients.
Farber & Heifetz (1982)	Mixed Methods: semi-structured interview, coded, & chi-squared analysis	N=60	Psychotherapists: psychiatrists (n=24), psychologists (n=21), social workers (n=15)	Found that 70% of psychologists reported burnout perceived as a function of constant attention and responsibility of the profession, as well as perceived lack of success. Approximately 80% reported disillusionment.
Bridgeman & Galper (2010)	Survey	N=658	Psychologists from APA membership	59% of psychologists reported feeling worried about burnout or compassion fatigue. 49%

			database	reported their issues were all in the past; 51% reported they were current challenges.
Linnerooth et al. (2011)	Theoretical	No Sample	Literature	Discussed challenges faced by clinical military psychologists, such as emotional trauma, occupational stress, vicarious experiences, and burnout, before, during, as well as after deployment. Argued that occupational hazards and professional demands impact psychologists' psychological distress leading to concerns, such as burnout and stress.
Bearse et al. (2013)	Survey	N=260	Professional psychologists	Identified burnout, vicarious traumatization, compassion fatigue, and countertransference as being major risk factors for those practicing in the field of mental health. Psychologists may be affected by the potentially graphic information they hear in their professional cases and potentially lose their empathy toward their patients, which in turn affects their responses to patient content when presented to them.

Analysis of Theme 4: Burnout and Compassion Fatigue. Approximately 49% to 59% of psychologists reported issues with burnout and compassion fatigue over the course of their lifetime, despite having a higher tolerance for such distress as compared to other professions. The following dimensions were related to the attributions of burnout and occupational hazards: non-reciprocated interpersonal dynamics in the therapeutic relationship (57%), workload (22%), various beliefs leading to lack of control of work activities (19%), transference (13%), complexity/difficulty of patients (20%), not seeing quicker progress (13%), the psychologists' level of commitment to their work, working in settings that have high demands and less

opportunities for consultation (11%), attention and responsibility of profession (70%), disillusionment (80%), as well as perceived therapeutic accomplishments, hours worked, conflict in the home, over-involvement with clients, paperwork, managed-care demands, agency types (e.g., private versus group practice), and administrative duties. Among psychologists, the identified gender and work settings (e.g., private practice versus agency) changed the individuals' susceptibility to burnout. Typical signs of burnout included emotional dysregulation, grandiosity, engaging in risky behaviors, paranoia, substance use, low work productivity, and increased working time. Work environments play a role in burnout among genders. Female psychologists are at particular susceptibility to burnout and compassion fatigue, working in an agency-employment setting and for men, working in independent practices. With compassion fatigue, the following variables were correlated causes: working with clients dealing with traumatic material, countertransference, prolonged exposure to source of stress, as well as feeling a lack of achievement and satisfaction with therapeutic work. Typical signs of compassion fatigue included experiencing traumatic recollections. Times of year were proposed to have varying levels of susceptibility to burnout, for example, winter months (40.8%) and a smaller amount in spring (16.3%) and summer (14.3%).

Theme 5: Impairment. The data set in Table 6 represents the demonstration in the professional literature that impairment is a prevalent feature of psychological distress and mental illness for psychologists.

Table 6

Prevalence of Mental Illness and Psychological Distress, Impairment Data Set

Prevalence of Mental Illness and Psychological Distress, Impairment Data Set Theme 5: Impairment				
Researchers	Methods	Sample Size	Sample	Purpose and Findings
Wood et al. (1985)	Survey	N=157	Academic and clinical psychologists	Licensed psychologists offered their opinions about the prevalence of personal distress and professional impairment among psychologists. They reported believing that impaired psychologists are a serious problem and that significant proportions were impaired. Researchers estimate that 15.2%–27% are practicing as impaired; of that, 7%–14% of the profession that has a problem is not seeking help. 42% of the sample offered help or referred an impaired practitioner to therapists, 7.9% reported such a colleague to governing institutions. They estimated that 52% of their colleagues (also psychologists) regarded their use as a serious problem and 40% of that group's work was impaired by their use.
Guy et al. (1989)	Randomized anonymous survey using a multiple discriminant analysis	N=318	Psychologists who are members belonging to APA divisions: 12 (clinical), 29 (psychotherapy), and 42 (independent-practitioners)	Examined personal distress and therapeutic effectiveness among practicing psychologists. 74.3 % of psychologist reported experiencing "personal distress" within three years and of those, 36.0% indicated that it negatively impacted their ability to give quality patient care. 4.6% admitted that it resulted in

				inadequate treatment.
Smith & Moss (2009)	Review	No Sample	Literature	The research found professional impairment among psychologists as a result of personal and professional functioning, such as mental illness, substance use, and burnout.
Skorina et al. (1990)	Semi-structured interviews	$N=70$	International Doctors in AA and Psychologists Helping Psychologists. All professional active: 41% in clinical or counseling, 23% in academic settings, and other in fields such as school and industrial. They identified as abstinent alcoholic psychologists.	Examined routes to recovery for alcoholic psychologists. Psychologists experienced relatively advanced, visible signs of alcoholism, causing impairment during working hours. None lost the privilege to practice or receive any disciplinary consequences; sanctions were rare and almost never combined with effective interventions.
Floyd et al. (1998)	Survey	$N=633$	Psychologists	Researchers sought to identify the percentage of psychologists who are or were impaired by either a psychological condition or substance use and give examples of such impairment. Psychologists estimated that 10% of colleagues were currently impaired in their ability to practice due to psychological conditioning and 9% were impaired as a result of substance use. Psychologists identified that 15% of their colleagues were impaired in the past due to psychological reasons and 13% due to substance use. 75% of psychologists agreed that the following characteristics are evidence of impairment: alcohol on breath during working hours, frequent intoxications at social functions, erratic mood swings, excessive use of sick time,

				complaints about professional performance, and gossip.
Sherman & Thelen (1998)	Survey	N=522	Practicing psychologists	Set out to examine the nature and extent of distress and impairments due to work factors and life events among psychologists. There were high correlations between distress and professional impairment among psychologists in clinical practice as a result of life distress, stressful life events, life occurrence, and work distress. Women reported significantly greater distress and impairment regarding work factors than men.
Bridgeman (2006)	Review	No Sample	Literature	Discussed prevalence of impaired psychologists. The researcher identified the rate of impairment as approximately 60%.
Bridgeman & Galper (2010)	Survey	N=658	Psychologists from APA Membership database	Psychologists reported an assortment of concerns, which included psychiatric illness, psychological distress, burnout, and compassion fatigue. In addition to this, 63% of psychologists were concerned about the safety of the patient due to the worries with professional and personal challenges. 49% reported their issues were all in the past, 51% reported they were current challenges.
Coster & Schwebel (1997)	Interview & Questionnaire	N=339	Licensed psychologists	26% of psychologists endorsed professional impairment currently and in the past.
Good et al. (2009)	Theoretical	No Sample	Literature	The researchers examined wellness and impairment among psychologists. They argued that psychologists' level of functioning changes on a continuum and those changes can be impacted by the professional demands causing impairment.

Analysis of Theme 5: Impairment. Impairment is a prevalent theme of psychological distress among psychologists, ranging from 4.6% to 63% over the course of their lifetime. Both the impaired psychologists and their colleagues (ranging from 8% to 15%) have observed such impairment. Approximately 8% of psychologists report their colleagues to governing institutions. Despite identified impairment, 4.6% to 14% of psychologists continue to operate in professional settings. This impairment fluctuates and sits on a continuum. Substance use (9% to 13%), psychological conditions (10%), and work factors among psychologists seem to be closely linked to impairment. Female psychologists may be more susceptible to impairment at work than male psychologists.

Final Synthesis to the Prevalence of Mental Illness and Psychological Distress Among Psychologists

There is a prevalence of mental illness and psychological distress among psychologists. The following themes were found within the domain of lifetime prevalence of mental illness and psychological distress among psychologists: psychiatric disorders reported reaching at approximately 81%, substance use (primarily ethanol) vacillating from 1% to 70%, psychological distress ranging from 10% to 74%, impairment varying from 4.6% to 63%, as well as burnout and compassion fatigue found stretching from 49% to 80%. Most, if not all, of these findings were based on self-reported diagnosis/analysis by either the psychologist in question or their colleague. In some subthemes, gender plays a role in severity, prevalence, and susceptibility. For example, Male psychologists' ideations were found to be similar to males in the general public; however, female psychologists have a three times greater risks than females in the general population. In comparison to male and female psychologists, females have higher symptomology and severity of symptoms. Within a psychologists' sample pool, male

psychologists are more likely to successfully commit suicide than female psychologists. Gender differences were found, demonstrating that work environments also play a significant role to burnout among genders, as female practitioners reported higher levels of compassion fatigue and burnout in agency settings than male practitioners; however, male psychologists showed higher levels in private practice settings. There are signs and susceptibilities to mental illness and psychological distress of which psychologists should be wary, such as relational problems (oscillating from 11% to 61%), job-related concerns (varying from 21% to 72%), mental illness (3%), life span adjustment and events (16% to 24%), personal and family physical illness (ranging from 4% to 50%), diverse problems (varying from 7% to 44%), legal problems (7% to 10%), isolation (9%), financial (21% to 33%), somatic complaints (ranging from 7% to 43%), having a personal history with trauma and/or childhood trauma (fluctuating from 4% to 67%), exposure to others with trauma, other unidentified problems (11%), depressive-type disorders that included symptoms such as isolation and loneliness (9%), mood dysregulation, relationship dissatisfaction (11%), somatic illness (10%), hopelessness/helplessness, and suicidal ideation (varying from 18% to 29%). Female psychologists appeared to be more susceptible to impairment then males. The next domain will identify the barriers that impact psychologists from acquiring appropriate intervention services for their reported prevalence of mental illness and psychological distress.

Barriers Psychologists Face When Accessing Mental Health Treatment

As documented by the literature, psychologists are facing a plethora of barriers when seeking mental health care. Mental health treatment barriers for psychologists are considered impediments in the process to accessing mental health care when in need of treatment. This

domain seeks to identify barriers psychologists are experiencing when trying to access mental health care. Themes of these barriers are listed and then synthesized for analysis.

       Theme 1: Denial. The data set in Table 7 represents the literature on denial as a barrier for psychologists in accessing mental health care.

Table 7

Barriers, Denial Data Set

Barriers, Denial Data Set Theme 1: Denial				
Researchers	Methods	Sample Size	Sample	Purpose and Findings
Skorina (1982)	Theoretical	No Sample	Literature Review	Discussed the urgent need for the profession to effectively address impaired psychologists as a result of alcoholism. The researcher speaks to the barriers psychologists faced, which included: denial, the myth of invulnerability with an underlying fear of impairment/helplessness, and involvement in herculean tasks to overcompensate for substance use.
Guy et al. (1989)	Randomized anonymous survey using a multiple discriminant analysis	N=318	Psychologists who are members belonging to APA divisions: 12 (clinical), 29 (psychotherapy, and 42 (independent-practitioners)	Examined personal distress and therapeutic effectiveness among practicing psychologists. Despite the researchers finding high levels of distress among psychologists, they denied it impacting their work quality. Individuals may have denied its impact because of insecurity regarding professional competency. Psychologists struggling with denial is a major role of their psychological distress (e.g., substance abuse) and

				negatively impacts their professional work. Finally, the authors argue that the use of research that is guided by self-reported surveys from psychologists creates circumstances for under-reporting, response biases, vague responses, ambiguous interpretation, incorrect estimates to psychologists' functioning level.
Skorina et al. (1990)	Structured Interview	N=70	International Doctors in AA and Psychologists Helping Psychologists. All professional active: 41% in clinical or counseling, 23% in academic settings, and other in fields such as school and industrial	Examined routes to recovery for alcoholic psychologists. Psychologists underestimated and struggled to recognize psychiatric disorders such as alcoholism, in their colleagues as well as in themselves. The researchers linked this unawareness to the lack of them receiving formal and effective interventions. There was an assumption that their intelligence and professional education could protect them against mental illness.
Barnett & Hillard (2001)	Survey	N=59	State and provincial psychological associations (SPPAs)	Investigated colleague assistance programs available among SPPAs, as well as prevention, identification, and rehabilitation practices. Researchers found that psychologists were concerned about negative consequences in receiving help for impairment. There is a denial and minimization of one's distress impeding their ability to detect personal wound.
Good et al. (2009)	Theoretical	No Sample	Literature	The researchers examined wellness and impairment among psychologists. They identified denial and lacking awareness of shortcomings regarding mental health as a human response, but is especially of concern with psychologists because these characteristics are amplified. Researcher argued this susceptibility is due to psychologists viewing wellness and

				impairments in dualistic perspectives; there is "denial, shame and reluctance to seek professional assistance" (p. 21) that is then hindering their ability to identify impairment.
Smith & Moss (2009)	Review	No Sample	Literature	Argued that few colleagues intervene after becoming aware of colleague impairment, there is no supporting literature that indicates psychologists are effective at identifying impairments, however rely heavily on colleague and self - identification; findings indicate psychologists lack the knowledge to do so, they fail to identify impairment in themselves. They reported that psychologists have difficulty differentiating the "margin between their colleague's distress and impairment" (p. 5).
Practice Central (2010)	Review	No Sample	Theoretical	Psychologists are trained to help patients with their various presented problems, psychologists are at risk of disregarding their own stress levels until it becomes damaging to their health and practice.
Bridgeman & Galper (2010)	Survey	N=658	Psychologists from APA membership database	Identified the following barriers to using colleague assistance or other self-care activities as: 43% of psychologists minimized or denied issues, 40% experienced shame/guilt, 30% worried about what could happen, and 29% feared loss of professional status.
O'Connor (n.d.)	Theoretical	No Sample	Literature	Discussed a plethora of reasons as to why intervening with an impaired colleague is so stressful. Some of the reasons identified as stressful, which included personal failings, are not often discussed, fostering the myth of denial and psychologists having to suppress their personal concerns or problems.

Firmin et al. (2012)	Survey	*N*=260	College psychology students	While the sample reported perceptions of psychologists as being competent and professional, it demonstrated that there are stereotypes and constructs of psychologists from the general public and professional community as it relates to perceived mental health status. This information, too, suggested that despite psychologists reporting traits of psychiatric disorders, psychologists are able to publicly display a professional identity that does not depict a need for mental health help, although this identity is false.
Kleespies et al. (2011)	Literature Review & Semi-structured interview	*N*=14	Unpublished data from the National Institute of Occupational Safety and Health & CPA members	Examined suicide among psychologists: its impact, incidence, and suggestions for preventions and intervention. Found that psychologists who had been a colleague to a psychologist who committed suicide identified as not foreseeing suicide as possibility among their colleagues and struggled to identify the level of impairment they were facing.

Analysis of Theme 1: Denial. Approximately 43% of psychologists struggle to see the presentation of mental illness and psychological distress within themselves. Denial of such distress is highlighted as an obstacle to insight. When psychologists recognize that they have any possible mental illness, the issue is likely to generate shame, denial, and reluctance among their personal and professional identities. Denial appears to work as a way for psychologists to avoid dealing with the shame that comes with awareness of the identified mental illness or psychological distress (40%). Thirty percent of psychologists experience amplified shame around having psychological problems suggesting incompetence due to pressures from the psychological profession, thus supporting beliefs that psychologists are or should be immune to

mental illness. Many seem to lack awareness of the benefits of treatment. Denial appears to not only apply within themselves, but also toward their colleagues.

Theme 2: **Lack of Education and Prevention.** The data set in Table 8 represents the demonstration in the professional literature that there is a lack of information on education and prevention of mental health awareness and psychological health, which presents as another barrier for psychologists in accessing mental health care.

Table 8

Barriers, Lack of Education and Prevention Data Set

Barriers, Lack of Education and Prevention Data Set Theme 2: Lack of Education and Prevention				
Researchers	Methods	Sample Size	Sample	Purpose and Findings
Smith & Moss (2009)	Review	No Sample	Literature	Argued that although psychologists are able to conduct research, educate, intervene, and offer preventative measures for their clients, they are not as vigilant on providing similar care for themselves. Argued that the research for and on the impaired professional is "sparse at best" (p. 4) and stated that psychologists lack the knowledge of how to appropriately intervene with an impaired colleague. There are deficiencies in psychology training programs and program directors hold responsibilities to prevent impairment. Researchers also argued that APA has not mandated coverage of impairment and wellness during training as criteria for accreditation.

O'Connor (2001)	Review	No Sample	Literature	Examined the effective management of professional distress and impairment among psychologists. The research suggested that there was need to improve the effectiveness for both the consumer and the psychologists. They argued that little training is offered to psychologists in the management of personal difficulties, available resources, or how that impacts the patients they treat.
Bridgeman & Galper (2010)	Survey	N=658	Psychologists from APA membership database	30% identified not knowing about available resources as a barrier to colleague assistance or self-care activities.
O'Connor (n.d.)	Theoretical	No Sample	Literature	Discussed a plethora of reasons as to why intervening with an impaired colleague is so stressful. Some of the reasons identified as stressful included: personal failings are not often discussed and there are concerns with not knowing the most effective way to intervene with an impaired colleague.
Schwebel & Coster (1998)	Surveyed	N=107	Heads of APA-approved programs	In efforts to learn views on well-functioning psychologists, program heads found lack of programmatic efforts to develop means to prevent impairment and suggested ways to improve education about well-functioning and impairment prevention, however saw lack of time and space in the curriculum, as well as a lack of funding as significant obstacles. They projected that in order for more education to be incorporated into the curriculum, it would have to be mandated and funded.

Analysis of Theme 2: Lack of Education and Prevention. Psychologists lack the needed education and prevention tools to better identify prevalence of mental illness and psychological distress. Contributions to the lacking education and prevention were attributed to limited research on prevention and ways to effectively intervene, as well as deficiencies in educating

young psychologists.

  Theme 3: Keeping Secrets. The data set in Table 9 represents the literature on how

psychologists' keeping secrets can be a barrier for psychologists to accessing mental health care.

Table 9

Barriers, Keeping Secrets Data Set

Barriers, Keeping Secrets Data Set Theme 3: Keeping Secrets				
Researchers	Methods	Sample Size	Sample	Purpose and Findings
Pope & Tabachnick (1994)	Survey	*N*=476	Psychologists randomly selected from APA divisions	Identify thematic reports of shame and secrecy among the profession as it relates to possible mental illness. For example, 1 out of 5 psychologists withhold important information from their therapists due to fear of sensitive information breaching confidentiality.
Barnett & Hillard (2001)	Survey	*N*=59	State and provincial psychological associations (SPPAs)	Investigated colleague assistance programs available among SPPAs, as well as prevention, identification, and rehabilitation practices. Researchers found that psychologists were concerned about negative consequences in receiving help for impairment that would minimize one's distress. They believed the consequences of admitting to distress or impairment may result in embarrassment, loss of status, loss of friends, loss of clients, and fears that reports will be

				made to state licensure boards and possibly result in a restricted or lost license.
Gilroy et al. (2002)	Survey		*N*=425	Psychologists from the APA Counseling Psychology Division	Psychologists who self-identified with being depressed indicated the major reason for not seeking treatment was due to confidentiality concerns.
Thomas (2005)	Review		No Sample	Literature	Examined licensing board complaints and how psychology minimizes the impact it has on the profession. Psychologists face a wide range of responses to being deemed impaired, which include terror, guilt, embarrassment, anger, worry, and depression.
Smith & Moss (2009)	Review		No Sample	Literature	Argued that although psychologists are able to conduct research, educate, intervene, and offer preventative measures for their clients, they are not as vigilant on providing similar care for themselves. More specifically, psychologists may perceive that intervening with an impaired colleague would lead toward being confronted with one's own flaws.
Practice Central (2010)	Review	Survey	No Sample	Literature	Psychologists are at risk of disregarding their own stress levels until it becomes damaging to their health and practice. For example, 14% of psychologists who reported suicidal ideation did not tell anyone about their mental health concerns; this included their therapist.
Bridgeman & Galper (2010)	Survey		*N*=658	Psychologists from APA membership database	Identified the following obstacles to getting help for distress: confidentiality concerns (43%), shame/guilt (40%), worry about what could happen (30%), fear of loss of professional status (29%),

				and inadequate social support (27%).
O'Connor (n.d.)	Theoretical	No Sample	Literature	Discussed a plethora of reasons as to why intervening with an impaired colleague is so stressful. Some of the reasons identified as stressful included: personal failings are not often discussed, fostering the myth of denial; psychologists have to suppress their personal concerns or problems; psychologists' tendency to value independent thought/action, making atypical behavior more difficult to discern; and concerns about how a colleague's impairment may reflect on the profession.

Analysis of Theme 3: Keeping Secrets. Another barrier that psychologists face is their secretive behaviors regarding their mental health and psychological distresses. One in five psychologists withholds information about their mental illness and psychological distress. They are fearful of the consequences they will experience if these secrets are exposed. Reported consequences included: embarrassment, shame/guilt (40%), inadequate social support (27%), terror, anxiety, fear, being seen as a personal failing, confidentiality breaches, receiving a negative reputation for himself or herself and the profession, as well as possible negative effects on licensing status (30%).

Theme 4: Institutions of Psychology. The data set in Table 10 represents the literature of how institutions of psychology have created barriers for psychologists' access to mental health care.

Table 10

Barriers, Institutions of Psychology Data Set

Barriers, Institutions of Psychology Data Set Theme 4: Institutions of Psychology				
Researchers	Methods	Sample Size	Sample	Purpose and Findings
Laliotis & Grayson (1985)	Review & Quantitative Survey	$N=50$	State examining boards of psychology	Surveyed licensing states to determine what regulations exist for handling psychologists' impaired situations. Research found that there were no states in the mid 1980s that had programs for impaired psychologists. A number were in the process of developing some. Guidelines were offered.
Floyd et al. (1998)	Survey	$N=633$	Licensed psychologists	Researched psychologists' knowledge and utilization of a state association colleague assistance committee (SACAC) when experiencing an impaired colleague. Their research found that psychologists seem to be unaware of many aspects of SACAC programs and policies, despite the association's ongoing efforts.
Barnett & Hillard (2001)	Survey	$N=59$	State and provincial psychological associations (SPPAs)	Investigated colleague assistance programs (CAPs) available among SPPAs, as well as prevention, identification, and rehabilitation practices. Between 1998-1999, 69% of SPPAs reported not having colleague assistance programs for distressed or impaired psychologists in their jurisdiction. Of these, 24% reported having no formal program available in the past. Common reasons reported included: lack of use (70%), risk of liability too great (10%), lack of volunteer support (10%), and unknown (10%). 60% of

these programs reported no intention of creating a program in the future and 54% reported that there was no need for such implementations. They found major implications of barriers from their findings:
(a) There is a strong need for CAPs; however, because they are not used, there is a perception that psychologists do not benefit from CAPs; (b) there are limited CAPs available; (c) psychologists feel more comfortable seeking private assistance from those who specialize in treating impaired psychologists; (d) fears that reports will be made to state licensure boards and possibly result in a restricted or lost license; (e) not all SPPAs have the same resources available to them, e.g., larger SPPA CAPs have more resources available to them than smaller ones; and (f) there are no established and effective models that conceptualize the development and refinement of CAPs for other SPPA groups who may want to develop one and do not have the insight or resources to do so.

Thomas (2005)	Review	No Sample	Literature	Examined licensing board complaints and how psychology minimizes the impact it has on the profession. Licensing board complaints affect psychologists' concurrent and future ethical work. Researchers argued that ethical committee boards, such as the American Psychological Association, are set up to help psychologists function within the profession, and their focus on harm avoidance is geared toward the client, therefore neglecting the psychological needs of the psychologists.
O'Connor (2001)	Review	No Sample	Literature	Examined the effective management of professional distress and impairment among psychologists. The research suggested that there was need to improve the effectiveness for both the consumer and the

psychologists to use colleague assistance programs. The researcher argued that current policies regarding distress and impaired practitioners are inconsistent and incomplete. They argued that little training is offered to psychologists in the management of personal difficulties, available resources, or how that impacts the patients they treat. Instead, interventions are focused on code enforcement rather than preventative efforts, e.g., there is an emphasis on code enforcement and punishment over primary prevention, as they do not see a way to help the practitioner in the process. The researcher also argued that there was a lack of systemic assessment to the identified impaired psychologists and their extent of disability, as well as determining the appropriateness of treatment or likely success of treatment to the rehabilitation programs that psychologists would be referred to.

Smith & Moss (2009)	Review	No Sample	Literature	The research is limited on the utilization and outcome of colleague assistance interventions among impaired and distressed psychologists. The researchers blame this on the lack of formal programs and research on effectiveness of existing programs. Researchers argued that ethical guidelines become ambiguous to address and psychologists rationalize their concerning behavior by differentiating the "margin between their colleague's distress and impairment" (p. 5). Researchers argued that within APA, there is a lack of impairment prevention in the psychology profession, e.g., training programs.
Good Et al(2009)	Theoretical	No Sample	Literature	The researchers examined wellness and impairment among psychologists. They argued that it is "unreasonable to expect licensing

				boards to create professional renewal services" (p. 22), as their mission is to protect the public from unethical professionals. They also stated that it is unlikely that colleague assistance programs and psychological associations will increase their services, because they do not have enough funding, there is limited utilization when they are offered, and these services are of low priority.
Bridgeman & Galper (2010)	Survey	*N*=658	Psychologists from APA membership database	Identified the following barriers to using colleague assistance programs or other self-care activities: confidentiality concerns (43%), financial constraints (33%), not knowing about available resources (31%), worry about what could happen (30%), and fear of loss of professional status (29%). The researchers found the following reasons for greatly diminished well-being: economic uncertainty (31%), conflicts with boss/supervisor (29%), possibility of complaints by clients or students (24%), physical health (21%), and legal issues (21%).
Zur (2014)	Review	No Sample	Literature	Compared ethical codes among divisions of mental health practitioners (e.g., social workers, psychologists, psychiatrists, etc.) when addressing burnout and self-care. The researcher argued that reviewing the codes of ethics serves as a type of proof that the practice of psychotherapy alone poses hazards to practitioners, as well as demonstrating that ethics boards focus on the interventions for clients, not practitioners.

Analysis of Theme 4: Institutions of Psychology. Psychological institutions, such as licensing boards, ethical boards, and state provincial psychology associations, have created barriers for psychologists to access mental health. Psychological associations and colleague

assistance programs were found to be new to the profession; for example, approximately 31% of states did not have colleague assistance programs by 2000. Psychologists utilizing programs such as these found the programs to be unaccommodating and reactive versus preventative, lacking depth in understanding the mental health needs of psychologists. Psychologists have limited accessibility to these programs (31%). Ten percent often associated these programs with code/ethical reinforcement to protect the public against unethical psychologists; psychologists also noted financial constraints (31%) and that these programs were of low priority for the profession. Additionally, ethical codes pose hazardous to practitioners, demonstrating that the focus of intervention is for the client, not practitioners. Codes of conduct generally rely on psychologists to recognize their psychological distress and compromising impairment and seek mental health treatment. Psychologists see greater threat in exposing psychological distress, such as compromising licensure status and loss of professional status, varying from 29% to 43%. Finally, there is concern as to whether the current interventions in place are effective, as there has been little empirical evidence to support them.

Theme 5: Lacking Evidence-Based Research on Psychologists. The data set in Table 11 represents the demonstration in the professional literature that the lack of research on this population has served as a barrier for psychologists accessing mental health care.

Table 11

Barriers, Lacking Evidence-Based Research on Psychologists Data Set

Barriers, Lacking Evidence-Based Research on Psychologists Data Set Theme 5: Lacking Evidence-Based Research on Psychologists				
Researchers	Methods	Sample Size	Sample	Purpose and Findings
Guy et al. (1989)	Randomized anonymous survey using a multiple discriminant analysis	N=318	Psychologists who are members belonging to APA divisions: 12 (clinical), 29 (psychother-apy), and 42 (independent-practitioners)	Discussed concerns about the use of research that is guided by self-reported surveys from psychologists as they likely lead to under-reporting and response biases that occur despite its anonymous nature. It can also lead to vague responses, leaving it open to interpretation, incorrect estimates, and/or psychologists' functioning level.
O'Connor (2001)	Review	No Sample	Literature	Examined the management of professional distress and impairment among psychologists. The research suggested that there was need to improve the effectiveness for both the consumer and the psychologists to use colleague assistance programs. One of the barriers includes problems with the current empirical data, that is, limited research on psychologists' mental health as it relates to distress and impairment, which has included limited sample size, the use of self reports and other methodologies, and contradictory findings.
Smith & Moss (2009)	Review	No Sample	Literature	Argued that the research for and on the impaired professional is "sparse at best" (p. 4) and stated the research is limited on the utilization and outcome of colleague assistance interventions among psychologists

				and related to the lack of formal programs and the lack of research on the effectiveness in existing programs.
Bridgeman & Galper (2010)	Survey	N=658	Psychologists from APA membership database	Identified the following as some of the barriers for psychologists to access mental health care, e.g., using colleague assistance or other self-care activities. They found that there was little current information available on psychologists' use of self-help strategies and the barriers they face.
Kleespies et al. (2011)	Literature Review	No Sample	Unpublished data from the National Institute of Occupational Safety and Health	Examined suicide among psychologists: its impact, incidence, and suggestions for preventions and intervention. They argued that psychologists have not been included in occupational categories in epidemiological studies that examine psychiatric illness within professions as they have among physicians, dentists, nurses, etc.

Analysis of Theme 5: Lacking Evidence-Based Research on Psychologists. Evidence-based research on psychologists' mental illness, psychological distress, and impairment is lacking in the literature, both within the profession and among epidemiological categories. The research that does exist presents concerns of validity and reliability based on the methodologies used; for example, the use of self-reports and sample size create ambiguity of prevalence. There is also a need to study the effectiveness of mental health programs and how well they are working for psychologists.

Theme 6: Avoidance and Lacking a Culture of Support. The data set in Table 12 represents the demonstration in the professional literature that psychologists exist in a professional culture that has a lack of support and avoids collegial distress, causing a barrier for psychologists attempting to access mental health care.

Table 12

Barriers, Avoidance and Lacking a Culture of Support Data Set

Barriers, Avoidance and Lacking a Culture of Support Data Set Theme 6: Avoidance and Lacking a Culture of Support				
Researchers	Methods	Sample Size	Sample	Purpose and Findings
Skorina (1982)	Theoretical	No Sample	Literature Review	Discussed the urgent need for the profession to effectively address impaired psychologists. The researcher spoke to the barriers psychologists faced, which included a myth of invulnerability to impairment or helplessness among psychologists. The researcher argued that protecting this myth has been solidified by collegial dynamics in having a strong consensual agreement to not interfere with another colleague's professional facets.
Skorina et al. (1990)	Structured Interview	*N*=70	International Doctors in AA and Psychologists Helping Psychologists. Professionally active: 41% clinical/`counseling, 23% academia, & other	Examined routes to recovery for alcoholic psychologists. Psychologists avoided, "carefully left alone" (p. 25), lied, and missed several opportunities to intervene with impaired and psychologically distressed psychologists, despite visible impairment. 36% of the 33% chose to confront their impaired colleagues and most were ineffective, though it was not identified why. They attributed reluctance to confront as a result of denial, conspiracy of silence, and misguided protectiveness toward one's self.

Good et al. (1995)	Descriptive Survey	*N*=393	APA Counseling Psychology Division 17 members	Surveyed counseling psychologists examining their past and current substance use, identification and confrontation of impaired psychologists, life satisfaction, work stress, and psychological distress. Respondents who believed their colleague had a substance abuse problem and did not confront their colleague listed the following reasons as why: lacking tangible evidence (53%), the abuse was not detrimental to their job performance (42%), and concerns that the confrontation would not improve the situation (39%).
Floyd et al. (1998)	Survey	*N*=633	Licensed psychologists	Researched psychologists' knowledge and utilization of a state association colleague assistance committee (SACAC) when experiencing an impaired colleague. They equated colleague reluctance to confront an impaired colleague due to confusions between collegial relationships and uneasiness to colleague assistance in general. For example, personal vulnerability, fear of retaliation, denial or one's own impairment, or family origin issues.
O'Connor (2001)	Review	No Sample	Literature	Examined the etiology and effective management of professional distress and impairment among psychologists. The researcher found problems related to the professional role, which included practitioners often working in isolative environments with limited resources and control over their outcomes. They also found that psychologists distance

				themselves from a colleague who is showing signs of distress and impairment.
Smith & Moss (2009)	Review	No Sample	Literature	Argued that although psychologists are able to conduct research, educate, intervene, and offer preventative measures for their clients, they are not as vigilant on providing similar care for themselves. Research highlighted major points in their review: There is no supporting literature that indicates psychologists are effective at identifying impairments, however, they rely heavily on colleague and self-identification; findings indicate psychologists lack the knowledge to do so. Their research found that psychologists may perceive that intervening with an impaired colleague would negatively affect their relationship and lead toward undesirable risks, i.e., termination, loss of license, fear of litigation, fear of being confronted with one's owns flaws. They also are unaware of the benefits of treatment.
Bridgeman & Galper (2010)	Survey	N=658	Psychologists from APA Membership database	Identified barriers to using colleague assistance programs or other self-care activities. They emphasized needing to reduce stigma associated with psychologists acknowledging and accessing support.
Good et al. (2009)	Theoretical	No Sample	Literature	The researchers examined wellness and impairment among psychologists. The researchers identified isolation as a professional hazard for psychologists. They found that psychologists generally conduct most of their professional tasks in isolation and have limited

time as well as support from colleagues that can help them navigate the psychological distress and professional hazards. They also discussed how psychologists cannot rely on their colleagues to challenge or have a strong reaction to distress/impairment among their colleagues. They reported this being due to ignoring the signs, avoiding engaging in behaviors to minimize and manage the identified problem/impairment, which also means identifying problems within the identifier and a willingness to seek treatment when they too are faced with impairment.

Analysis of Theme 6: Avoidance and Lacking a Culture of Support. One of the barriers psychologists face in accessing mental health care is facing a professional culture that lacks a supportive disposition. Psychologists lack support from the profession due to a strong consensual agreement to not interfere with a colleague's mental health, as well as a reluctance to intervene when they identify distress toward impairment, and their work being isolative in nature. Psychologists avoid signs of mental illness, psychological distress, and impairment within themselves and among their colleagues. Psychologists avoid both the visible signs and contact with impaired psychologists. Some researchers suspect this is due to a desire to protect psychologists and elements of denial. There are also concerns that such intervention will not improve the distressed psychologists (39%). Psychologists foresaw consequences for intervening, which included fear of retaliation and personal vulnerability. Psychologists cannot rely on colleague interventions to help improve their distress, as there is a lack of supportive evidence that colleagues are effective at intervening.

Theme 7: Limited Opportunities for Psychotherapy. The data set in Table 13

represents professional literature that observes that limited opportunity for psychotherapy can be

a barrier for psychologists accessing mental health care.

Table 13

Barriers, Limited Opportunities for Psychotherapy Data Set

Barriers, Limited Opportunities for Psychotherapy Data Set Theme 7: Limited Opportunities for Psychotherapy				
Researchers	Methods	Sample Size	Sample	Purpose and Findings
Mahoney (1997)	Survey	*N*=155	Psychotherapy practitioners: respondents earned degrees of either a masters (48%), doctorate (46%), or bachelors (6%).	Researched psychotherapists' personal problems and self-care patterns. For psychologists, findings indicated cost (41.3%) and accessibility (32.3%) as the most frequently noted barriers to getting personal therapy.
Good et al. (2009)	Theoretical	No Sample	Literature	The researchers examined wellness and impairment among psychologists and argued that psychologists' insufficient income can be a barrier for many psychologists.
Gilroy et al. (2002)	Survey	*N*=425	Psychologists from the APA Counseling Psychology Division	Psychologists who self-identified with being depressed indicated the major reason for not seeking treatment was due to confidentiality concerns.
Bearse et al. (2013)	Survey	*N*=260	Professional psychologists	Investigated the frequency of various stressors they are impacted by and experience when seeking

mental health services. Found psychologists are open to seeking psychotherapy and usually find it useful when they do; however, there were factors that deterred them from doing so. Psychologists' greatest barrier to seeking mental health treatment was the inability to find an acceptable psychotherapist, as well as difficulty in making the time needed for treatment. The financial strain was also a potential deterrent, depending on the professional stage and maturity of the psychologist. Female psychologists reported higher rates of deterrents to seeking psychotherapy, indicating challenges with money, time, and finding an acceptable therapist. Despite obstacles, more women than men tend to participate in therapy. Neither professional nor personal stigma was seen as being a reason to create obstacles for psychologists to access mental health care.

Analysis of Theme 5: Limited Opportunities for Psychotherapy. Another barrier for psychologists to access mental health care is those obstacles found when attempting to participate in personal psychotherapy. The following areas are obstacles for psychologists: funding, not finding an acceptable therapist, lacking time, the financial strain, and limited accessibility.

Final Synthesis to the Barriers Psychologists Are Facing When Dealing With Psychological Distress and Trying to Access Treatment

There are at least seven dominant barriers in place that create obstacles for psychologists to access appropriate and effective mental health services. The following barriers were found: psychologists have limited insight, the field is lacking education and prevention strategies,

psychologists are keeping distress secretive, institutions of psychology are generally

unsupportive to distressed psychologists and utilize reactive interventions versus preventative

ones, the field is lacking evidence-based research on psychologists' distress as well as

interventions that are currently used to remediate such stress, there is a developed culture that

encourages a lack of support and avoidance in dealing with psychological distress, and there are

identified limitations for psychotherapy. The next domain will identify the suggested

interventions for psychologists experiencing mental health distress and psychological

impairment.

Current Literature on Suggested Interventions for Psychologists Experiencing Mental Health Distress and Psychological Impairment

This section highlights the suggested remediation for clinical psychologists to better

access appropriate mental health care. In the section, I highlight suggested remediation to

barriers for psychologists to access mental health care. This section concludes with a final

synthesis bringing together the themes found in this domain.

Theme 1: Educating and Increasing Awareness. The data set in Table 14 represents

the suggested need of increasing education and awareness to help remediate barriers found when

accessing mental health care.

Table 14

Suggested Interventions for Psychologists Experiencing Mental Health Distress and Psychological Impairment, Educating and Increasing Awareness Data Set

Suggested Interventions for Psychologists Experiencing Mental Health Distress and Psychological Impairment, Educating and Increasing Awareness Data Set
Theme 1: Educating and Increasing Awareness

Researchers	Methods	Sample Size	Sample	Purpose and Findings
Wood et al. (1985)	Survey	N=167	Academic & clinical psychologists	Examined the perception of psychologists' opinions on prevalence and their recommended interventions for impaired practitioners. Researchers found that training received in ethics courses during graduate training years increased the likelihood of intervening with an impaired colleague and seeking help.
Thoreson et al. (1989)	Survey: Psychologist Health Questionnaire (PHQ)	N=379	Psychologists from Midwestern state psychological association	Examined the prevalence of distress among psychologists and treatment considerations. Treatment recommendations for distressed psychologists included: (1) promoting good health (being free of physical illness, not smoking, drinking in moderation, exercise regularly); (2) recognizing the multi-facets of distress and underlying issues that it is associated with; and (3) increasing awareness with substance use and its impact.
Skorina et al. (1990)	Structured Interview	N=70	International Doctors in AA and Psychologists Helping Psychologists. Professionally active: 41% in	Examined routes to recovery for alcoholic psychologists. Psychologists received effective recovery from non-formal interventions and treatments. Researchers suggested that psychologists do, at times,

			clinical/counseling, 23% in academic settings, and other in fields such as school and industrial	recognize impairment in their colleagues, and to overcome barriers of not intervening requires an awareness of the prevalence of mental illness and psychological distress among psychologists, as well as the confidence to recognize that intervention and treatment work when suggested; "psychologists must do better for one another" (p. 251).
Pope & Tabachnick (1994)	Survey	N=476	Psychologists randomly selected from APA Divisions	Researchers argued the need for training programs to put more emphasis on increasing awareness and insight to psychiatric and psychological illness, such as depression and suicidal ideation. They proposed that psychologists-in-training need more education on recognizing and responding to the onset of "depression, assurance that such experiences are not inherently discordant with professional identity, opportunities to discuss how to fulfill the ethical responsibility" (p. 255) and ways of engaging in professional roles as such while avoiding harm.
O'Connor (2001)	Review	No Sample	Literature	Examined effective management of professional distress and impairment among psychologists. Intervention strategies were suggested to continue to increase education related to distress and impairment and the possible predispositions that impact a clinician.
Coster & Schwebel (1997)	Interview and Questionnaire	N=345	Licensed psychologists	The researchers argued that the issue of impairment is primarily a deficiency in using adequate coping resources to deal with the stressors overwhelming the psychologists. They found

				multiple themes that help facilitate well-functioning aspects of professional psychologists, which included having an affiliation with a graduate program. They argued this relationship offered a culture of cooperation, building confidence, helping to develop skills to solve professional problems, and causes one to be in roles of leadership.
Sherman & Thelen (1998)	Survey	N=522	Practicing psychologists	Set out to examine the nature and extent of distress and impairments due to work factors and life events among psychologists. The researchers argued for training programs to be more proactive in preparing trainees for coping effectively with distress and impairment. They suggested education on the matter to be included in mandatory workshops, addressing the topic in professional issues or ethics courses, instituting discussion in clinical practicum sequence, as well as ongoing informal discussions between faculty and students.
Schwebel & Coster (1998)	Surveyed	N=107	Heads of APA-approved programs	Researches well-functioning in professional psychologists as a program head understands it. Program heads proposed the following changes: require therapy, have ongoing support groups, participate in ongoing direct supervision and feedback, incorporate course content-curriculum and professional issues, and ethics training, including training on impairment. Additionally, the following interventions need to be made: student selection processes should screen out students "unhealthy" (p. 290) who may not be able to handle

| | | | | the stress of graduate school, revise course curricula to incorporate the development of well-functioning psychologists, find common purpose in the diversity of students and faculty, faculty stay involved in both academics and practitioner roles, and faculty role model to students through reorientation to the transformation of becoming a psychologist. Program heads proposed in order for change to occur, education on impairment prevention would need to be mandated and funded. |
| APA (2006) | Theoretical | No Sample | Monograph | Developed a monograph to aid licensing boards in developing and providing adequate colleague assistance to distressed or impaired psychologists. Their hopes are to provide contextual understanding to psychologists' competence problems and provide strategies from a developmental model to remediate the problem. One identified need included addressing the following issues to also be addressed: learning about self-care and warning signs for problems beginning in graduate school, utilizing colleague assistance programs as needed. Researchers also argued for increased assessment of impaired psychologists by having experienced and well-trained psychologists who are able to evaluate distress in psychologists while participating in treatment. This training must include relevant domains applicable to psychologists, such as: current stressor and personal history, mental health, medical, professional training and |

				competency issues, office and business management practices, practice problems, impacts of personal life on professional practice, drugs and alcohol use, interpersonal relationships, motivation to resolve problem, likelihood of ability to remediate, and self-awareness of the problem and its consequences.
Barnett & Cooper (2009)	Theoretical	No Sample	Literature	Examined vulnerabilities of distress among psychologists and argued as to how a culture of self-care is created. Researchers argued that self-care is a professional responsibility and needs to be built into the professional identity of the psychologists. Specific recommendations were made for psychologists who train graduate students and for professional associations. They suggested graduate programs offer their students with ongoing presentation on the culture of self-care. They suggested this being done through formal coursework and regularly scheduled colloquia with faculty. They argued that students' professional identity is primarily developed during their training, and attention must be paid to self-care as it relates to the practice of ongoing prevention. They also recommended school make self-care opportunities regularly available to their students.
Smith & Moss (2009)	Review	No Sample	Literature	Examined impairment in psychologists: what it is, how it can be prevented, and what could be done to address it. The researchers argued the best way to decrease psychological distress among

				psychologists was by educating themselves about personal and professional attributes that may be vulnerable to impairment, such as burnout. The researchers argued to increase education and awareness among psychologists regarding risk factors for impairment. They suggested having similar programs that medical practitioners have, which mandates inclusions in their training curriculum to identifying characteristics attributing to impairment, as well as the intervention methods used in those particular instances. Thus, teaching psychologists to identify impairment and mental illness while simultaneously encouraging a culture of wellness, training, and comfort in tackling instances of impairment.
Good et al. (2009)	Theoretical	No Sample	Literature	Examined wellness and impairment among psychologists. They identified denial and lacking awareness of shortcomings regarding mental health being as a human response, but were especially of concern with the amplified characteristics of psychologists. The researchers urged psychologists to stop ignoring the signs, avoid engaging in behaviors to minimize and manage the identified problem/impairment, and increase willingness to identify problems within themselves and seek treatment when they too are faced with impairment; it means "monitoring and staying in tune with the changes that

				occur over the course of our lives" (p. 21).
O'Connor (n.d.)	Theoretical	No Sample	Literature	Discussed a plethora of reasons as to why intervening with an impaired colleague is so stressful. An intervention model was suggested that offered guidance on how to intervene with an impaired colleague, which included: evaluating the information presented to you, deciding who should confront the individual, preparing for the meeting, considering how you will approach your colleague, speaking, listening, and discussing, as well as following up. Ethical responsibilities were emphasized as a reason to intervene with fellow psychologists and to view it as decreasing the risk of ethical violation.
Barnett & Hillard (2001)	Survey	*N=59*	State and Provincial psychological associations (SPPAs)	Researchers argued the need to break down barriers in psychologists utilizing colleague assistance programs. Psychologists should not see themselves psychologically different from their clients, because their functioning changes continuously, similar to what they may see among their clientele. Psychologists are in need of attention to themselves around psychiatric disorders from outside professionals; for example, developing outreach programs targeted to educate psychologists about colleague assistance resources.

Analysis of Theme 1: Educating and Increasing Awareness. A suggested intervention to help psychologists to have access to effective mental health is by educating and increasing awareness within the profession. Psychologists especially need this, as they are more susceptible

to lack of awareness due to cultural implications of the profession. Remediation included increasing the training and education around recognizing and responding to the onset of psychiatric disorders, as well as possible predispositions that may impact them. Suggestions included incorporating this training and education during different points of the professional life span of the psychologists, for example, during graduate school training years and post-graduate/independent years. It was identified as important to training psychologists to be able to identify mental distress not only in themselves, but also in their colleagues, with a clear understanding of how to intervene. Specific focus suggested increasing insight with assessing psychiatric disorders within themselves, utilizing colleague assistance programs, building insight to recognizing the vulnerabilities psychologists face, no longer demonizing distress, no longer ignoring/avoiding the signs of problems within themselves, implementing a system that helps psychologists monitor their mental health, being mindful of the agencies that increase psychological risks and vulnerabilities for psychologists, mandating personal therapy in training years, screening out students and psychologists more susceptible to stress, and developing outreach programs to educate psychologists on how they can get help. Many of these interventions suggested mandated funding. Finally, the research has suggested that psychologists who treat impaired psychologists need specialized training to better assess symptomology and effective treatment options.

Theme 2: Improving Systemic Influences. The data set in Table 15 represents the suggested need of remediating systemic influences to help remediate barriers found in accessing mental health care.

Table 15

Suggested Interventions for Psychologists Experiencing Mental Health Distress and Psychological Impairment, Improving Systemic Influences Data Set

Suggested Interventions for Psychologists Experiencing Mental Health Distress and Psychological Impairment, Improving Systemic Influences Data Set Theme 2: Improving Systemic Influences				
Researchers	Methods	Sample Size	Sample	Purpose and Findings
Laliotis & Grayson (1985)	Review & Quantitative Survey	*N*=50	State examining boards of psychology	Surveyed licensing states to determine what regulations exist for handling psychologists' impaired situations. Research found that there were no current states that had programs for impaired psychologists though a number were in the process of developing some. Guidelines were offered, which included: (1) assess the need, (2) develop a model and plan for program, (3) develop program guidelines, and (4) develop a strategy to evaluate the program. Research found that no states had programs for impaired psychologists; guidelines were offered. The researchers believed that there are issues of legislation that needed to be addressed. More specifically, they argued that committees established to help distressed psychologists must have recognition and standing in the law. Funding should be considered for the development of these institutions, but also consideration for psychologists who may need loans during treatment or income loss while in treatment. They argued possible sources of revenue to include increasing licensing fees and developing grants from state

				associations. Finally, they urged the issues of confidentiality to be addressed with clarifying limits and whether treatment providers within these programs are mandated reporters for the psychologists they are serving.
Orr (1997)	Review	No Sample	Literature	Argued there is need for policy development around the impaired psychologists and boundary violations. The researcher suggested the following remediation: (a) assessment and treatment of impaired disorders are mandated, (b) recognizing that the relationships psychologists have with impaired psychologists is collegial in nature, (c) many impaired psychologists can be helped, (d) identified impairment does not negate consequences for unethical behavior, and (e) believing that policies that encourage rehabilitation and monitoring can greatly improve the suspected impaired psychologists' lives.
Sherman & Thelen (1998)	Survey	N=522	Practicing psychologists	Set out to examine the nature and extent of distress and impairments due to work factors and life events among psychologists. The researchers argued for more supportive enforcement of ethical codes, as well as the provisions made to support programs for distressed psychologists. They urged the need for them to be more supportive as it relates to ethics. More specifically, financial and logistic support is given to these programs from the profession's policy makers and leaders. For example, continuing education courses and symposiums at conferences on coping with distress. They also suggested agencies have preexisting systems in place for dealing with distressed

				psychologists by giving accommodations by default with the expectation that they will not be able to perform their professional duties during the identified time. They stated these suggestions not only offer effective intervening, but also will likely break down the stigma associated with impairment.
Barnett & Hillard (2001)	Survey	N=59	State and Provincial psychological associations (SPPAs)	Investigated colleague assistance programs (CAPs) available among SPPAs, as well as the prevention, identification, and rehabilitation of practices. The researchers identified the following interventions to help improve the barriers the programs were facing: (1) work toward improving the reputation and need for CAPs; (2) investigate why psychologists appear to be reluctant to access available services from SPPA CAPs; (3) investigate and remediate how SPPA contributes to or perpetuates the low rates of use, e.g., increase outreach efforts targeting to educating psychologists about CAP; (4) encourage the passage of legislation to mandate CAPs that state licensure boards might use as a non-punitive means of responding to a perceived distressed and/or impaired psychologists; and (5) set effective uniform standards for training and intervention, creating prevention and intervention programs.
O'Connor (2001)	Review	No Sample	Literature	Examined the effective management of professional distress and impairment among psychologists. The research suggested that there was need to improve the effectiveness for both the consumer and the psychologists to use colleague assistance programs. The

following intervention strategies were suggested: (1) make the use of diversion available to the identified impaired psychologists so that they are given the opportunity to receive rehabilitation (i.e., their mental illness, substance use, or other type of impairment) while possibly continuing their practice and undergoing monitored, prescribed treatment and education in lieu of license suspension, revocation, or other consequences. If psychologist is unable to remediate "requirements of treatment program, then enforcement of consequences for professional failures then proceed as originally defined" (p. 348). Researcher argued that psychologists need to insist on finding agreements between psychologists and regulatory boards to protect the public and correct board policies that are not supported by the research and damage the suspected offender. (2) Recognize impairment does not negate consequences for unethical behaviors or incompetence. (3) Governing boards need better-informed oversight about the dynamics of distress and impairment and the role of client motivations and/or transference in the compliant process; this means expanding understanding of client diagnoses that are more likely to result in complaints.

| Gilroy et al. (2002) | Survey using Likert scaling | N=425 | Members of the APA Counseling Association Division (17) | Proposed that the current policies for psychologists' psychological distress should place greater emphasis on prevention. They believe that at a systemic level, the inclusion of guidelines regarding practice of self-care needs to be incorporated within the professional codes of ethics. |

				Recommendations are offered for self-care practices for psychologists experiencing mental health problems. The researchers argued that systemic changes needed to be made to the inclusion of guidelines for practicing self-care. They argued that this should be built into the APA's professional codes of ethics. Additionally, they suggested regular provisions of continuing education credits for participation in self-care activities, "such as personal therapy, peer supervision, [and] meditation" (p. 406). They also suggested personal therapy become mandated in training programs and make self-care and possible risk factors more of a focus in the curriculum.
Good et al. (2009)	Theoretical	No Sample	Literature	Examined wellness and impairment among psychologists. The researchers found that graduate programs need to incorporate teachings about professional wellness, as well as the risks and signs of distress. This can prevent impairment. The researchers suggested using professional renewal centers locally available, while recognizing that insufficient income can be a barrier for many psychologists.
Bridgeman (2006)	Review	No Sample	Literature	Discussed psychologists needing to embrace wellness. The researcher argued that utilizing Colleague Assistance and Support Programs (CLASP) to enhance coping skills during distress to reduce the impact it has on future wellness, as it pulls from a precautionary principle to encourage colleagues. The researcher believes that by "employing models of

				compassion, fatigue prevention, and resilience, CLASP can help to protect psychologists during times of challenge and lessen the impact of negative experiences" (p. 32).
Thomas (2005)	Review	No Sample	Literature	Examined licensing board complaints and how psychology minimizes the impact it has on the profession. The mental health treatment needs of psychologists and their clients are not addressed in a comprehensive manner. A need for licensing boards to attempt to minimize the impact of complaints to psychologists' clinical practice by increasing the states' awareness of the cognitive, emotional, and behavioral responses that can occur and can compromise their clinical work and psychological state. The researcher pleads for further awareness to fill the gaps in the profession that do not support psychologists when ethical concerns are brought up against them as a result of impairment.
Bearse et al. (2013)	Survey	$N=260$	Professional psychologists	Investigated the frequency of various stressors they are impacted by and experience when seeking mental health services. Researchers argued effective training should be included in graduate programs, postdoctoral fellowships, and early career practitioner positions that encourage students in training and practitioners to seek psychotherapy throughout their career when issues arise. This training should include examining the complexities of finding a psychotherapist given the various nuances of the profession (e.g., dual relationships, finances, and time demands).
APA (2006)	Theoretical	No Sample	Monograph	Developed a monograph to aid licensing boards in developing

| | | | | and providing adequate colleague assistance to distressed or impaired psychologists. Their hopes are to provide contextual understanding to psychologists' competence problems and provide strategies from a developmental model to remediate the problem. The researchers argued a need to have state and provincial and territorial psychological associations (SPTSA), as well as licensing boards and APA collaborate to develop and provide adequate system for colleague assistance. It was argued that the use and controversy of the diversion program must be addressed. Suggestions were also made about important features of setting up an effective system for colleague assistance programs, which included: developing an effective structure, policies with records kept, accountability for the process outcomes, responsibilities of the system, entry into the system determines procedures, implications for a professional referring a colleague, consent and confidentially, funding, liability, tracking progress through the system, professionals involved and their roles, and outcomes measures. |
| Kleespies et al. (2011) | Literature Review & Semi-structured interview | $N=14$ | Unpublished data from the National Institute of Occupational Safety and Health & CPA members | Examined suicide among psychologists: its impact, incidence, and suggestions for preventions and intervention. Argued the need for State Psychological Associations, and specifically those that have Colleague Assistance Programs (CAP), to continue to make efforts to normalize challenges faced in the profession when psychologists are seeking out CAP, as well as mitigate the stigma associated with psychological and psychiatric distress leading toward |

				impairment. They suggested regular self-assessment, which can be found on many colleague assistance program websites, and allows for a confidential check-in. This can help to develop and clearly identify warning signs in psychologists while directing psychologists to sites for coping with such signs. They also argued for mandated and funded implementation for graduate curriculum programs.
Smith & Moss (2009)	Review	No Sample	Literature	Examined impairment in psychologists: what it is, how it can be prevented, and what could be done to address it. They suggested ways to decrease psychological distress among psychologists. They recommend tertiary interventions should be offered at the state and national levels. This included having similar programs to medical practitioners, which governing licensing boards mandates curriculum training during their academic training years to learn how to identify impairment and mental illness among themselves and in their colleagues. They suggested looking at how medical residency programs have built in practitioner training in identifying characteristics attributing to impairment and the intervention methods used in those particular instances.
Barnett & Cooper (2009)	Theoretical	No Sample	Literature	Examined vulnerabilities of distress among psychologists and argued as to how a culture of self-care is created. The researchers argued that in order for ongoing self-care and psychological wellness to remain highlighted as important, APA, state, provincial, and territorial psychological associations must double the efforts to educate and inform

				psychologists about such issues. They argued the need for licensing boards to make changes to licensure laws to have ongoing continuing education that is mandated for incorporating issues of distress, impairment, burnout, and self-care in each renewal.
O'Connor (n.d.)	Theoretical	No Sample	Literature	An intervention model was suggested that included how the American Psychological Association's efforts to improve psychological distress among psychologists, the researcher discussed stressors psychologists face when intervening with an impaired colleague and offered a model of intervention to combat the stress involved. The author discussed how preparing special communication skills, as well as self-care, decreases some of the hazards involved with the stressful roles of being a psychologist.

Analysis of Theme 2: Improving Systemic Influences. Systemic changes are a relevant aspect to decreasing barriers for psychologists accessing mental health care. Governing boards need better-informed oversight and policy development of psychologists' mental health as it relates to prevention and intervention. In the early 1980s, licensing states had yet to determine regulations or agencies to help support impaired psychologists, though independent agencies were attempting to develop modules to help prevent the hiring of high-risk psychologists, as well as address ways to intervene with psychologists identified as impaired. By the 1990s and moving into the 21st century, there was a push to develop training in graduate programs that included learning skills for self and colleague assessment. There was also an emphasis for state, provincial, and territorial psychological associations to develop and provide an effective system for colleague assistance programs (CAPs), which included improving their reputation and

increasing the use by remediation of bad reputation, as well as creating uniform prevention and

intervention for psychologists. Finally, there was a stated demand for legislative mandates to

decrease punitive measures associated with impairment when interventions, such as CAPs,

remediate the problem. Diversion policies were highlighted as a possible starting point.

Mandating from governing boards for personal therapy and self-care were suggested, as well as

building such interventions into the codes of ethics. Researchers also proposed that mandating be

funded.

Theme 3: Utilizing Self-Care. The data set in Table 16 represents the demonstration in

the professional literature that utilizing self-care is a suggested intervention for psychologists

experiencing mental health distress and psychological impairment.

Table 16

Suggested Interventions for Psychologists Experiencing Mental Health Distress and Psychological Impairment, Utilizing Self-Care Data Set

Suggested Interventions for Psychologists Experiencing Mental Health Distress and Psychological Impairment, Utilizing Self-Care Data Set Theme 3: Utilizing Self-Care				
Researchers	Methods	Sample Size	Sample	Purpose and Findings
Mahoney (1997)	Survey	*N*=155	Psychotherapy practitioners: respondents earned degrees of either a masters (48%), doctorate (46%), or bachelors (6%).	Examined psychotherapists' personal problems and self-care patterns. Researcher reported patterns of coping with self-care have improvement on mental health among psychologists. For example, pleasurable reading, exercise, hobbies, vacations, peer supervision, prayer and/or

				mediation, and volunteer work were most frequently reported. Least common forms of self-care were reported as: personal therapy, attending church services, massages, chiropractic care, and keeping a personal diary.
Coster & Schwebel (1997)	Interview and Questionnaire	$N=345$	Licensed psychologists	The researchers argued that the issue of impairment is primarily a deficiency in using adequate coping resources to deal with the stressors overwhelming the psychologists.
Sherman & Thelen (1998)	Survey	$N=522$	Practicing psychologists	Set out to examine the nature and extent of distress and impairments due to work factors and life events among psychologists. They identify frequent prevention behaviors among psychologists. Participating in non-work-related activities and periodic vacations were the most frequently reported preventative behaviors to the distressed and professionally impaired clinical psychologists with correlations to high personal relationship problems and difficult clients.
Good et al. (2009)	Theoretical	No Sample	Literature	Examined wellness and impairment among psychologists. Their research found that it is important for psychologists to engage in good self-care to help monitor functioning. Offered recommendations for individuals in the profession to promote wellness when faced with impairment, which included: eating well, exercising, sleeping, managing stress, and keeping positive interpersonal relationships.

Smith & Moss (2009)	Review	No Sample	Literature	Examined impairment in psychologists: what it is, how it can be prevented, and what could be done to address it. Argued psychologists need to increase their behaviors of intervening preventative measures for themselves. They noted that psychologists needed to completely disconnect from their professional practice when engaging in leisure activities and argued that self-care is the strongest method in diffusing psychological distress and preventing impairment.
Kleespies et al. (2011)	Literature Review & Semi-structured interview	$N=14$	Unpublished data from the National Institute of Occupational Safety and Health & CPA members	Examined suicide among psychologists: its impact, incidence, and suggestions for preventions and intervention. The researchers suggested that one of the key features to mitigating barriers includes the need for frequent implementations of self-care strategies, similar to what is typically prescribed to patients. This included regular self-assessment from outside sources (e.g., CAP).
Gilroy et al. (2002)	Survey using Likert scaling	$N=425$	Members of the APA Counseling Association Division (17)	Recommendations are offered for self-care practices for psychologists experiencing mental health problems. The researchers argued systemic changes need to be made for the inclusion of guidelines for practicing self-care. They argued that this should be built into the APA's professional codes of ethics. Additionally, they suggested regular provisions of continuing education credits for participations in self-care activities, "such as personal therapy, peer supervision,

				[and] meditation" (p. 406).
Bridgeman & Galper (2010)	Survey	*N*=658	Psychologists from APA Membership database	The researchers argued that because the practice of psychology is a stressful profession, there needs to be a balance between life in our personal and professional lives, as well as the incorporation of self-care practices early in one's career. Frequently incorporated coping strategies suggested included: maintained balance between personal and professional lives (96%), sought support from peers (95%), talked to a colleague (94%), participated in hobbies (91%), spent more time/effort on work (74%), received psychotherapy or counseling (64%), reduced clinical load or professional responsibilities (63%), and used spiritual resources (62%). Their research found that 75% of psychologists are very likely to initiate a new coping strategy when under severe stress. Female psychologists reported reaching out for support and using coping strategies significantly more than males. Their link between well-being and self-care included: taking time for yourself (63%), taking time off work (63%), having financial security (61%), spending private time with family (58%), spending private time with friends (52%), being in nature (49%), spending private time with partner (47%), availability of my partner (47%), social recreational activities (41%), reflecting on positive experiences (29%), and attending cultural/artistic events (28%). They found seven domain of wellness/well-

				being: physical, emotional, spiritual, intellectual, social, relational, as well as safety and security.
Farber & Heifetz (1982)	Mixed Methods: semi-structured interview, coded, & chi-squared analysis	*N*=60	Psychotherapists: psychiatrists (*n*=24), psychologists (*n*=21), social workers (*n*=15)	After determining that approximately 70% of psychologists perceived burnout as a function of constant attention, responsibility of the profession, and lack of success. Found the role of support systems essential in the process and dimensions of disillusionment (approximately 80%) including: supervision, colleague consultation, and activity outlets. Discussed the need for the topic to become more public without fear of negative consequence, develop support groups, and have interdisciplinary options.
Advisory Committee on Colleague Assistance ([ACCA], 2016)	Theoretical	No Sample	Literature	Argued that self-care is needed as it offers balance. They suggested maintaining awareness of stressors, frequent self-assessment, taking adequate care of yourself, and giving priority to mental and physical needs. The association suggested the following tips for self-care: keeping yourself healthy, valuing balance, listening to what is offered to our clients, accept suggestions from others, aim for balance in the workplace, assess as well as readjust various work demands, set healthy boundaries, and limit isolation.

Analysis of Theme 3: Utilizing Self-Care. Utilizing self-care is a suggested intervention

for psychologists to improve their mental health, and approximately 75% of psychologists are

likely to initiate a new coping strategy under severe stress. It serves not only as a tool to monitor functioning, but also serves as both a preventative and intervening strategy. The following coping strategies were suggested, based within wellness domains that included physical, emotional, spiritual, intellectual, social, relational, safety, and security. The following coping skills were found helpful to achieve mental health balance: participating in pleasurable non-work activities (91%); taking time off of work (63%); spiritual practices (62%); healthy physical practices (e.g., eating well, exercising); maintaining a variety and quantity of private time with interpersonal relationships (ranging from 47% to 58%); balancing work load (63%); and limiting isolation. Women were noted as more likely to reach out for support than males. There is a push to have legislative mandates that incorporate teaching psychologists about the benefits and suggested use of coping strategies. It is argued that this should be built into the American Psychological Association's code of ethics, training programs, and continuing education, such as national conferences. There were some arguments given that impairment is caused due to inadequate use of coping strategies.

Theme 4: Developing a Culture of Support. The data set in Table 17 represents the demonstration in the literature that developing a culture of support is a suggested intervention for psychologists' mental health and to help remediate barriers found in accessing mental health care.

Table 17

*Suggested Interventions for Psychologists Experiencing Mental Health Distress and
Psychological Impairment, Developing a Culture of Support Data Set*

Suggested Interventions for Psychologists Experiencing Mental Health Distress and Psychological Impairment, Developing a Culture of Support Data Set Theme 4: Developing a Culture of Support				
Researchers	Methods	Sample Size	Sample	Purpose and Findings
Freudenberger (1986)	Theoretical	No Sample	Literature	Identified preventive measures for institutions utilizing psychologists to provide mental health services: (1) guard yourself over rapid turnover environments, (2) help training staff to judge and evaluate differences in unrealistically committed persons, (3) avoid sending the same staff member into a job situation, (4) limit the amount of hours a person works for you, allowing staff members to take time off as they need, (5) embracing a more collective work environment, (6) share difficult experiences with colleagues, (7) allow time for didactic training, (8) hire more staff if needed, and (9) increase physical exercise.
Coster & Schwebel (1997)	Interview and Questionnaire	*N*=345	Licensed psychologists	The researchers argued that the issue of impairment is primarily a deficiency in using adequate coping resources to deal with the stressors overwhelming the psychologists. They found multiple facets that help facilitate well-functioning in professional psychologists, which included: relying heavily and having highest

				priority for utilizing interpersonal support, such as collegial support. They also recommended keeping affiliations with graduate programs as it provides cooperation between colleagues and students that builds confidence, helps to develop skills to solve professional problems, and offers opportunities to be in roles of leadership. The researchers also suggested professional and civic activism as part in promoting mental health, stating that it promotes individual's welfare, satisfaction, a self of empowerment, as well as increases opportunities for intra-support.
Schwebel & Coster (1998)	Surveyed	N=107	Heads of APA-approved programs	Researched well-functioning in professional psychologists as how program heads understand it. Program heads proposed the following changes: require ongoing support groups, develop orientations that manifest a supportive environment, increase student involvement in school governance, stop over-burdening and working students, and faculty role model to students through reorientation to the transformation of becoming psychologists.
O'Connor (2001)	Review	No Sample	Literature	Examined the effective management of professional distress and impairment among psychologists. The following intervention strategies were suggested: (1) stop demonizing distressed and impaired psychologists and build a culture that recognizes and empathizes the vulnerabilities

psychologists face from circumstances to life events, and (2) minimize isolation among psychologists and encourage ongoing consultation, peer support, and openness to our students and colleagues.

Barnett & Cooper (2009)	Theoretical	No Sample	Literature	Examined vulnerabilities of distress among psychologists and argued as to how a culture of self-care is created. Researchers argued that self-care is a professional responsibility and needs to be built into the professional identity of the psychologists and the culture of the profession. They argued that students' professional identity is primarily developed during their training and attention must be paid to self-care as it relates to acknowledgement of personal vulnerabilities, learning to speak openly about such vulnerabilities, and the need to seek assistance.
Smith & Moss (2009)	Review	No Sample	Literature	Examined impairment in psychologists: what it is, how it can be prevented, and what could be done to address it. The researchers recommended that psychologists seek out support to help maximize mental health and occupational competency. This included using mentoring relationships to ensure psychologists' well-being and receive feedback from valued peers and seek out ongoing consultation.
Good et al. (2009)	Theoretical	No Sample	Literature	Examined wellness and impairment among psychologists. Argued that psychologists have "choices and responsibilities in dealing with the pain and suffering

				from which we are not immune. We have a deep and true responsibility to care for ourselves and to support and confront one another" (p. 22). They also encouraged having peer consultation groups in place to help build support as well as build insight to when perceived issues are emerging.
Kleespies et al. (2011)	Literature Review & Semi-structured interview	N=14	Unpublished data from the National Institute of Occupational Safety and Health & CPA members	Examined suicide among psychologists: its impact, incidence, and suggestions for prevention and intervention. Argued it is important for psychologists to not only identify risks, but also to reduce the stigma associated with acknowledging hopelessness and despair.
O'Connor (n.d.)	Theoretical	No Sample	Literature	Discussed a plethora of reasons as to why intervening with an impaired colleague is so stressful, but argued the need for psychologists to be apart of the process regardless of its difficulty. They highly recommended individuals to participate in ongoing consultation with peers, supervisors, and experts as needed.

Analysis of Theme 4: Developing a Culture of Support. An effective intervention for distressed psychologists is developing a culture of support for psychologists. Support systems serve as an avenue to mental wellness and an essential part to eliminating risk factors for psychologists. Suggestions for promoting a supportive culture included: improving work conditions, increasing peer support, consultation, and supervisory support, being affiliated with a teaching or training program, involvement with civic and activist positions, as well as being in roles of leadership and mentorship roles. There is also a push to remove the stigmas associated

with psychologists asking for support when in distress, and creating a culture of making such topics public and eliminating stigma associated with it. Suggestions were also made to screen out work environments and unhealthy psychologists from employment positions.

Theme 5: Utilizing Personal Therapy and Treatment Programs. The data set in Table 18 represents the demonstration in the literature that using therapy and treatment programs for psychologists experiencing mental health distress and psychological impairment is a suggested intervention to remediate barriers.

Table 18

Suggested Interventions for Psychologists Experiencing Mental Health Distress and Psychological Impairment, Utilizing Personal Therapy and Treatment Programs Data Set

Suggested Interventions for Psychologists Experiencing Mental Health Distress and Psychological Impairment, Utilizing Personal Therapy and Treatment Programs Data Set Theme 5: Utilizing Personal Therapy and Treatment Programs				
Researchers	Methods	Sample Size	Sample	Purpose and Findings
Skorina et al. (1990)	Structured Interview	N=70	International Doctors in AA and Psychologists Helping Psychologists. All professional active: 41% in clinical or counseling, 23% in academic settings, and other in fields such as school and industrial	Examined routes to recovery for alcoholic psychologists. Psychologists received effective recovery from non-formal interventions and treatments. Psychologists reported benefiting from effective treatment programs they sought out privately, such as, the uses of personal therapy. Psychologists primarily reported seeking therapy as a result of multiple happenstances in their environment.
Mahoney	Survey	N=155	Psychotherapy	Focused on psychotherapists

(1997)			practitioners	discussing their personal problems related to burnout and disillusionment in the profession. 20% reported currently participating in personal therapy and 28% reported previously using personal therapy as a self-care pattern.
Coster & Schwebel (1997)	Interview and Questionnaire	*N*=345	Licensed psychologists	The researchers argued that the issue of impairment is primarily a deficiency in using adequate coping resources to deal with the stressors overwhelming the psychologists. They found multiple facets that help facilitate well-functioning aspects of professional psychologists, one being the use of personal psychotherapy.
Sherman & Thelen (1998)	Survey	*N*=522	Practicing psychologists	Set out to examine the nature and extent of distress and impairments due to work factors and life events among psychologists. The researchers argued for support groups or affordable individual therapy options to psychologists in training.
Barnett & Hillard (2001)	Survey	*N*=59	State and Provincial psychological associations (SPPAs)	Investigated colleague assistance programs (CAP) available among SPPAs, as well as prevention, identification, and rehabilitation practices. They found that the option of private therapy is not only desired, but appears to works as a mental health treatment options due to decreasing the risk of negative consequences regarding loss of stature, embarrassment, and compromising licensure status.
APA (2006)	Theoretical	No Sample	Monograph	Developed a monograph to aid licensing boards in developing and providing adequate colleague assistance to distressed or impaired psychologists. Researchers argued for increased assessment of impaired psychologists by having

				experienced and well-trained psychologists who are able to evaluate distress in psychologists while participating in treatment.
Bridgeman & Galper (2010)	Survey	N=658	Psychologists from APA Membership database	The researchers argued that because the practice of psychology is a stressful profession, there needs to be a balance between life in our personal and professional lives, as well as the incorporation of self-care practices early in one's career. A frequently incorporated coping strategy included receiving psychotherapy or counseling (64%).
Smith & Moss (2009)	Review	No Sample	Literature	Examined impairment in psychologists: what it is, how it can be prevented, and what could be done to address it. They suggested ways to decrease psychological distress among psychologists. They argued that private therapy is a highly desired option for intervening with mental health. Psychologists reported appreciating the benefits of personal therapy over employee assistance programs. Discussed how personal therapy for psychologists is an important option to help avoid concerns about punitive consequences from state associations and helps to alleviate distress.

Analysis of Theme 5: Utilizing Personal Therapy and Treatment Programs. Utilizing

personal therapy and treatment options for psychologists to remediate mental health distress and

psychological distress is an important option they have used thus far. Twenty to 64% of

psychologists reported participating in personal therapy at some point in their lives.

Psychologists prefer seeking personal therapy options for the purposes of controlled privacy, a

viable coping option to manage distress, as well as minimizing punitive consequences regarding

loss of stature, embarrassment, and licensure status. There is also a need for psychologists to be

trained to work with such a specialized population as psychologists, as there are distinctive risk

factors to be considered and enhanced assessment and treatment options must be available to

them for more effective treatment outcomes.

Theme 6: Increasing Empirical Evidence. The data set in Table 19 represents the

demonstration in the professional literature that improving empirical research is a suggested

intervention for psychologists experiencing mental health distress and psychological impairment.

Table 19

*Suggested Interventions for Psychologists Experiencing Mental Health Distress and
Psychological Impairment, Increasing Empirical Evidence Data Set*

Suggested Interventions for Psychologists Experiencing Mental Health Distress and Psychological Impairment, Increasing Empirical Evidence Data Set Theme 6: Increasing Empirical Evidence				
Researchers	Methods	Sample Size	Sample	Purpose and Findings
Smith & Moss (2009)	Review	No Sample	Literature	Examined impairment in psychologists: what it is, how it can be prevented, and what could be done to address it. The researchers argued that empirical studies are needed to more accurately evaluate the practices of professionals that are showing a decline in professional functioning, as well as research on why so few intervene with impaired colleagues. Researchers also pleaded to increase research around psychologist impairment, effective colleague interventions, and effectiveness of current colleague

				assistance programs. They argued that the research for and on the impaired professional is "sparse at best" (p. 4) and stated the research is limited on the utilization and outcome of colleague assistance interventions among psychologists and related to the lack of formal programs and the lack of research on the effectiveness in existing programs.
APA (2006)	Theoretical	No Sample	Monograph	Developed a monograph to aid licensing boards in developing and providing adequate colleague assistance to distressed or impaired psychologists. Their hopes are to provide contextual understanding of psychologists' competence problems and provide strategies from a developmental model to remediate the problem. Suggestions were also made about important features of setting up an effective system for colleague assistance programs, which included: accountability for the process outcomes, tracking progress through the system, and outcomes measures.
Barnett & Cooper (2009)	Theoretical	No Sample	Literature	Examined vulnerabilities of distress among psychologists and argued as to how a culture of self-care is created. The researchers argued the need for more efforts to be put toward better understanding the nature, causes, and effective prevention for dealing with distress among psychologists.
Gilroy et al. (2002)	Survey using Likert scaling	N=425	Members of the APA Counseling Association Division (17)	Recommendations are offered for self-care practices for psychologists experiencing mental health problems. The researchers urged the regular inclusion of research using both qualitative and quantitative methodologies that increase awareness of psychologists.

Analysis of Theme 6: Increasing Empirical Evidence. Increasing the output of empirical research on psychologists is a suggested intervention for helping to understand and remediate prevalence and barriers among psychologists. There is agreement that the current data on this population is limited. The research areas suggested included investigating the prevalence of distress, impairment, and burnout among psychologists, as well as the effectiveness of current interventions such as colleague assistance programs, and correlations between psychological distress and effective intervention.

Final Synthesis to the Suggestions for How Psychologists Can Remediate Barriers to Accessing Mental Health Services

There were at least six suggestions identified for intervening with psychologists facing barriers to accessing mental health care. Educating and increasing awareness among psychologists was deemed as a relevant intervention for remediating barriers. There was attention to increasing the training and education around recognizing and responding to the onset of psychiatric disorders, as well as possible predispositions that may impact them during different phases of their professional life spans. Improving the role and influences of systemic structures was also identified as an important intervention to remediate barriers for psychologists. Governing boards need better-informed oversight and policy development of psychologists' mental health as it relates to prevention and intervention. It is also believed that funding should be sourced from these systems. The utilization of self-care was also identified as a viable intervention method, noting that approximately 75% of psychologists are likely to initiate a new coping strategy under severe stress. It was argued that self-care serves not only as a tool to monitor functioning, but also serves as both a preventative and intervening strategy. Wellness domains were identified as relevant to coping strategies, which included physical,

emotional, spiritual, intellectual, social, relational, safety, and security. Multiple coping strategies that were found helpful were listed. Another identified theme was the encouragement of developing a culture of support in the professional community. Suggestions for promoting a supportive culture included: improving work conditions; increasing peer, consultation, and supervisory support; being affiliated with a teaching or training program; involvement with civic and activist positions, as well as being in roles of leadership, mentorship roles; and decreasing the stigmas associated with making public psychological distress. The utilization of personal therapy and treatment options was identified as another theme, as 20% to 64% of psychologists reported participating in personal therapy at some point in their lives. Psychologists appear to prefer this option as they can control its privacy, it is a viable coping option to manage distress, and it minimizes punitive consequences regarding loss of stature, embarrassment, and licensure status. The final theme suggested increasing empirical evidence. Suggested areas of research included investigating the prevalence of distress, impairment, and burnout among psychologists, as well as the effectiveness of current interventions such as colleague assistance programs, and correlations between psychological distress and effective intervention.

Chapter V: Conclusion

This study completed a critical review of psychologists' mental health by completing a conceptual analysis based on the current empirical literature of the mental health needs of clinical psychologists, as it has been a blind spot in the research. In this area of psychology where clinical and systemic issues intersect, there has been a lack of organized description and development of remedies for psychologists to access mental health treatment, creating a significant blind spot to social justice issues among psychologists. Distress among psychologists was explored by examining the following domains: (a) the prevalence of mental illness and psychological distress that exist among them, (b) the barriers they encounter to seeking treatment when experiencing this distress, and (c) current interventions and integrating remedies for access to mental health care that best meets psychologists' needs. Results found several themes within each domain shaping a contextual picture of some of the challenges faced by psychologists.

Prevalence rates of mental illness and psychological distress were found among psychologists and the first domain to be examined (found in Table 2). Approximately 81% of psychologists identified with having diagnosable psychiatric disorders and approximately 70% believed they also presented with personality-disordered traits over the course of their lifetime (Nachshoni et al., 2008). More specific psychiatric symptoms noted were substance abuse (predominantly alcohol) ranging from 8% to 52%, mood problems (68%), depression reaching from 11% to 62%, anxiety stretching from 36% to 51%, eating disorders (49%), paranoia, social phobia, sexual dysfunction/challenges (20%), narcissism, and avoidant, obsessive compulsive, and dependent disorders (Bridgeman & Galper, 2010; Gilroy et al., 2002; Good et al., 2009; Nachshoni et al., 2008; Pope & Tabachnick, 1994; Smith & Moss, 2009; Thoreson et al., 1989; Wood et al., 1985). Psychologists reported lifetime suicidal ideation varying from 18% to 29%

and attempted suicides were noted at 4% (Bridgeman & Galper, 2010; Kleespies et al., 2011; Mausner & Steppacher, 1973; Phillips, 1999; Pope & Tabachnick, 1994; Practice Central, 2010). Male psychologists' ideations were found to be similar to males in the general public; however, female psychologists have a three times greater risks than females in the general population. In comparison to male and female psychologists, females have higher symptomology and severity of symptoms. Within a psychologists' sample pool, male psychologists are more likely to successfully commit suicide than female psychologists. (Gilroy et al., 2002; Mausner & Steppacher, 1973).

Substance use was another theme found within the domain of lifetime prevalence of mental illness and psychological distress among psychologists (found in Table 3). There has been a fluctuation in the data over the last three decades, with reported rates of use among psychologists vacillating from 1% to 70%. The primary substance identified was ethanol, with reported rates ranging from 1% to 70%; 16% of psychologists reported using alcohol daily. Other substances highlighted were cannabis, cigarettes (38%), tranquilizers (ranging from 7% to 14%), hallucinogens, opiates, ethanol, and cocaine (Elliott & Guy, 1993; Floyd et al., 1998; Guy et al., 1989; Kleespies et al., 2011; Skorina et al., 1990; Thoreson et al., 1989). Approximately 40% were also unable to identify psychiatric distress and/or receive effective outside treatment and interventions that were effective (Guy et al., 1989; Skorina et al., 1990).

Psychological distress was the third theme identified under prevalence in Table 4, and both psychologists and their peers have identified psychological distress over the course of their lifetime as a prevalent feature among this population, reaching from 10% to 74%. The types of correlations of psychological distress have been reported as: relational problems (oscillating from 11% to 61%), job-related concerns (varying from 21% to 72%), mental illness (3%), life

span adjustment and events (16% to 24%), personal and family physical illness (ranging from 4% to 50%), diverse problems (varying from 7% to 44%), legal problems (7% to 10%), isolation (9%), financial (21% to 33%), somatic complaints (ranging from 7% to 43%), having a personal history with trauma and/or childhood trauma (fluctuating from 4% to 67%), exposure to others with trauma, and other unidentified problems (11%) (Baird & Kracen, 2006; Bridgeman & Galper, 2010; Elliott & Guy, 1993; Guy et al., 1989; Mahoney, 1997; Sherman & Thelen, 1998; Thoreson et al., 1989). Attributions of psychological distress led to depression (60%), substance use (52%), emotional exhaustion (43%), and sexual overtures (32.3%) (Mahoney, 1997; Wood et al., 1985).

Burnout and compassion fatigue were identified as the fourth theme under prevalence found in Table 5. Approximately 49% to 59% of psychologists are reporting issues with burnout and compassion fatigue. Despite having a higher tolerance for such distress as compared to those in other professions, there were multiple contributions of stress that attributed to burnout and compassion fatigue, such as demands of attention and responsibility, difficulty of workload, agency types, home conflict, therapeutic dynamic, disillusionment, and other factors (Bearse et al., 2013; Bridgeman & Galper, 2010; Farber & Heifetz, 1982; Linnerooth et al., 2011; Rupert & Morgan, 2005; Rupert et al., 2009; Smith & Moss, 2009). There is particular susceptibility to working in an agency-employment setting for female psychologists and for men, working in independent practices (Rupert & Morgan, 2005). Finally, a fifth theme was identified as impairment, which can be found in Table 6 indicating ranges from 4.6% to 63% among psychologists. Approximately 8% of psychologists report their colleagues to governing institutions (Wood et al., 1985). Despite identified impairment, 4.6% to 14% of psychologists continue to operate in professional settings (Floyd et al., 1998; Guy et al., 1989; Wood et al.,

1985). Female psychologists were found to be more susceptible to impairment at work than male psychologists (Sherman & Thelen, 1998).

Psychologists face barriers to acquiring appropriate intervention services for their mental health care. At least seven dominant barriers were found in place that create obstacles for psychologists to access appropriate and effective mental health services. The first prominent theme was denial, identified in Table 7; researchers found that approximately 43% of psychologists struggle to see the presentation of mental illness and psychological distress within themselves (Barnett & Hillard, 2001; Bridgeman & Galper, 2010; Good et al., 2009; Guy et al., 1989; Kleespies et al., 2011; O'Connor, n.d.; Skorina et al., 1990; Smith & Moss, 2009). Denial appeared to work as a way for psychologists to avoid dealing with the shame that comes with awareness of the identified mental illness or psychological distress (40%) (Barnett & Hillard, 2001; Bridgeman & Galper, 2010; Good et al., 2009; Guy et al., 1989). Psychologists experience amplified shame to having psychological problems suggesting incompetence due to pressures from the psychological profession, which reached to 30%, thus supporting beliefs that psychologists are or should be immune to mental illness (Bridgeman & Galper, 2010; Firmin et al., 2012; Good et al., 2009). Many seemed to lack awareness of the benefits of treatment (Barnett & Hillard, 2001; Good et al., 2009; Skorina et al., 1990).

The second theme identified was lack of education of prevention among psychologists (found in Table 8). Researchers found that psychologists lack the needed education and prevention tools to better identify prevalence of mental illness and psychological distress (Bridgeman & Galper, 2010; O'Connor, n.d.; Schwebel & Coster, 1998; Smith & Moss, 2009). Contributions to the lacking education and prevention were attributed to limited research on prevention and ways to effectively intervene, as well as deficiencies in educating young

psychologists (Bridgeman & Galper, 2010; O'Connor, 2001; Schwebel & Coster, 1998; Smith & Moss, 2009).

The third theme, identified in Table 9, was keeping secrets; 20% of psychologists withhold information about their mental illness and psychological distress, due to fears of the consequences they will experience as a result of exposing such information (Barnett & Hillard, 2001; Bridgeman & Galper, 2010; Pope & Tabachnick, 1994; Thomas, 2005). Reported consequences included: embarrassment, shame/guilt (40%), inadequate social support (27%), terror, anxiety, fear, seen as a personal failing, confidentiality breaches, receiving a negative reputation for themself and the profession, as well as possible negative effects on licensing status (30%) (Barnett & Hillard, 2001; Bridgeman & Galper, 2010; Gilroy et al., 2002; O'Connor, n.d.; Pope & Tabachnick, 1994; Smith & Moss, 2009; Thomas, 2005). The fourth theme identified was with institutions of psychology found in Table 10. Psychological institutions, such as licensing boards, ethical boards, and state or provincial psychology associations, have created barriers for psychologists to access mental health. Psychological associations and colleague assistance programs were found to be new to the profession: for example, approximately 31% of states did not have colleague assistance programs by 2000 and many psychologists were unaware of the availability of such programs (Barnett & Hillard, 2001; Floyd et al., 1998; Laliotis & Grayson, 1985). Psychologists utilizing programs such as this found these programs to be unaccommodating, reactive versus preventative, having limited accessibility or availability to psychologists, lacking depth in understanding the mental health needs of psychologists, often associated with code/ethical reinforcement to protect the public against unethical psychologists, and causing financial hardship for psychologists (Bridgeman & Galper, 2010; Good et al., 2009; O'Connor, 2001; Smith & Moss, 2009). Additionally, ethical codes posed hazardous to

practitioners, demonstrating that the focus of intervention is for the clients, not practitioners (Good et al., 2009; O'Connor, 2001; Thomas, 2005; Zur, 2014). Psychologists see a greater threat in exposing psychological distress, such as compromising their licensure status and loss of professional status, varying from 29% to 43% (Bridgeman & Galper, 2010). This finding helps to explain psychologists' desire to keep their mental illness and psychological distress secret.

The fifth theme highlighted the lack of evidence-based research on psychologists. When referring back to Table 11, psychologists' mental illness, psychological distress, and impairment is lacking in the literature, both within the profession and among epidemiological categories (Bridgeman & Galper, 2010; Guy et al., 1989; Kleespies et al., 2011; O'Connor, 2001; Smith & Moss, 2009). The research that does exist presents concerns of validity and reliability based on the methodologies used; for example, the use of self-reports and sample size create ambiguity of prevalence (Guy et al., 1989; Kleespies et al., 2011; O'Connor, 2001). There was a large push in the literature to study the effectiveness of mental health programs and how well they are working for psychologists (Bridgeman & Galper, 2010; O'Connor, 2001; Smith & Moss, 2009). The sixth identified theme for the barriers psychologists face in accessing mental health care was psychologists having to interface with a professional culture that lacks a supportive disposition and is avoidant in nature (found in Table 12). There was an agreement in the literature that psychologists lack support from the profession, due to a strong consensual agreement to not interfere with a colleague's mental health, as well as a reluctance to intervene when they identify distress toward impairment (O'Connor, 2001; Skorina et al., 1990; Smith & Moss, 2009). The work was identified as isolative in nature, but additionally, psychologists avoid signs of mental illness, psychological distress, and impairment within themselves and among their colleagues (Floyd et al., 1998; Good et al., 2009; O'Connor, 2001; Skorina, 1982; Smith & Moss, 2009).

Some researchers suspected that this has been due to a desire to protect psychologists and to protect elements of denial, and concerns that the interventions will have more harm than good (Bridgeman & Galper, 2010; Floyd et al., 1998; Good et al., 1995; Skorina et al., 1990; Smith & Moss, 2009). Finally, in Table 13, the seventh identified theme highlighted limited opportunity for psychotherapy for psychologists. This was due to lack of funding, not finding an acceptable therapist, lacking time, the financial strain, and limited accessibility (Bearse et al., 2013; Gilroy et al., 2002; Good et al., 1995; Mahoney, 1997).

The final domain identified the suggested interventions for psychologists experiencing mental health distress and psychological impairment and the barriers they face. There were at least six suggestions identified for intervening with psychologists facing barriers to accessing mental health care. In theme one, in Table 14, researchers identified the need to educate and increase awareness among psychologists. The literature noted psychologists especially needing increased education and training, as they are more susceptible to denial due to cultural implications and punitive systems of the profession. Remediation included increasing the training and education around recognizing and responding to the onset of psychiatric disorders, as well as possible predispositions that may impact them (APA, 2006; Good et al., 2009; O'Connor, 2001; Pope & Tabachnick, 1994; Smith & Moss, 2009; Thoreson et al., 1989; Wood et al., 1985). Suggestions included incorporating this training and education during different points of the professional life span of the psychologists and specialized training for those psychologists who treat impaired psychologists to better assess symptomology and effective treatment options (APA, 2006; Barnett & Cooper, 2009; Good et al., 2009; Pope & Tabachnick, 1994; Sherman & Thelen, 1998; Smith & Moss, 2009; Wood et al., 1985). Specific focus was given to practitioners and training programs who interface with psychologists to increase insight

with assessing psychiatric disorders within themselves, encourage the utilization of colleague

assistance programs, build insight to recognizing the vulnerabilities psychologists face, no longer

demonizing distress, no longer ignoring/avoiding the signs of problems within themselves,

implementing a system that helps psychologists monitor their mental health, being mindful of the

agencies that increase psychological risks and vulnerabilities for psychologists, mandating

personal therapy in training years, screening out students and psychologists more susceptible to

stress, and developing outreach programs to educate psychologists on how they can get help

(APA, 2006; Barnett & Cooper, 2009; Barnett & Hillard, 2001; Coster & Schwebel, 1997; Good

et al., 2009; O'Connor, n.d.; Pope & Tabachnick, 1994; Sherman & Thelen, 1998; Skorina et al.,

1990).

The second theme identified was the need to improve efforts with systemic influences

(found in Table 15). Systemic changes are a relevant aspect to decreasing barriers for

psychologists accessing mental health care because they govern and create a professionally

influential system and have the opportunity to educate and intervene (APA, 2006; Bearse et al.,

2013; Good et al., 2009; O'Connor, n.d.; Smith & Moss, 2009). For example, governing boards

need better-informed oversight and policy development of psychologists' mental health as it

relates to prevention and intervention (Kleespies et al., 2011; Laliotis & Grayson, 1985;

O'Connor, 2001; Orr, 1997). There has been an emphasis for state, provincial, and territorial

psychological associations to develop and provide an effective system for colleague assistance

programs (CAPs), which included improving their reputation and increasing their use by

remediation of their bad reputation, as well as creating uniform prevention and intervention for

psychologists (Barnett & Cooper, 2009; Barnett & Hillard, 2001; Gilroy et al. 2002; O'Connor,

2001; Thomas, 2005). With these changes, there was a stated demand for legislative mandates to

decrease punitive measures associated with impairment when interventions, such as CAPs, remediate the problem (APA, 2006; Barnett & Hillard, 2001; Gilroy et al. 2002; Kleespies et al., 2011; O'Connor, 2001; Orr, 1997; Sherman & Thelen, 1998).

Utilizing self-care was the third theme, encoded in Table 16 as an opportunity to improve to improve their mental health, and approximately 75% of psychologists are likely to initiate a new coping strategy under severe stress (Bridgeman & Galper, 2010). It serves not only as a tool to monitor functioning, but also serves as both a preventative and intervening strategy (Advisory Committee on Colleague Assistance, 2016; Coster & Schwebel, 1997; Good et al., 2009; Kleespies et al., 2011; Smith & Moss, 2009). There was a diverse amount of coping skills based within wellness domains that included physical, emotional, spiritual, intellectual, social, relational, safety, and security (Advisory Committee on Colleague Assistance, 2016; Bridgeman & Galper, 2010; Farber & Heifetz, 1982; Good et al., 2009; Mahoney, 1997; Sherman & Thelen, 1998; Smith & Moss, 2009). Women were noted to be more likely to reach out for support than males (Bridgeman & Galper, 2010). There is a push to have legislative mandates that incorporate teaching psychologists about the benefits and suggested use of coping strategies (Gilroy et al., 2002; Kleespies et al., 2011). It is argued that this should be built into American Psychological Association's code of ethics, training programs, and continuing education, such as national conferences (Gilroy et al., 2002; Kleespies et al., 2011).

Developing a culture of support was the fourth theme identified to break down mental health barriers (found in Table 17). Researchers noted the need for support systems as an essential part to eliminating risk factors discussed for psychologists, as this appears to promote well-being and is an effective intervention method for distressed psychologists (Barnett & Cooper, 2009; Coster & Schwebel, 1997; Freudenberger, 1986; Good et al., 2009; O'Connor,

2001; Schwebel & Coster, 1998; Smith & Moss, 2009). Suggestions for promoting a supportive culture included: improving work conditions; increasing peer support, consultation, and supervisory support; being affiliated with a teaching or training program; and involvement with civic and activist positions, as well as being in roles of leadership and mentorship roles (Coster & Schwebel, 1997; O'Connor, n.d., 2001; Schwebel & Coster, 1998; Smith & Moss, 2009). There has also been a push to remove the stigmas associated with psychologists asking for support when in distress, and to create a culture of making such topics public and eliminating the stigmas (Kleespies et al., 2011; O'Connor, 2001).

The fifth theme, identified in Table 18, found the utilization of personal therapy and treatment programs as a viable option to remediate mental health distress and psychological distress identified in psychologists. Twenty to 64% of psychologists reported participating in personal therapy at some point in their lives. Psychologists prefer seeking personal therapy options for the purposes of controlled privacy, a viable coping option to manage distress, as well as minimizing punitive consequences regarding loss of stature, embarrassment, and licensure status (Barnett & Hillard, 2001; Bridgeman & Galper, 2010; Coster & Schwebel, 1997; Mahoney, 1997; Skorina et al., 1990). There is also a need for psychologists to be trained to work with such a specialized population such as psychologists, as there are distinctive risk factors to be considered, and enhanced assessment and treatment options must be available to them for more effective treatment outcomes (APA, 2006). The sixth and final theme identified was increasing the output of empirical research on psychologists to help understand and remediate prevalence and barriers among psychologists (found in Table 19). There has been an agreement that the current data on this population are limited (APA, 2006; Barnett & Cooper, 2009; Gilroy et al., 2002; Smith & Moss, 2009). Research areas suggested included examining

prevalence of distress, impairment, and burnout among psychologists, as well as investigating effectiveness of current interventions, such as colleague assistance programs, and correlations between psychological distress and effective intervention (APA, 2006; Barnett & Cooper, 2009; Gilroy et al., 2002; Smith & Moss, 2009).

Discussion

The researcher performed a systematic review and conceptual analysis of the available literature to examine mental illness and clinical psychological distress among psychologists. In this research, the following questions were answered: What does the combined research indicate regarding prevalence of mental illness and psychological distress among clinical psychologists? What has research attributed as barriers psychologists face to accessing mental health treatment? And what new insights can be gained regarding remedies for psychologists in accessing appropriate mental health care? By answering these questions, increased awareness of psychiatric distress and barriers became known, thus facilitating empirically informed interventions from an integrative perspective. The results open the discussion for not just the concerns of prevalence of mental illness and psychological distress found among psychologists, but how vitality and wellness can be improved within the population. The barriers identified in this study highlight the social justice issues among psychologists and the need for advocacy from the professional community. This leads to one of the many questions: How can a professional culture of wellness be built? In the literature, there have been efforts made to identify viable remediation for psychologists accessing mental health care and facing obstacles, but these efforts fell short of full answering this question.

Inconsistencies and pitfalls in the results. There are gaps in the research that do not completely address the prevalence found, the barriers listed, and the suggested interventions for

remediation; the domains do not cancel each other out nor do they entirely integrate with one another. The following chart lists the identified themes within these domains, as well as how they overlap with one another and fall short of fully addressing concerns brought up in previous categories.

Table 20

Domains and Themes Compared

Prevalence	Barriers	Suggested Interventions
• Psychiatric Disorders • Substance Use • Psychological Distress • Burnout & Compassion Fatigue • Impairment	• Denial • Lack of Education and Prevention • Keeping Secrets • Insitutitons of Psychology • Lacking Evidence - Based Research on Psychologists • Lacking a Culture of Support • Limited Opportunity for Psychotherapy	• Educating and Increasing Awareness • Improving Systemic Influences • Utilizing Self-Care • Developing a Culture of Support • Utilizing Personal Therapy & Treatment Programs • Increasing Empirical Evidence

If we are to critically review the themes identified within each domain, there are concerns that the themes are not collaboratively addressing one another and instead are incorrectly attending to or completely ignoring highlights in the research. For example, under the domain of suggested interventions, a theme emerged of increasing the empirical evidence (found in Table 19) to shed light on this population needing more coverage in the community (APA, 2006; Barnett & Cooper, 2009; Gilroy et al., 2002; Smith & Moss, 2009). Unfortunately, the theme or

domain did not address investigating more accurate and up-to-date reports of psychiatric prevalence and psychological distress. The focus in this theme of increasing empirical research was primarily to investigate impairment and burnout, as well as compassion fatigue and effectiveness of colleague assistance programs.

Many concerns arise with the lack of focus on psychiatric and psychological distress; what is the profession trying to hide? Why have so many other professions been able to objectively examine and bring forward mental health concerns? There are particular concerns with reliability and validity of reported prevalence. Data were predominantly self-report, despite barriers identifying psychologists' difficulties with recognizing mental health symptoms. Few researchers noted reliability of data and there is a general push to increase objective measures for assessing psychologists (Guy et al., 1989; Kleespies et al., 2011; O'Connor, 2001). Additionally, prevalence ranges vacillated tremendously, rendering it at times meaningless. Having a better understanding of prevalence and symptomology of depression or substance use among psychologists will provide evidence-informed treatment interventions to colleague assistance programs and the practitioners working in treatment agencies. In order to truly understand the effectiveness of colleague assistance programs or any intervention implemented, empirical data must be developed to provide a better understanding of the specific mental health vulnerabilities psychologists face, particularly from more objective measures.

Another pitfall was the use of personal therapy among psychologists when comparing barriers (found in Table 13) and interventions (found in Table 18). Utilizing personal therapy and treatment programs to remediate mental health distress was identified as an important option for psychologists; however, it was also identified as a barrier for psychologists. Under the domain of barriers, psychologists noted limited opportunity for psychotherapy due to difficulties with

funding and finding an acceptable therapist, a lack of time, financial strain, and limited accessibility (Bearse et al., 2013; Gilroy et al., 2002; Good et al., 1995; Mahoney, 1997). The researchers noted psychologists preferring to seek personal therapy options for the purposes of controlled privacy, a viable coping option to manage distress, as well as minimizing punitive consequences regarding loss of stature, embarrassment, and licensure status (Barnett & Hillard, 2001; Bridgeman & Galper, 2010; Coster & Schwebel, 1997; Mahoney, 1997; Skorina et al., 1990). Yet in the remediation for suggested interventions, 20 % to 90% of psychologists reported participating in personal therapy at some point in the lives. This inconsistency does not negate the barrier; in fact, some may argue that it undermines or even eliminates it. It appears that personal psychotherapy is an option for some psychologists, particularly those with more privilege concerning time, funds, and location; however, others lack the time, financial opportunity, and accessibility to participate in such an option, highlighting further social injustices built into the interventions system.

Fortunately, states are attempting to adopt a more creative delivery system of mental health care based on additional allocated funding, which has been allotted for integrated care, increasing the amounts of professional alliance, as well as offering peer support specialists and telecare services (NAMI, 2014). In this regard, mental health is beginning to be thought of as part of one's medical treatment, thus being funded through insurance care, as it is believed to reduce overall medical cost spending in the United States (NAMI, 2014). The motion has also driven states to provide loan forgiveness and financial incentives to attract mental health clinicians to underserved communities (NAMI, 2014). Some states, including Nebraska, Wisconsin, Illinois, and Kentucky, are offering other educational incentives for furthering the profession that include increasing the number of internships and grant programs and giving

prescribing rights to mental health clinicians (NAMI, 2014). This is all good news, as it speaks to a general movement of advocacy for mental health practitioners in diverse stages of their career. This movement of new mental health parities promoting one's mental health care and access to it is profound in the promotion of wellness and vitality. Some criticisms include that because these parities are not directly focused for psychologists, many can benefit from them and many will not. Early career psychologists will likely have to move to rural non-desirable locations or underpaid positions for opportunities for loan forgiveness or they will have to further drive themselves into debt for prescribing privileges. Increased government funding for mental health treatment will also likely benefit some; however, it does not directly speak to the concerns of confidentiality for psychologists and may not eliminate this noted barrier (found in Table 13). It can be argued that new mental health parities heighten the potential for penalization from governing licensing boards, as these types of records can be investigated as a result of certain job opportunities, as well as legal and ethical situations. Leaders in the field need to better address this issue, as so much of the data reported psychologists' preference in seeking private therapy, which makes it a viable option to make as accessible as possible.

Other inconsistencies were found in the data in the development of evidence-based research on psychologists and the areas in which that research should blossom. For example, among barriers listed (found in Table 11), there was an identified need to increase empirically based research that focuses primarily on psychologists' mental illness, psychological distress, and impairment (Bridgeman & Galper, 2010; Guy et al., 1989; Kleespies et al., 2011; O'Connor, 2001; Smith & Moss, 2009). However, in the domain of interventions suggested (found in Table 19), the remediation proposed primarily assessing colleague assistance programs (Barnett & Cooper, 2009; Barnett & Hillard, 2001; Gilroy et al., 2002; O'Connor, 2001; Thomas, 2005), the

same programs that are marked in the barrier domain as being unused or useless to meet psychologists' needs (found in Table 15). In the same domain, there was some discussion of the need to study the effectiveness of mental health programs and how well they are working for psychologists, so there is reason to believe that researching CAPs will inevitably help to determine its place for psychologists. However, when trying to determine what to research in a population and prioritize said research, it appears that the field of psychology is shying away from addressing more difficult but notably more appropriate questions being brought up in the literature on barriers.

This pattern speaks to the themes of professional culture housing prevalence of denial and shame. For example, in Table 17, eliminating stigmas was addressed as an intervening theme (Kleespies et al., 2011; O'Connor, 2001), but not brought up as one of the barriers psychologists reported. When we start summarizing these inconsistencies, what does it mean? Are psychologists underreporting concerns with the stigmas they face when needing mental health services? Is there lack of efficient research on this topic, causing leaders and researchers to make assumptions that are not empirically based? Is said denial and shame stopping us from both asking and answering questions that highlight vulnerabilities of psychologists? Regardless of the reason, this blind spot is likely wreaking havoc for many psychologists in isolation. Some can argue that by increasing awareness and creating a culture of support, denial may decrease; however, further considerations need to be made for ways to deconstruct this issue. It is simply neither ethical nor efficient to ignore the tremendous rates of denial reported.

Finally, there is a need to critically address the suggested intervention that adequate utilization of self-care will eliminate risk factors noted in the prevalence domain (refer to Table 16). If psychologists are susceptible to psychiatric disorders such as depression and substance

use, as well as struggles with denial and secret keeping, an intervention such as coping skill management would play only one role in minimizing symptoms of distress and impairment. This contingency would likely be greatly suffocated by the isolative and unsupportive nature of the profession found in the domains of prevalence and barriers. For example, if a client sought treatment with symptoms of depression (Gilroy et al., 2002; Good et al., 2009; Nachshoni et al., 2008; Pope & Tabachnick, 1994; Smith & Moss, 2009; Thoreson et al., 1989; Wood et al., 1985), substance use (Elliott & Guy, 1993; Floyd et al., 1998; Guy et al., 1989; Kleespies et al., 2011; Skorina et al., 1990; Thoreson et al., 1989), and secrecy of the problem (Barnett & Hillard, 2001; Bridgeman & Galper, 2010; Pope & Tabachnick, 1994; Thomas, 2005), would we send them off with a list of self-care skills to use on their own and write it off as a successful case? No. We would develop an integrative approach to treat the symptoms, which would likely take time, support from potentially multiple providers, and ongoing guidance. It is also important to note that the lack of self-care utilization was not noted in the barrier domain as a relevant theme, so despite the current use of it, it seems to be playing an irrelevant role in helping to eliminate barriers. In fact, some may argue that it continues to harbor the professional culture of keeping secrets and isolative practices for mental health.

Implications for practice. Understanding the vulnerabilities that psychologists may have regarding their prevalence, barriers, and suggested interventions offers significant insight to how the professional community can better assist psychologists with nourishing their vitality and wellness. Based on the evidence found, there is a great need to provide special attention to their wellness. There is an overall general need to increase mental health services for psychologists that offer profession-specific interventions and sensitivities (APA, 2006; Bearse et al., 2013; Good et al., 2009; Kleespies et al., 2011; Laliotis & Grayson, 1985; O'Connor, n.d., 2001; Orr,

1997; Smith & Moss, 2009). This is likely due to the research indicating that psychologists present with special needs and vulnerabilities as a population and would benefit from receiving professional treatment interventions by professionals who have specific training with such needs. The integration of training psychologists, as well as the supervisors, teachers, and therapists, is likely to have profound effects on their wellness.

This likely means improving the available education sources and services available to them: for example, building organizations that are supportive to psychologists' mental health, similarly to how psychologists have built a culture of continued learning and strong academic foundations. Multiple professional bodies have demanded the need to increase the mental health services provided to psychologists (APA, 2006; Barnett & Cooper, 2009; Barnett & Hillard, 2001; Good et al., 2009; O'Connor, 2001; Pope & Tabachnick, 1994; Smith & Moss, 2009; Thoreson et al., 1989; Sherman & Thelen, 1998; Wood et al., 1985). One particular area to highlight is the services they receive through private and organizational centers. These treatment centers need to be aware of the prevalence of denial and secret-keeping behaviors by psychologists. Treatment providers need to familiarize themselves with the symptoms associated with the themes found in the prevalence domain (e.g., substance use, mood dysregulation, etc.). Services must include awareness of psychological vulnerabilities and the culture psychologists have developed to avoid addressing such issues. This is particularly more applicable to psychologists who seek treatment and supervisors who work with psychologists.

Finally, ethical considerations were consistently brought up as another area needing revisions in the profession of psychology (APA, 2006; Barnett & Hillard, 2001; Gilroy et al. 2002; Good et al., 2009; Kleespies et al., 2011; O'Connor, 2001; Orr, 1997; Sherman & Thelen, 1998; Thomas, 2005; Zur, 2014). Transformations of policy change, as well as protection and

rights for psychologists' mental wellness, must be brought to light. Psychologists are asking for greater support and protection of their mental health, as well as a sense of protection from the profession. This potentially means revising punitive measures by licensing boards that work against psychologists and solely for the population they serve. There was a stated demand for legislative mandates to decrease punitive measures associated with impairment when interventions, increase remediation options, and build protection codes for psychologists into their ethics and standards of practice (APA, 2006; Barnett & Hillard, 2001; Gilroy et al. 2002; Kleespies et al., 2011; O'Connor, 2001; Orr, 1997; Sherman & Thelen, 1998).

Limitations

Several limitations of this study should be recognized. This study did not use a universal framework within the research to define relevant terms found in the literature such as burnout, impairment, and compassion fatigue, which can leave the reader with ambiguous frameworks making it difficult to then criticize. Another limitation to highlight is that the prevalence rates identified among psychologists were determined by self-reports. This increases subjective and guarded responses in the literature. There was also no standard tool that weighed each resource based on quality, quantity, and universality. This allowed for increased bias by the researcher during the data selection process or possible over- or under-reporting on various themes. Furthermore, protective factors psychologists have were not addressed in this research. It would be interesting to see how this weighs in on the themes found in prevalence, barriers, and interventions, as there are likely variables that may mitigate the risks of psychological distress.

Additionally, some of the data being analyzed were decades old. There were critical liberties taken by the primary researchers in efforts to offer generalizable information to the audience and help predict what 21st-century psychologists have faced based on some data from

the 20th century. For example, how could researchers, such as Creswell, who played a significant role in the methodological framework of this study, predict in 1994 that data sets developed in 2015 would be transferable to psychologists from the general population? No doubt the reader should be critical in recognizing that there are limitations when pulling data from history without analyzing the sociopolitical connections and influences. Unfortunately, without using historical data, we then diminish voices of many psychologists, which some may argue to render the conclusions somewhat meaningless.

Finally, many types of mental health practitioners were mentioned during the development of this research project during the introduction and literature review. For example, psychiatrists, social workers, and other mental health clinicians' voices were used to harness the gaps psychologists are facing when discussing their mental health and various professional obstacles; however, these other mental health practitioners were excluded during the data analysis. This concept was vital in the data analysis in keeping it congruent to the methodology and framework, as well as finding relevant results that were specific to psychologists. Some may argue that this exclusionary method significantly impacts the results; the researchers found that by excluding other mental health professionals' attributions, the research loudly highlights the voice of psychologists and the particularities of prevalence, barriers, and remedies they are facing. Thus, the results may not be applicable to other divisions of mental health care. This was deemed a relevant need, as the literature indicated psychologists facing different types of cultural dispositions, ethical frameworks, and employment positions than that of other mental health practitioners.

Future Research Areas

Areas for future research should include examining this topic more closely, particularly looking at some of the gaps that were not addressed. This may include further investigating whether psychologists' prevalence of mental health diagnoses preceded them entering the profession or whether they are consequences of the psychologists' work demands; for example, Table 5 and 6 discuss burnout, compassion, fatigue, and impairment, which is likely the result of post professional stature (Bearse et al., 2013; Bridgeman & Galper, 2010; Farber & Heifetz, 1982; Linnerooth et al., 2011; Rupert & Morgan, 2005; Rupert et al., 2009; Sherman & Thelen, 1998; Smith & Moss, 2009). However, psychiatric disorders and substance use were discussed in the context of a lifetime prevalence. This brings to attention whether these themes, along with psychological distress prevalence, can be avoided while in the profession and/or warned as a risk factor, such as personality traits developed over the course of a lifetime. As noted before, general detail to this domain requires more attention, including ranges being examined more closely.

It would also be interesting to compare doctoral level professionals' suggestions on how to manage prevalence, barriers, and remediation of obstacles between the various specializations of psychology, such as academic, forensic, health, counseling, organizational, and other practice areas of psychology practice. Are psychologists in certain specialties more susceptible to mental illness or psychological distress than psychologists in other specialties, therefore requiring specialized interventions that cater to their specific needs? For example, in Table 2, the theme of psychiatric disorders were identified; however, Wood et al. (1985) were the only researchers who specified in their sample particular specialties of training (i.e., academic versus clinical). They found significant proportions of impairment as a result of psychologists' distress eventually leading to 60% reports of depressed symptomology. This was the general theme of the project;

few researchers specified the type of psychologists, likely due to concerns with sample size. Although the questions of this research project did not elicit information about types of psychologists, future research can help to further delineate relevant characteristics, if applicable.

Another area in the research that was uncovered, but not fully addressed was female psychologists' susceptibility to higher symptomology of suicidal ideation and severity of symptoms, as well as their higher rates of impairment at work than males. Female psychologists were also noted to be more likely than males to reach out for support. These data are surprising and bring more questions about why such vulnerabilities exist and if this impacts what remediation would be more or less effective for female versus male psychologists. Also, no data were found on the use of prescription medications among psychologists. Data like these can increase awareness to more objective diagnoses and clinical symptomology among psychologists, thus providing more evidence for prevalence rates. Considering the parity laws reported by NAMI (2014) for mental health that have become available to many psychologists in approximately 30 states, further examination of parity changes will be a relevant component as to whether this remediation has been effective for psychologists accessing mental health care or if barriers remain for them. Finally, future research should also examine the historical and socio-political elements of psychologists' vitality and wellness over the years and its connection to the prevalence, barriers, and remedies. This research can lend a more critical eye to the influential systems that play a role in one's wellness. More importantly, research in these areas will help to eliminate the blind spot in our professional social justice activities and advocacy for practicing psychologists; for example, highlighting the areas of prevalence and barriers noted in this project will give psychologists the advantage they deserve to have professional vitality and wellness

while practicing in their personal lives. It is the duty of the psychological profession to provide

the opportunity for wellness.

References

Advisory Committee on Colleague Assistance. (2016). *Tips for self-care.* Washington, DC: APA Practice Organization. Retrieved from http://www.apapracticecentral.org/ce/self-care/acca-promoting.aspx

American Counseling Association. (2014). *Code of ethics.* Alexandria, VA: Author. Retrieved from http://www.counseling.org/Resources/aca-code-of-ethics.pdf

American Psychiatric Association. (1952). *Diagnostic and statistical manual of mental disorders* (1st ed.). Washington, DC: Author.

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). Washington, DC: Author.

American Psychiatric Association. (1974). *Diagnostic and statistical manual of mental disorders* (2nd ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2013a). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

American Psychiatric Association. (2013b). *The principles of medical ethics with annotations especially applicable to psychiatry.* Arlington, VA: Author. Retrieved from http://www.psychiatry.org/File Library/Practice/Ethics Documents/principles2013--final.pdf

American Psychological Association. (2006). *Advancing colleague assistance in professional psychology.* Washington, DC: Author. Retrieved from http://www.apa.org/practice/resources/assistance/monograph.pdf

American Psychological Association. (2010). *Ethical principles of psychologists and code of conduct.* Washington, DC: Author. Retrieved from http://www.apa.org/ethics/code/principles.pdf

American Psychological Association. (2014). *Ethical principles of psychologists and code of conduct.* Washington, DC: Author. Retrieved from www.apa.org/ethics/code/index.aspx

Anxiety and Depression Association of America. (2015). *Facts and statistics.* Silver Spring, MD: Author. Retrieved from http://www.adaa.org/about-adaa/press-room/facts-statistics

Baird, K., & Kracen, A. C. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counselling Psychology Quarterly, 19*(2), 181–188. doi:10.1080/09515070600811899

Barnett, J. E., & Cooper, N. (2009). Creating a culture of self-care. *Clinical Psychological Scientific Practice, 16,* 16–20. doi:10.1111/j.1468-2850.2009.01138.x

Barnett, J. E., & Hillard, D. (2001). Psychologist distress and impairment: The availability, nature, and use of colleague assistance programs for psychologists. *Professional Psychology: Research and Practice, 32,* 205–210. doi:10.1037/0735-7028.32.2.205

Barrier. (2015). In *Merriam-Webster's online dictionary*. Retrieved from http://www.merriam-webster.com/dictionary/barrier

Bearse, J. L., McMinn, M. R., Seegobin, W., & Free, K. (2013). Barriers to psychologists seeking mental health care. *Professional Psychology: Research and Practice, 44,* 150–157. doi:10.1037/a0031182

Boden, J. M., Fergusson, D. M., & Horwood, L. J. (2007). Anxiety disorders and suicidal behaviours in adolescence and young adulthood: Findings from a longitudinal study. *Psychological Medicine, 37,* 431–440. doi:10.1017/s0033291706009147

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and dose development.* Thousand Oaks, CA: Sage.

Braquehais, M. D. (2011). Reconsidering suicide prevention strategies in physicians. *The Royal Australian and New Zealand College of Psychiatrists, 45*(12), 1095–1096. doi:10.3109/00048674.2011.615292

Braun, V., & Clarke, V. (2008). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. doi:10.1191/1478088706qp063oa

Bridgeman, D. L. (2006). Embracing wellness/prevention for psychologists: Bold or boring? *The California Psychologist, 39*(2), 31–32. Retrieved from http://c.ymcdn.com/sites/www.cpapsych.org/resource/resmgr/imported/files/clasp/articles/cp/EmbracingWellness-Prevention.pdf

Bridgeman, D. L., & Galper, D. I. (2010, August). *Listening to our colleagues: 2009 Practice Survey—Worries, wellness, and wisdom* [PowerPoint slides]. Presented at the 118th Annual Convention of the American Psychological Association, San Diego, CA. Retrieved from https://www.apa.org/practice/resources/assistance/acca-2010-convention.pdf

Centers for Disease Control and Prevention. (2011). Mental illness surveillance among adults in the United States. *Morbidity and Mortality Weekly Report, 60*(3), 1–32. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/su6003a1.htm?s_cid=su6003a1_w

Coster, J. S., & Schwebel, M. S. (1997). Well-functioning in professional psychology. *Professional Psychology: Research and Practice, 28,* 5–13. doi:10.1037//0735-7028.28.1.5

Creswell, J. W. (1994). *Research design: Qualitative and quantitative approaches.* Thousand Oaks, CA: Sage.

Dearing, R. L., Maddux, J. E., & Tangney, J. P. (2005). Predictors of psychological help seeking in clinical and counseling psychology graduate students. *Professional Psychology: Research and Practice, 36,* 323–329. doi:10.1037/0735-7028.36.3.323

Elliott, D. M., & Guy, J. D. (1993). Mental health professionals versus non-mental-health professionals: Childhood trauma and adult functioning. *Professional Psychology: Research and Practice, 24,* 83–90. doi:10.1037/0735-7028.24.1.83

Farber, B. A., & Heifetz, L. J. (1982). The process and dimensions of burnout in psychotherapists. *Professional Psychology, 12*(2), 293–301. doi:10.1037/0735-7028.13.2.293

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods, 5*(1), 1–11. Retrieved from http://www.ualberta.ca/~iiqm/backissues/5_1/PDF/FEREDAY.PDF

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *In Session: Psychotherapy in Practice, 58*(11), 1433–1441. doi:10.1002/jclp.10090

Firmin, M. W., Wantz, R. A., Holmes, H. J., Stoltzfus, M. R., Brigitte, N., & Geib, E. F. (2012). Undergraduate college students' perception of psychologists. *North American Journal of Psychology, 14*(2), 371–382. Retrieved from http://najp.8m.com

Fleischer, J. A., & Wissler, A. (1985). The therapist as a patient: Special problems and considerations. *Psychotherapy, 22*(3), 587–594. doi:10.1037/h0085544

Floyd, M., Myszka, M. T., & Orr, P. (1998). Licensed psychologists' knowledge and utilization of a state association Colleague Assistance Committee. *Professional Psychology: Research and Practice, 29,* 594–598. doi:10.1037/0735-7028.29.6.594

Freudenberger, H. J. (1974). Staff burnout. *Journal of Social Issues, 1,* 159–165. doi:10.1111/j.1540-4560.1974.tb00706.x

Freudenberger, H. J. (1986). Chemical abuse among psychologists: Symptoms, causes, & treatment issues. In R. R. Kilburg, P. E. Nathan, & R. W. Thoreson (Eds.), *Professionals in distress: Issues, syndromes, and solutions in psychology* (pp. 135–152). Washington, DC: American Psychological Association.

Gilroy, P. J., Carroll, L., & Murra, J. (2002). A preliminary survey of counseling psychologists' personal experiences with depression and treatment. *Professional Psychology: Research and Practice, 33,* 402–407. doi:10.1037/0735-7028.33.4.402

Good, G. E., Khairallah, T., & Mintz, L. B. (2009). Wellness and impairment: Moving beyond noble us and troubled them. *Clinical Psychological Scientific Practice, 16,* 21–23. doi:10.1111/j.1468-2850.2009.01139.x

Good, G. E., Thoreson, R. W., & Shaughnessy, P. (1995). Substance use, confrontation of impaired colleagues, and psychological functioning among counseling psychologists: A national survey. *The Counseling Psychologist, 23*(4), 703–721. doi:10.1177/0011000095234010

Grafanaki, S., Pearson, D., Cini, F., Godula, D., McKenzie, B., Nason, S., & Anderegg, M. (2005). Sources of renewal: A qualitative study on the experience and role of leisure in the life of counselors and psychologists. *Counselling Psychology Quarterly, 18*(1), 31–40. doi:10.1080/09515070500099660

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105–117). Thousand Oaks, CA: Sage.

Guest, G., MacQueen, K. M., & Namey, E. E. (2012). *Applied thematic analysis*. Thousand Oaks, CA: Sage.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry, 10,* 113–122. doi:10.1186/1471-244x-10-113

Guy, J. D., Poelstra, P. L., & Stark, M. J. (1989). Personal distress and therapeutic effectiveness: National survey of psychologists practicing psychotherapy. *Professional Psychology: Research and Practice, 20,* 48–50. doi:10.1037//0735-7028.20.1.48

Howitt, D., & Cramer, D. (2007). *Introduction to research methods* (2nd ed.). Upper Saddle River, NJ: Prentice Hall.

Kaslow, F. W. (1986). Therapy with distressed psychotherapists: Special problems and challenges. In R. R. Kilburg, P. E. Nathan, & R. W. Thoreson (Eds.), *Professionals in distress* (pp. 188–198). Washington, DC: American Psychological Association.

Kazdin, A. E. (2002). *Methodological issues and strategies in clinical research* (3rd ed.). Washington, DC: American Psychological Association.

Kersting, L. (2004). Psychologists knock down practice barriers. *Monitor on Psychology, 35*(10), 36–39. doi:10.1037/e308892005-025

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 593–602. doi:10.1001/archpsyc.62.6.593

Kessler, R. C., Gonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., . . . Kendler, K. S. (1994). Lifetime and 12-month prevalence of DSM-II-R psychiatric disorders in the United States: Results from the National Comorbidity Survey. *Archives of General Psychiatry, 51,* 8–19. doi:10.1001/archpsyc.1994.03950010008002

Kleespies, P. M., Van Orden, K. A., Bongar, B., Bridgeman, D., Bufka, L. F., Galper, D. I., . . . Yufit, R. I. (2011). Psychologist suicide: Incidence, impact, and suggestions for prevention, intervention, and postvention. *Professional Psychology: Research and Practice, 42,* 244–251. doi:10.1037/a0022805

Kutz, S. L. (1986). Defining "impaired psychologist." *American Psychologist, 41*(2), 220. doi:10.1037//0003-066x.41.2.220.a

LaFreniere, P. (2009). A functionalist perspective on social anxiety and avoidant personality disorder. *Development and Psychopathology, 21*(4), 1065–1082. doi:10.1017/S0954579409990046

Laliotis, D., & Grayson, J. (1985). Psychologist heal thyself: What is available to the impaired psychologist? *American Psychologist, 40,* 84–96. doi:10.1037/0003-066x.40.1.84

Linnerooth, P. J., Mrdjenovich, A. J., & Moore, B. A. (2011). Professional burnout in clinical psychologists: Recommendations before, during, and after deployment. *Professional Psychology, 42*(1), 87–93. doi:10.1037/a0022295

Mahoney, M. J. (1997). Psychotherapists' personal problems and self-care patterns. *Professional Psychology: Research and Practice, 28,* 14–16. doi:10.1037//0735-7028.28.1.14

Mausner, J. S., & Steppacher, R. C. (1973). Suicide in professionals: A study of male and female psychologists. *American Journal of Epidemiology, 98*(6), 436–445. Retrieved from http://aje.oxfordjournals.org/

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3,* 131–149. doi:10.1002/jts.2490030110

McCann, I. L., Sakheim, D. K., Abrahamson, D. J. (1988). Trauma and victimization: A model of psychological adaptation. *The Counseling Psychologist, 16*(4), 531–594. doi:10.1177/0011000088164002

Mojtabai, R., Olffson, M., Sampson, N., Jin, R., Druss, B., Wang, P. S., . . . Kessler, R. C. (2011). Barriers to mental health treatment: Results from the National Comorbidity Survey Replication (NCR-S). *Psychological Medicine, 41*(8), 1751–1761. doi:10.1017/S0033291710002291

Mulvale, G., & Hurley, J. (2008). Insurance coverage and the treatment of mental illness: Effect on medication and provider use. *The Journal of Mental Health Policy and Economics, 11*(3), 177–199. Retrieved from http://www.icmpe.org/test1/journal/journal.htm

Nachshoni, T., Abramovitch, Y., Lerner, V., Assael-Amir, M., Kotler, M., & Strous, R. D. (2008). Psychologists' and social workers' self-descriptions using DSM-IV psychopathology. *Psychological Reports, 103,* 173–188. doi:10.2466/pr0.103.1.173-188

National Alliance on Mental Illness. (2015). *Mental health treatment and services.* Arlington, VA: Author. Retrieved from https://www.nami.org/Learn-More/Treatment

National Alliance on Mental Illness. (2016). *Parity for mental health coverage.* Arlington, VA: Author. Retrieved from https://www.nami.org/Learn-More/Mental-Health-Public-Policy/Parity-for-Mental-Health-Coverage

National Institute of Mental Health. (2014). *State mental health legislation 2014: Trends, themes, & effective practices.* Bethesda, MD: Author. Retrieved from https://www.nami.org/legreport2014

National Institute of Mental Health. (2015a). *Statistics.* Bethesda, MD: Author. Retrieved from http://www.nimh.nih.gov/health/statistics/index.shtml

National Institute of Mental Health. (2015b). *Suicide: A major, preventable mental health problem.* Bethesda, MD: Author. Retrieved from http://www.nimh.nih.gov/health/publications/suicide-a-major-preventable-mental-health-problem-fact-sheet/index.shtml

National Institute of Mental Health. (2015c). *What is prevalence?* Bethesda, MD: Author. Retrieved from http://www.nimh.nih.gov/health/statistics/prevalence/index.shtml

Newell, J. M., & MacNeil, G. A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventive methods for clinicians and researchers. *Best Practices in Mental Health: An International Journal, 6*(2), 57–68. Retrieved from http://lyceumbooks.com/MentalHJournal.htm

New York State Department of Health. (1999). *Basic statistics: About incidence, prevalence, morbidity, and mortality—Statistics teaching tools.* Retrieved from https://www.health.ny.gov/diseases/chronic/basicstat.htm

Norcross, J. C., Strausser-Kirtland, D. J., & Faltus, F. J. (1988). The therapist's therapist. *American Journal of Psychotherapy, 42*(1), 53–66. Retrieved from http://www.ajp.org

O'Connor, M. F. (n.d.). *Intervening with an impaired colleague.* Washington, DC: American Psychological Association Practice Organization. Retrieved from http://www.apapracticecentral.org/ce/self-care/intervening.aspx

O'Connor, M. F. (2001). On the etiology and effective management of professional distress and impairment among psychologists. *Professional Psychology: Research and Practice, 32,* 345–350. doi:10.1037//0735-7028.32.4.345

Orr, P. (1997). Psychology impaired? *Professional Psychology: Research and Practice, 28,* 293–296. doi:10.1037/0735-7028.28.3.293

Pearlman, L., & Saakvitne, K. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C. Figley, (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* Florence, KY: Brunner/Mazel.

Phillips, S. M. (1999). U.S. psychologists' suicide rates have declined since the 1960s. *Archives of Suicide Research, 5,* 12–25. doi:10.1080/13811119908258312

Pope, K. S., & Tabachnick, B. G. (1994). Therapists as patients: A national survey of psychologists' experiences, problems, and beliefs. *Professional Psychology: Research and Practice, 25,* 247–258. doi:10.1037//0735-7028.25.3.247

Practice Central. (2010). *Survey findings emphasize the importance of self-care for psychologists.* Washington, DC: APA Practice Organization. Retrieved from http://www.apapracticecentral.org/update/2010/08-31/survey.aspx

Ray, S. L., Wong, C., White, D., & Heaslip, K. (2013). Compassion satisfaction, compassion fatigue, work life conditions, and burnout among frontline mental health care professionals. *Traumatology, 19*(4), 255–267. doi:10.1177/1534765612471144

Robins, L. N., Locke, B. Z., & Regier, D. A. (1991). *Psychiatric disorders in America: The epidemiologic catchment area study.* New York, NY: Free Press.

Rowe, C. (2007, July 26). Seattle psychologist suspected of voyeurism takes own life. *Seattle Post-Intelligencer.* Retrieved from http://www.seattlepi.com/local/article/Seattle-psychologist-suspected-of-voyeurism-takes-1244832.php

Rupert, P. A., & Morgan, D. J. (2005). Work setting and burnout among professional psychologists. *Professional Psychology: Research and Practice, 36,* 544–550. doi:10.1037/0735-7028.36.5.544

Rupert, P. A., Stevanovic, P., & Hunley, H. A. (2009). Work-family conflict and burnout among practicing psychologists. *Professional Psychology: Research and Practice, 40,* 54–61. doi:10.1037/a0012538

Schwebel, M., & Coster, J. (1998). Well-functioning in professional psychologists: As program heads see it. *Professional Psychology: Research and Practice, 29,* 284–292. doi:10.1037/0735-7028.29.3.284

Sherman, M. D., & Thelen, M. H. (1998). Distress and professional impairment among psychologists in clinical practice. *Professional Psychology: Research and Practice, 29,* 79–85. doi:10.1037//0735-7028.29.1.79

Showalter, S. E. (2010). Compassion fatigue: What is it? Why does it matter? Recognizing the symptoms, acknowledging the impact, developing the tools to prevent compassion fatigue, and strengthen the professional already suffering from the effects. *American Journal of Hospice & Palliative Medicine, 27*(4), 239–242. doi:10.1177/1049909109354096

Skorina, J. K. (1982). Alcoholic psychologists: The need for humane and effective regulation. *Professional Practice of Psychology, 3*(2), 33–41.

Skorina, J. K., Bissell, L., & de Soto, C. B. (1990). Alcoholic psychologists: Routes to recovery. *Professional Psychology: Research and Practice, 21,* 248–251. doi:10.1037/0735-7028.21.4.248

Smith, P. L., & Moss, S. B. (2009). Psychologist impairment: What is it, how can it be prevented, and what can be done to address it? *Clinical Psychology: Science and Practice, 16*(1), 1–15. doi:10.1111/j.1468-2850.2009.01137.x

Sprang, G., Clark, J. J., & Whitt-Woosley, A. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life. *Journal of Loss and Trauma, 12,* 259–280. doi:10.1080/15325020701238093

Thomas, J. T. (2005). Licensing board complaints: Minimizing the impact on the psychologist's defense and clinical practice. *Professional Psychology: Research and Practice, 36,* 426–433. doi:10.1037/0735-7028.36.4.426

Thompson, I. A., Amatea, E. S., & Thompson, E. S. (2014). Personal and contextual predictors of mental health counselors' compassion fatigue and burnout. *Journal of Mental Health Counseling, 36*(1), 58–77. doi:10.17744/mehc.36.1.p61m73373m4617r3

Thompson, M. (2013, January 11). Dr. Peter J. N. Linnerooth, 1970-2013: How an Army psychologist, who won a Bronze Star in Iraq for keeping troops from killing themselves, couldn't save his own life. *Time.* Retrieved from http://nation.time.com/2013/01/11/dr-peter-j-n-linnerooth-1970-2013

Thoreson, R. W., Miller, M., & Krauskopf, C. J. (1989). The distressed psychologist: Prevalence and treatment considerations. *Professional Psychology: Research and Practice, 20,* 153–158. doi:10.1037//0735-7028.20.3.153

Vogel, D. L., Wester, S. R., & Larson, L. M. (2007). Avoidance of counseling: Psychological factors that inhibit seeking help. *Journal of Counseling & Development, 85,* 410–422. doi:10.1002/j.1556-6678.2007.tb00609.x

Wood, B. J., Klein, S., Cross, H. J., Lammers, C. J., & Elliott, J. K. (1985). Impaired practitioners: Psychologists' opinions about prevalence, and proposals for intervention. *Professional Psychology: Research and Practice, 16,* 843–850. doi:10.1037/0735-7028.16.6.843

World Health Organization. (1992). *ICD-10 Classification of mental and behavioural disorders: Clinical descriptions and diagnosis* (1st ed.). Geneva, Switzerland: Author. Retrieved from http://www.who.int/classifications/icd/en/bluebook.pdf

World Health Organization. (2010). *International statistical classification of disease and related health problems* (10th ed.). Geneva, Switzerland: Author. Retrieved from http://www.who.int/classifications/icd/ICD10Volume2_en_2010.pdf

Young, J. L. (2014, January 29). Addressing mental health treatment barriers. *Psychology Today.* Retrieved from https://www.psychologytoday.com/blog/when-your-adult-child-breaks-your-heart/201401/addressing-mental-health-treatment-barriers

Zur, O. (2014). *Codes of ethics on therapists' impairment, burnout and self-care.* Sonoma, CA: Zur Institute. Retrieved from http://www.zurinstitute.com/ethicsofburnout.html