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D&I BLUEPRINT FOR CLINICAL DOCTORAL SUPPORT

ABSTRACT

Recent psychological research has emphasized a graduate student mental health crisis precipitating from a wide range of stressors (Evans, et al., 2017, Evans et al., 2018, Rawlins, 2019, Yusoff, et al., 2013). While the topic of student wellness and self-care is frequently discussed in academic circles, the problem of burnout, characterized by symptoms of emotional exhaustion, depersonalization, and reduced feelings of personal accomplishment in the workplace continues to persist and is not specific to the field of clinical psychology (Maslach & Leiter, 2006).

This study will serve as a pilot to both implement an assessment and intervention model in a doctoral program, and to serve as a blueprint for other doctoral programs seeking to address student wellness. A two-part survey was distributed to clinical doctoral students at a Clinical Psychology doctoral program in the Northeast assessing interest in social-emotional, financial, and academic supports they were most likely to utilize, and a second part assessing their counselor burnout, perceived environmental support, and engagement in self-care behaviors. The first part of the survey found that students largely supported increased scholarship funding and greater accessibility to affordable therapy resources for themselves as the two factors which would mostly significantly support their wellness, if implemented. The study also found that students with higher counselor burnout were more likely to perceive themselves as less effective in their clinical work, highlighting important ethical considerations for programs. To promote systemic change, suggestions based on the results were provided at each ecological level for the program to consider, as well as other programs considering implementing similar assessments and interventions.
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Chapter I

Introduction

Existence of a Growing Crisis in Student Mental Health

Recent psychological research has emphasized a graduate student mental health crisis which has precipitated from a wide range of stressors (Evans, et al., 2017, Evans et al., 2018, Rawlins, 2019, Yusoff, et al., 2013). While the topic of student wellness and self-care is frequently discussed in academic circles, the problem continues to persist. In a sample of 2200 graduate students, approximately 39% of those students scored in the moderate to severe range of depression, as compared to only 6% in the general population, measured with the same scale (Evans et al., 2018). One study, which examined both graduate and undergraduate sample populations, found that 26.2% of doctoral students met criteria for a mental health problem (Rotenstein, et al., 2016). A 2009 American Psychological Association survey reported that 87% of psychology graduate students reported clinical anxiety, while 68% reported symptoms consistent with a diagnosis of depression, and 19% reporting suicidal thoughts – all significantly higher than the national averages (APA, 2009). It is also notable that while diagnosable mental health problems capture some of the issue, the extent of graduate student distress is high, ranging from stress to burnout to mental health symptoms (e.g., anxiety, sadness, low self-esteem), to diagnosable mental health disorders; all which impair functioning to varying degrees.

Despite the great need amongst students for resources, resources are sometimes in short supply, and utilization of available resources among distressed doctoral students is low due to issues of access and stigma (Barse et al., 2013, Digiuni, Jones, & Camic, 2012; Lipson, et al., 2016). It is
not difficult to imagine the ways in which mental health problems can impact functioning in an academic setting, and doctoral students are not immune to these typical barriers to mental health services experienced by the general population, such as stigma, financial insecurity, adequate insurance coverage, limited time, concerns about disclosure, and appropriate type of treatment (Mousavi, Sohrabpour, Anderson, Stemig-Vindedahl, & Golden, 2018; Storrie, et al., 2010). These barriers become even more pronounced in racial, gender, and sexual minority groups (Draper, & Baron, 2005; Dunbar, Sontag-Padilla, & Ramchand, 2017; Kearney, Przedworski, et al., 2015).

The Burden of Providing Care to Others

The concept of burnout, characterized by symptoms of emotional exhaustion, depersonalization, and reduced feelings of personal accomplishment in the workplace is not specific to the field of clinical psychology (Maslach, 2006). Individuals who work in close contact with others, such as those in helping professions like psychology and social work, are at greater risk for burnout as compared to others (Schaufeli & Enzmann 1998). For trainees in clinical psychology, a diverse array of administrative, clinical, supervision, and research responsibilities introduces a heightened risk of burnout (Richardson, Trusty, and George, 2018). One study revealed that younger age and limited psychotherapy experience were predictors of moderate-high levels of stress and burnout amongst psychotherapists (Simionato & Simpson, 2018). A cross-sectional survey examining burnout among clinical and counseling psychology trainees identified high burnout amongst 49.2% of its participants (Kaeding et al., 2017). Additionally, attention must be paid compassion fatigue, vicarious trauma, and secondary traumatic stress, as a failure to properly address said factors have the potential to worsen burnout and existing mental health
problems among students (Adams & Riggs, 2008; Butler, Carello, & Maguin, 2017; Harrison & Westwood, 2009).

**Psychotherapist Impairment and its Ethical Considerations**

That a therapist’s impairment has a direct impact on the quality of clinical care has empirical support (Sherman & Thelen, 1998). Survey data of 456 APA Division 29 members acknowledged having worked with clients “when too distressed to be effective” (Pope, Tabachnick, & Keith-Spiegel, 1987). In a study where college students were exposed to therapists with burnout symptoms, therapists were rated as significantly lower in likeability, display of empathy, attentiveness to patients, and suitability for a subsequent referral (Renjilian, Baum, & Landry, 1998). Thus, therapist impairment also introduces the potential for damage to the therapeutic alliance, which one study accounted for 7.5% of the variance in outcome (Horvath, Del Re, Fluckiger, & Symonds, 2011).

The American Psychological Association Ethical Principles and Code of Conduct for Psychologists emphasizes that clinicians should “refrain from initiating an activity when they know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent matter” (APA, 2016). Interestingly, one study found that 92% of doctoral programs and 75% of clinical internships endorsed that impaired trainees were hindered in the quality of the clinical care that they were able to provide (Huprich & Rudd, 2004). While the APA upholds this as an ethical standard, there is a dearth of research on the impact of a psychotherapist’s personal distress and psychopathology on their effectiveness as a clinician, possibly due to professional consequences one might experience from the field without the credibility of being a “competent” established clinician (Carey, 2011). Furthermore, studies
have also emphasized that many psychotherapy practitioners may have a blind spot to their own distress, symptoms, and needs (O’Connor, 2001). However, thorough assessment is the only factor that can provide an evidence-base which informs designing targeted interventions.

**Self-Care: What We’ve Tried So Far**

Current research on preventing professional burnout and distress has defined self-care as a promising salve for many of the difficulties that trainees encounter. The modern definition of self-care be expanded to include preventative (e.g., managing stress, decreasing negative states) and enhancement of overall functioning in physical, mental, and emotional domains, which may vary from individual to individual (Butler, et al., 2019). Self-care also requires self-reflection and a greater commitment to one’s well-being as a priority (Butler, et al., 2019).

Literature supports self-care as an intervention which can empower working professionals to strike a balance between their work and personal lives (Rupert, Miller, & Dorociak, 2015). Additionally, there is some evidence that mindfulness, in tandem with self-care practices encourage greater, albeit uncomfortable “self-reflection” which mediate and increase self-care engagement in medical and mental healthcare professionals and reductions in psychological distress (Richards, Campenni, & Muse-Burke, 2010; Slonim, Kienhuis, Bendetto, & Reece, 2015). Among psychology graduate students, mindfulness and self-care practices were significantly related to perceived stress levels (Myers, et al., 2011).

Given the extent of literature supporting self-care as a crucial factor, many researchers have gone on to implement self-care interventions in psychology graduate and medical programs to varying effects (Colman, et al., 2016; Drolet & Rodgers, 2010; Shapiro, Brown, & Biegel, 2007).
While myriad studies have examined the efficacy of “self-care” interventions on variables related to wellness (e.g., anxiety, stress, depressive symptoms, physical pain, etc.), the support for said interventions is mixed (Colman et al., 2016). One potential failure of these interventions is that they are laser-focused on building support and skills within the individual, rather than emphasizing the greater system in which these trainees exist.

This idea is supported by behavioral theorists who posit that contextual or environmental influences can enhance or inhibit the generalization of skills (Biglan & Hayes, 1996; Schultz, 2006). Despite promoting self-care “solutions,” it is unclear how many psychology graduate programs actively tout a culture of self-care which would enable students to effectuate these solutions (Vally, 2019). Furthermore, promotion of psychoeducational self-care programs may be useful, but not always sufficient to translate into behavioral change (Ross, Bevans, Brooks, Gibbons, & Wallen, 2017; Kravits, McAllister-Black, Grant, & Kirk, 2010). Unfortunately, this means that solutions for this mounting crisis may not be as straightforward as providing students with psychotherapy referrals or promotion of self-care programming. This deep, lasting change calls for a system-wide change in culture (Mousavi, et al., 2018; Wyper, 2010).

Dissemination and Implementation Models for Change

The emerging field of dissemination and implementation science, which focuses on spreading knowledge of effective interventions and executing them across settings, is uniquely positioned to address the issue of psychology graduate student mental health (Durlak, 2015). While research on protective and risk-factors for psychology doctoral student distress and mental health problems proliferates, there exists a growing gap between the transformation of this research into effective interventions, potentially due to lapses in understanding of barriers, needs, and resources
of various systems involved (Wandersman, et al., 2008). For example, within a psychology doctoral program, any individual interacts with many systems in their environment inside and outside of the school system (Bronfenbrenner, 2005).

Currently, the Ottawa Model of Research Use (OMRU) is one of the most evidence-based dissemination and implementation frameworks in the field currently (Logan & Graham, 2010; Neilsen, 2015; Tabak et al., 2012). This model focuses on two main parts, the Assessing, Monitoring, and Evaluation (AME) component, and six core elements: the innovation, adopting individuals, receiving environment, translation, adoption, and clinical outcomes. While the six core components highlight the considerations that one should make before implementing an intervention in a system, the AME process is more prescriptive and highlights necessary steps that should be taken to ensure success (Logan & Graham, 2010; Powell, et al., 2017; Fischer, et al., 2016). The OMRU model has been widely adopted to implement behavioral medicine interventions in healthcare systems (Reid, et al., 2010; Moore, Titler, Low, Dalton & Sampselle, 2015).

The Current Study

While extant research repeatedly emphasizes the need for improved psychology trainee wellness interventions, they tend to assess the same factors, while broadly concluding that “self-care” interventions are warranted. When interventions are implemented, they tend to be short-sighted, without any ongoing assessment of the impact of these interventions. Similar to clinical practice, it is crucial to tailor wellness interventions to best fit the needs of a specific individual within the context of the systems in which they interact. Thus, a thorough needs assessment of not only mental health symptoms and burnout, but also psychology graduate student climate and
functional impairment is warranted. There is a lack of analysis on the impact of factors outside of the individual on wellness, such as potential adopters and stakeholders in the community, and school climate and culture. Although many studies assess psychology graduate student distress to varying degrees, they often focus on specific factors (e.g., mentorship, stigma, financial insecurity, symptoms) across different datasets, rather than combing this data into a single sample, making it hard to detect relationships between these variables.

Given the new nature of this type of project, this study will serve as a pilot study to both implement this assessment and intervention model in a doctoral program, and to document the process, to serve as a blueprint for other doctoral programs seeking to address student wellness. The current study will have two branches: 1.) Pilot selection and implementation of a student mental health intervention within the Clinical Doctoral department and 2.) Establishment of a climate assessment battery, which will be used as an outcome monitoring measure to be administered biannually moving forward. This will occur in the clinical doctoral department of a mid-Atlantic clinical psychology doctoral program.

An implementation science framework, specifically the OMRU framework will be utilized to identify and work with stakeholders within the graduate program’s community. The scope of this study will be in integrating all three prescriptive elements of the AME process – Assessment, Measurement, and Evaluation. This study will focus on identifying stakeholders within the clinical psychology trainee community, such as the individual, family factors, mentorship, and the broader school system, including administration and faculty whose input and approval is required.
Chapter II
Methodology and Procedures

Participants

Participants were students who were enrolled at the time of the study in the Clinical Psychology Doctoral Program in a mid-Atlantic state with either full-time or part-time status. Participation in the survey will be optional for students, although participation will be encouraged. Students on clinical internship, or on non-traditional tracks in their 6th or 7th year of enrollment within the program will also be included in the study within the 5th year/on internship category. Any program alumnus or an incoming 1st year prospective student who had not engaged in coursework, supervision, or clinical work within the program were excluded from the study. A breakdown of students by year in the program can be visualized below in Figure 1.

Figure 1. Number of Student Participants, By Year in Program.
After accounting for surveys completed with insufficient data, the total sample size was n=76, approximately 69% of the overall possible 112 clinical students enrolled as of July 2021 at the program. More demographic information about the sample such as race/ethnicity, gender identity, sexual orientation, ability status, and faith were not collected due to the need to protect individual student identity, as the combination of school year and demographic information would be ultimately revealing (e.g., Black, cisgender woman 4th year student; White, nonbinary 1st year student).

**Procedure**

This data was collected via Rutgers Qualtrics and distributed via an email listerv accessible to all Clinical students within the program. The survey was composed of two main parts. The first part primarily focused on social-emotional, financial, and academic support that would best fit student needs. Interventions/supports were identified based on a combination of faculty suggestions, student suggestions from previous qualitative surveys, and research literature findings (Evans, et al., 2018). This section assessed the clinical faculty and administration, who were responsible for managing student support on four key perceived constructs: effectiveness, responsiveness, transparency, and dedication to students. The data from this survey was subsequently be utilized to determine the top 3 interventions from which students feel they are most likely to benefit, if implemented. This data would determine the direction of funding in the clinical department towards targeted supports (socio-emotional, financial, or academic) which clinical students may utilize. This survey, built from research, student, and faculty input, also
aimed to be a template for other programs interested in assessing student wellbeing for potential initiatives.

The second part of the survey aimed to capture more information about student social emotional factors such as burnout, anxiety, low mood, perceived school/institutional climate, and experiential avoidance, and self-care behaviors, all which contributed to overall wellbeing (Yusuf, Saitgalina, & Chapman, 2020). This survey is a pilot annual survey for the program and aims to serve as a potential template for other programs interested in implementing an annual student wellbeing survey. At the completion of the survey, participants were redirected to a separate survey where they could have input their email address to be entered into a digital gift card lottery where 2 participants would be randomly selected to receive a $50 digital gift card. Contact information and survey responses were stored separately and securely and were not connected in any way.

Measures

One-Time Student Supports Measure: lists targeted support interventions first by category (e.g., socio-emotional, financial, and academic) and then overall to provide students with an opportunity to identify targeted supports. Space for qualitative feedback to the department was allotted as well. These 2 items were suggested through multiple collaborative meetings and qualitative interviews with key stakeholders including the Clinical Chair of the department, the Assistant Director of Clinical Training, and additional members of Clinical Faculty, as well as the entire research team, and were informed by previous research (Logan & Graham, 2010). A more detailed summary of qualitative results can be found in Appendix B.
Pilot Climate Assessment in the Clinical Department: The second portion of this survey was a pilot measure, which sought to establish ongoing measurement of student wellness, and incorporated items from the following previously established measures:

Gallup Workplace Audit (Gallup-12; Harter, Schmidt, and Hayes, 2002)

The Gallup Workplace audit is a measure that examines overall workplace satisfaction and employee perceptions of work. Items are rated on a 5-point Likert scale rated from (1) strongly disagree to (5) strongly agree. The measure has convergent validity to other well-established measures of job satisfaction and engagement of 0.91.

New Jersey School Climate Survey (Middle School) – Revised; Parent/Youth (NJSCS-R; NJ Dept of Education, 2012)

This measure consists of 53-items, rated (1) strongly disagree to (5) strongly agree, assessing 7 domains of school climate: physical environment, teaching and learning, community morale, student relationships, parental support, physical safety, and emotional environment. Internal scale structure and reliability have been demonstrated, confirming hypothesized factor structure and Cronbach’s α ranging from .63 - .87 for subscales. For this study, selected items were chosen that highlight constructs such as physical environment, community morale, safety, and emotional environment.

Counselor Burnout Inventory (CBI; Lee et al., 2007)

The CBI is a 20-item survey that includes five subscales that were identified and validated as distinct constructs during measure development (Lee et al., 2007). The subscales map on to different domains of burnout, as related to the job demands of counseling - exhaustion,
incompetence, devaluing client, negative work environment, and deterioration in personal life because of being a counselor and subsequent burnout that may be experienced. For the purposes of our survey, items relating to devaluation of client and deterioration in personal life were selected.

**APA Division 29 Members Ethics Survey (Pope, Tabachnick, Keith-Speigel, 1987)**

This one-time survey was utilized originally to assess the beliefs licensed psychologists within APA Division 29 members about their compliance to ethical behavior and practice. For the purposes of the present study, only one item was utilized from this measure which assessed the degree to which clinicians have recently engaged in clinical work while too distressed/exhausted to be effective.

**Self-Care Behavior Inventory (SCBI; Santana & Foad, 2017)**

The SCBI is a 19-item survey which measures the frequency with which an individual as engaged in different self-care behaviors over the last 6 months on a 5-point Likert scale from 1 (never) to 5 (always). Preliminary validity analyses have demonstrated good internal consistency, with strong support for convergent and divergent validity. Although the measure was originally validated in a sample of doctoral students, certain items which closely mirrored other items on the measure were removed to help shorten the overall survey length.

**Patient Health Questionnaire-2 (PHQ-2; Lowe, et al., 2005)**

The PHQ-2 is a brief 2-item measure which assesses the presence of depressive symptoms. The measure has good criterion validity with reference to the Structured Clinical Interview for DSM-
IV (SCID) and has demonstrated sensitivity and specificity to depressive symptoms at baseline and follow-up. This measure was included in its entirety in the overall study.

**Generalized Anxiety Disorder-2 (GAD-2; Kroenke, et al., 2005)**

The GAD-2 is a brief 2-item measure which is comprised of the first two items on the GAD-7 and screens for anxiety disorders. This measure has been shown to be equally effective in primary care settings at detecting and screening for anxiety. This measure was included in its entirety in the overall study.

**Data Analyses**

Means, standard deviations, and frequencies will be reported to represent student supports data and will help identify which supports would be most meaningful and useful to clinical doctoral students. In addition to this, independent sample t-test and correlational analyses will be utilized to examine relationships between variables in the student wellness pilot survey. Qualitative responses will be grouped according to theme and will be reported in this way in a table format to facilitate interpretation.

Many constructs (e.g. counselor burnout, mood symptoms, school climate, self-care behaviors) were incorporated into this survey, and items or partial measures were incorporated due to survey length and voluntary participation, and selected based on best available research around single-item measures for construct measurement, and stakeholder (i.e., student and faculty and research team) input (Fuchs & Diamantopoulos, 2009). Several unique variables were generated in the context of this study to approximate the constructs aimed to be measured for which there was not already an existing item or measure. The variable “Perceived Environmental Support” was
created for the purposes of this study and is comprised of the sum of the 7 Gallup items and the 13 School Climate items, where a higher score indicated that the student perceived higher support from the school environment, and a lower score indicated the student perceived lower support from the school environment. School items were reverse coded before inclusion in variable computation where necessary.

Because the complete Counselor Burnout Inventory (CBI) was determined too long for its inclusion in the pilot climate assessment, the five items most representative of key constructs from this survey and 1 item from the APA Ethics Survey were selected to represent this item. The CBI items and the APA Ethics Item were summed to represent “CBI Total” variable. Finally, there are no existing measures in the literature which represent a self-assessment of perceived clinician effectiveness, that is the extent to which the clinician believes that the quality of their work with patients is effective. For the purposes of this study, this variable is equated to the APA Ethics Question, asking participants how often they have “seen clients while too distressed/exhausted to be effective” (APA, 1987).

For this study, we hypothesize that:

1. Students will support departmental financial investment in social-emotional supports.
2. Burnout levels will decrease as the student progresses through the program.
3. Low perceived environmental support (school climate) will be related to higher burnout symptoms.
4. Burnout symptoms will be related to a significant decrease in perceived quality of clinical care.
5. Analyses will demonstrate preliminary evidence that burnout levels are lower in individuals who engage in self-care behaviors with greater frequency.
Hypothesis 1: Students will support departmental financial investment in social-emotional supports.

Quantitative Data

In the first part of the survey, students were first presented with three lists of supports of different types: social-emotional (SE), financial (FIN), and academic (ACA). These were presented alone, without taking other types of supports into consideration. Students were directed to select the two supports in each category that they would be most likely to utilize, if implemented. As represented by Figure 2, when presented SE alone, the top 3 most endorsed supports were providing a vetted referral list of providers who accept the student insurance in-network, a more extensive list of alumni psychologists who can offer deeply reduced rate therapy ($50 and below), and an in-house therapist, in that order. The 4 most frequently endorsed SE suggests a need for mental health resources that are affordable and accessible for clinical psychology graduate students in this sample.
As represented by Figure 2, students were next provided a list of direct financial supports. When presented FIN alone, the top 3 most endorsed supports were increased funding for scholarships, providing funding for externship travel, and providing funding for internship applications. The 4 most frequently endorsed FIN supports suggest a need for student funding for expenses that are required by the nature of the clinical program’s training, rather than supplemental supports such as app memberships and additional training experiences outside of the requirements.
As represented by Table 3, students were next provided a list of academic/departmental supports. When presented ACA alone, the top 3 most endorsed supports were more extensive faculty-student mentorship, more extensive peer mentorship, and faculty trainings on how to support student wellness, providing funding for externship travel and providing funding for internship applications. The 3 most frequently endorsed ACA supports suggest that students could benefit from more rigorous faculty-student mentorship, more extensive peer mentorship, and faculty trainings on how to best support student wellness.
Finally, students were presented with a final series of items which included all items from the prior 3 questions. Taking all three domains of supports into consideration, students were directed to select their top three priorities of the supports. When presented SE, FIN, and ACA supports all together, the top 3 priorities were: increased funding for student scholarships. The 3 most frequently endorsed supports suggest that students would benefit from and utilize financial resources, direct (scholarship) or indirect (reduced rate/in-network therapy).

Thus, PI’s Hypothesis 1 is reveals mixed support; although two of the three top endorsed supports were in the SE category as predicted, the top support, increased scholarship funds for students was a FIN support. However, the other two top endorsed items, therapy referrals that accept the student insurance and deeply discounted out-of-network therapy referrals could be
interpreted as necessary supports regarding student finances, as their implementation would indicate lower cost spending for students on personal mental health services.
Figure 5. Frequency of Supports Endorsed When Presented All Options, By Support Type.
Qualitative Data

Overall, the qualitative responses provided students with an open-ended section to field additional suggestions or concerns. These free response items provided an opportunity to 1. provide additional suggestions for social-emotional, financial, and academic supports and to 2. express any concerns that they had about the listed supports. A complete table with highlighted qualitative responses can be found in Appendix B.

Several comments discussed the importance of program culture, and the way that this impacts a student’s overall wellness, “…wellness should also include feeling heard and valued within [the program], citing circumstances where the student felt that this was not the case (Appendix B). Another student noted some well-meaning systems, such as peer mentorship and faculty mentorship may sometimes fall through when peer mentors with similar non-advanced student status, were unable to provide sufficient answers to questions, and faculty sometimes “seem[ed] to be unaware of the time and effort that students put into their [clinical, academic, work, and coursework responsibilities],” both which possibly contribute to a worsening of burnout symptoms.

While many students noted that resources for reduced fee and alumni therapy services have already been made available to the student body due to efforts of both faculty and special student interest groups, several identified key issues with these resources, including the quality of the referrals, a lack of doctoral level clinicians, and the high cost of even reduced-fee services. Another student expressed frustration with the large amount of documentation required of students seeking accommodations through the Office of Disability Services (ODS), noting that the program had a “reputation” within ODS for having some of the more stringent requirements for accommodations,
suggesting that further burden may be placed on students with disabilities struggling to meet program requirements without their accommodations.

It is important to note that because formal qualitative analysis of this data was not utilized for the purposes of this study, a greater emphasis was placed on the quantitative data gathered in the discussions and the suggestions made to the program, although qualitative analysis did inform some of that discussion.

**Hypothesis 2: Burnout levels will decrease as the student progresses through the program.**

Independent sample t-tests were utilized to compare differences in mean levels of burnout (as measured by the CBI variable) on the cohort level as students’ progress through the program. In this series of analyses, 1st and 2nd year cohorts, 2nd and 3rd year, 3rd and 4th year, 1st and 5th year, 4th and 5th year, 2nd and 3rd year, and 2nd and 4th year cohorts were compared. There were no significant differences between 1st Year burnout (M=16.24, SD=3.60) and 2nd Year burnout (M=17, SD=1.72), 2nd year and 3rd year burnout (M=15.05, SD=4.24), 3rd year and 4th year burnout (M=14.07, SD=2.59), 4th year and 5th year burnout (M=14.19, SD=3.10), or 1st year and 5th year burnout.

However, there were significant decreases in burnout between the 2nd year and 4th year cohort mean burnout data (p=.017) and the 2nd year and 5th year/internship cohort mean burnout data (p=.039). This result is significant as it confirms PI’s hypothesis that burnout would decrease as the student progresses through their clinical doctoral program. Table 1 below maps out mean counselor burnout and their standard deviations across years in the program.
Table 1.

*Mean (M) and Standard Deviation (SD) of Counselor Burnout, By Year in the Program.*

<table>
<thead>
<tr>
<th></th>
<th>1st Year</th>
<th>2nd Year</th>
<th>3rd Year</th>
<th>4th Year</th>
<th>5th Year/Internship</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>16.24</td>
<td>17</td>
<td>15.05</td>
<td>14.07</td>
<td>14.19</td>
</tr>
<tr>
<td>SD</td>
<td>3.60</td>
<td>1.72</td>
<td>4.24</td>
<td>2.59</td>
<td>3.10</td>
</tr>
</tbody>
</table>

**Hypothesis 3:** Low perceived environmental support (school climate) will be related to higher burnout symptoms.

A Pearson’s correlation coefficient was computed to assess the linear relationship between perceived environmental support and burnout symptoms. There was a significant negative correlation between these variables, where $r (74) = -.227$, $p=.05$. In general, the results suggest a small negative inverse relationship between perceived environmental support and burnout symptoms, meaning that the lower a student perceives the environmental support within the school environment to be, the higher their burnout symptoms will be.

**Hypothesis 4:** Burnout symptoms will be related to decrease in perceived quality of clinical care

A Pearson’s correlation coefficient was computed to assess the linear relationship between overall burnout symptoms and perceived low quality of clinical care (one aspect of burnout symptom scale). There was a significant moderate positive correlation between these variables,
where \( r(74)=.561, \ p=.01 \). In general, the results suggest a positive linear relationship between overall burnout symptoms and perceived low quality of clinical care, meaning that as a student’s burnout symptoms increase, they are more likely to endorse that they have engaged in clinical work while feeling too distressed or exhausted to be effective.

**Hypothesis 5:** Analyses will demonstrate preliminary evidence that burnout levels are lower in individuals who engage in self-care behaviors with greater frequency.

A Pearson’s correlation coefficient was computed to assess the linear relationship between frequency of engagement in self-care behaviors with counselor burnout. There was a significant strong positive correlation between these variables, where \( r(73)=.499, \ p=.01 \). In general, the results suggest a negative inverse relationship between engagement in self-care behaviors and counselor burnout, meaning that as a student engages in self-care behaviors with greater frequency, they will likely exhibit lower burnout symptoms.
Chapter IV

Discussion & Conclusion

This study had two main aims: 1) to survey doctoral students about mental health intervention options for future implementation by the Clinical Psychology Department, and 2) to establish and pilot test a student climate assessment battery, which would be used by the department or school as an outcome monitoring measure to be administered annually or biannually moving forward. After working with program administrators and leaders within the department to approve and finalize a survey, the pilot survey for these two goals was established and distributed. In general, there was mixed support for Hypotheses 1 & 2, and support for Hypotheses 3, 4, and 5, as detailed below. While a student mental health intervention has yet to be implemented, the findings from this study will contribute to the decision-making process in the Department this coming year. A discussion of the results and their implications, then recommendations, can be found below.

**Hypothesis 1: Students will support departmental financial investment in social-emotional supports**

Hypothesis 1 was partially supported by the qualitative and quantitative study findings. Although students appeared to support direct investment in mental health resources when presented solely with those options, when provided with a broader selection of supports, financial supports were most widely favored, specifically increased scholarships. The average PsyD student accrues hundreds of thousands of dollars in debt (Doran et al., 2016). This financial burden is somewhat less for Clinical PhD students who often work on research projects or teach for
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assistantships or fellowships, but not by much. For example, Borgongna et al. (2021), the author cites that while Clinical PhD students at their institution are provided with full tuition remission and approximately $11,000-14,000 annual stipend, this still places a single-person household on or near the federal poverty line. Students are typically guaranteed partial funding through their first year, with work opportunities and partial merit scholarships available throughout the other years. Given the geographic location of the program in NJ, and opportunities which are spread over the NYC and Philadelphia metropolitan areas, there are significant hidden expenditures, such as high real estate value in the NYC metro area, travel expenses, and car and related expenses (Doran et al, 2016). As suggested by the qualitative responses, students may take on additional side-jobs to make ends meet, rather than simply to bolster their CVs as many might assume. There is some recent research that also suggests a possible relationship between off-campus work opportunities for doctoral students, and the program’s completion rate such that students who seek job opportunities off campus are more likely to drop out of their program prematurely, potentially due to increased risk of burnout (Bekova, 2021).

Despite a recent increase in debt among psychology graduate students and early career psychologists, there continues to be stagnation in post-graduate salaries (Borogna, et al., 2021). Many individuals go on to delay major life milestones (e.g., marriage, having children, buying a home) due to financial stressors, delineating a clear impact on wellbeing (Doran, Marks, Reid, et al 2016). The extent to which a student experiences financial stress plays a clear role in their overall wellbeing and ability to engage in school (El-Ghoroury, et al, 2012; Borgogna et al., 2021). This finding suggests that perhaps greater attention be paid to individual financial situations and
individuals’ abilities to pay for the program by scholarship committees, administration, and faculty.

Students also expressed a desire for increased referral sources that accept the student insurance and psychologists out-of-network on the student insurance who offer deeply reduced rate therapy. While a list of curated mental health resources for students has been distributed among students, at some reduced rates, some students report that these rates are still too high to be affordable. Students are also provided with the link to student insurance website where they can search for licensed clinicians in their area. It is important to note that these options also assume a certain level of health and financial literacy of students to independently navigate copays, deductibles, filing claims and out-of-pocket expenses. Perhaps an initiative that programs could consider is providing education about how to navigate insurance barriers to care to students. Sliding fee scale therapy at training clinics are often not feasible, with many classmates completing placements at these affordable options, limiting confidentiality of a student’s psychotherapy treatment. The endorsement of affordable mental health provider options by students suggests that alleviating financial burdens would once again give students additional financial flexibility to invest in mental health resources.

Engagement in mental health care is a multifactorial issue that can be attributed to not only issues of access, but stigma, difficulties connecting with providers, and overall motivation to engage in what can be challenging work. One might imagine mental health providers would have decreased barriers to accessing mental health care among providers given the wealth of literature discussing the relationship between mental health literacy and help-seeking behaviors (Furnham & Swami, 2018). This is not necessarily the case. In fact, despite mental health problems among
clinical psychologists being common, concerns about disclosure and negative professional consequences still present a challenge for clinicians to seek help and engage in their own treatment, even when the resources are available (Tay, Alcock, Scior, 2018). This dimension should be considered further in the context of a hierarchical organization such as a doctoral program, where power dynamics between administration, faculty, and students are in motion. For example, given the ethical implications of a student’s clinical impairment due to acute or chronic mental health issues, a student may avoid seeking support from faculty or administration.

**Hypothesis 2: Burnout levels will decrease as the student progresses through the program**

The hypothesis that burnout levels will decrease as the student progresses through the program was partially supported by a significantly more burnout between 2nd year students in the program compared to 4th year students in the program. There was also a significant difference in burnout between 2nd year and 5th year/internship students in the program, such that burnout means significantly decreased between 2nd and 4th year students and 2nd and 5th year students. Mapping of mean counselor burnout across the 5 cohorts within the program demonstrates a peak in burnout at the 2nd year, decreasing steadily over time, as predicted.

We posit that this decrease can be explained by examining the differences in programmatic requirements and expectations of 2nd year and 4th year clinical students in the program, as well as some situational factors that may adjacently impact wellbeing. 2nd year clinical students are required to carry a full-time (12 credit) course load, participate in externship, carry clients at the school clinic, and begin to complete their four assessment battery cases. There are also significant developmental timelines that occur in the second year of the clinical doctoral training, including applying and interviewing for externships midyear, and beginning to prepare
for the written comprehensive exams, which are administered shortly after the end of the spring semester. This does not factor in any part-time work, research, or external responsibilities that a student may hold.

Comparatively, 4th and 5th year students do not engage in coursework, and no longer are required to therapy or assessments at the school clinic. Apart from internship applications early in the 4th year and continuing work on their dissertation, the student functions more independently from the program. By a student’s 5th year in the program, they are ideally completing their pre-doctoral internship at an external site. It is at this point that student begin to receive a fixed salary for their time and begin to prepare for graduation. This structure allows for more flexibility in a student’s schedule to engage in whatever form of self-care is most meaningful for them. We also feel it is important to mention that many students relocate by 4th year from central NJ to off-campus location closer to urban centers such as NYC or Philadelphia, potentially decreasing isolation and facilitating the ability to engage in self-care behaviors and relationships outside of their programs that are meaningful to them.

**Hypothesis 3: Low perceived environmental support (school climate) will be related to higher burnout symptoms**

As predicted, we found there to be a significant inverse relationship between a student’s perceived environmental support within the school and the extent of their burnout symptoms. Low perceived environmental support by a student at the school was related to higher counselor burnout symptoms within that student.
This finding emphasizes the fact that preventing and addressing burnout occurs not simply at the individual level, but at the systemic level. Because of the long reaching impact of counselor burnout and the implications on patient care, careful detail should be paid to the systemic factors outside of programmatic requirements that may be impacting a student’s experience of a graduate program. This is supported broadly by the literature, which has established that good organizational climate among healthcare workers was significantly associated with more positive employee (or student) mental health outcomes, including decreased burnout, depression, and anxiety. Furthermore, this literature concurs with the findings of the presents study that group relationships, leadership, and supervision can also impact these outcomes (Bronkhorst, Tummers, Steijn, and Vijverbeg, 2015). This study highlights the importance of expanding consideration of student wellness beyond the individual, case-by-case level and considering the interaction of the individual at various ecological levels of a system (Bronfenbrenner, 1992).

**Hypothesis 4: Burnout symptoms will be related to a significant decrease in perceived quality of clinical care**

We found there to be a significant negative inverse relationship between a student’s counselor burnout rating, and their perceived quality of clinical care. The greater a student’s burnout, the lower the perceived quality of their clinical care will be. This aligns with counselor burnout literature which has found that higher levels of burnout among some counselors can be associated with lower levels of empathy, counseling alliance, positive unconditional regard, and a greater desire to reduce time spent on clinical care (Caleshu, Kim, Silver, Austin, Tibben & Campion, 2021). These are crucial components to ethical clinical care, particularly for trainees
who often work with financially and socially oppressed and underserved populations. This finding suggests that burnout could be one factor in maintaining the Inverse Care Law which defines that socially and financially disadvantaged populations often receive greater quantities of health care, but at a lower quality, perpetuating mental and physical health inequities among groups (Cookson, Doran, Asaria, Gupta, & Mujica, 2021).

**Hypothesis 5: Burnout symptoms will be lower in individuals who engage in self-care behaviors with greater frequency**

The study findings revealed a significant negative inverse relationship between engagement in self-care behaviors and counselor burnout, meaning that as a student engages in self-care behaviors with greater frequency, they will likely exhibit lower burnout symptoms.

We believe that special attention should be paid to the SBCI inventory utilized to gather self-care behavior data in this study. The measure used in this study is different from other measures of self-care behavior because it includes forms of self-care across many categories. It was more possible for students to identify if they were engaging in not just typically prescribed self-care behaviors (e.g., mindfulness, yoga, exercise) but self-care behaviors that were meaningful on the individual level and aligned with their values (e.g., community, connectedness, well-being, altruism, achievement). Effectiveness of a values-based approach is more sustainable and should be considered when selecting and engaging in self-care rather than a one-size-fits-all. Information such as this could be distributed to students universally, such as in first year advising meetings, supervision, and professional development coursework that clinical doctoral students universally are required to take (Hayes, Pistorello, & Levin, 2012).
Limitations of the Current Study

There are limitations to any study. For this study, we only sampled one clinical psychology doctoral program. While there are some similar components per APA accreditation, no two programs are the same in terms of demands, location, culture, financial burden, and other factors, therefore, these results may not be generalizable to other clinical doctoral programs.

Furthermore, given that the Study PI was a student within the clinical program herself, it was particularly important to guarantee the anonymity of participants within the recruitment process. Students were briefed in the consenting process that core faculty, and the PI (student) would be involved in the design of the study and interpretation of its results. Even though students were given assurance that responses would remain anonymous, it is possible that this could have led to underreporting of burnout, school climate, and perceived effectiveness as a clinician. Due to additional concerns about maintaining anonymity of the students with increasingly identifying demographic information (e.g., race/ethnicity, gender identity, sexual orientation, year), these items were excluded from the study.

Identification of year in the program (e.g., 1st, 2nd, 3rd, etc.) was an important study variable as several hypotheses compared student experiences of climate, burnout, and self-care across developmental years in the program. However, many students reported difficulties with this section of the survey, as students were simply asked to self-identify their year. The data collection period of this study was in the Summer of 2021, a time when students were in transition between one year of the program (ending May 2021) and the next year of the program (Fall 2021). It is highly probable that this impacted the accuracy of data reporting.
It is also of note that more extensive measures of mental health were not administered in this study due to time constraints and other programmatic considerations. Because symptoms of burnout and mental health disorders such as anxiety, depressive symptoms, lack of motivation, and social isolation all overlap it is important to consider an individual student’s mental health symptoms and mental health history, as this also may pre-date their engagement in the program. It is possible that pre-existing mental health difficulties may exacerbate burnout, perceived environmental support, and perceived clinical effectiveness. However, these research questions are beyond the scope of this study, thus it is important to acknowledge these potential confounding factors. These measures should be included in future research when possible.

Future Directions

In conducting future research, we would recommend a larger national sample of clinical psychology doctoral students and incorporating both PsyD and PhD students. As mentioned throughout this paper, the author’s sample consisted of the students within her clinical program, as this sample was most readily available. Gathering a larger sample would provide enough statistical power to identify similarities and differences among clinical doctoral students and provide important insights as to specific areas on which specific programs might want to focus. Furthermore, by gathering a larger proportion of the national clinical doctoral student population, an individual’s responses would increase in anonymity, enabling researchers to study the intersection that race, ethnicity, sexual identity, gender identity, faith, ability status, and financial situation impact the study variables. There is a large body of literature supporting more inclusive demographics in study samples, and this angle was missing from the current study due to these
concerns about maintaining privacy (Wadsworth, Morgan, Hayes-Skelton, Roemer, & Suyemoto, 2016).

Due to time constraints, mental health related variables were not adequately assessed in this study beyond limited information about anxiety and depressive symptoms. More comprehensive mental health assessment will give researchers a better ability to differentiate counselor burnout and mental health difficulties and how each impacts student overall wellness and ability to engage in self-care behaviors.

This study aimed to provide this program with useful information about its clinical doctoral students’ well-being, while ultimately creating a sustainable blueprint for an annual wellbeing survey in this program as well as in other doctoral programs. In the spirit of a systems approach, we have generated a table of action steps in Figure 3, which summarizes both acting agents and action steps that can be taken at each ecological level. Some of these suggestions are also borrowed from Borogna, et al., while other suggestions were generated based on study data (2021).
Table 2.

Breakdown of actor-action steps to be taken to address burnout, by ecological level.

<table>
<thead>
<tr>
<th>Actor</th>
<th>Action Step- Mental Health</th>
<th>Action Step- Financial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Doctoral Student</td>
<td>Identify &amp; engage in values-based self-care activities, learning how to set boundaries with time</td>
<td></td>
</tr>
<tr>
<td>Cohort</td>
<td>Increased communication/check-ins among peers, sharing information about opportunities, communication with cohort-reps and faculty about gaps in knowledge</td>
<td></td>
</tr>
<tr>
<td>Faculty</td>
<td>Training to identify signs of burnout, encourage students to set boundaries, destigmatize conversations about acute/chronic student mental health in supervision/coursework, model self-care behaviors for students</td>
<td>Normalize discussions about finance/tuition as a part of training, providing advisees with financial education resources on an as-needed basis</td>
</tr>
<tr>
<td>Program Administration/Leadership</td>
<td>Reviewing program timelines and requirements, mandating program policies around time off, identifying a key person for students to approach for financial counseling</td>
<td>Seeking alternative funding sources (e.g. paid assistantship agreements with community organizations such as mental health agencies, government, community colleges), collect student-debt at graduation metrics</td>
</tr>
</tbody>
</table>
| University-Level Leadership  | Advocate for APA to factor in burnout prevention as a consideration for accreditation
Advocate for mean debt-at-graduation metrics as a part of APA accreditation data |                                                                                         |
Conclusion

Overall, the results of this study supported several of this study’s hypotheses. The study detailed that while students support social-emotional resources, increased financial support would ultimately provide students with the flexibility needed to engage in self-care. This study is consistent with existing literature on self-care and burnout in care providers and graduate students (See Introduction). Furthermore, the additional layer of assessment incorporating a student’s perceived environmental support integrates a nuanced approach to addressing burnout. The data in this study provides preliminary evidence that burnout is more complex than actions that can be taken on an individual level and suggests that burnout originate and perpetuate within a larger system. Thus, systems level interventions, as the author noted may be necessary to appropriately address them. It is important to note that this data is preliminary, and thus caution should be taken in interpreting the meanings of any individual finding. However, these promising findings indicate there are tangible steps beyond individual self-care that health care organizations and graduate programs can take to support the well-being of their clinicians in training.
References


Appendix A

Qualtrics Survey

1. Are you currently enrolled in the Clinical Doctoral Program (PsyD) at the Graduate School of Applied and Professional Psychology (GSAPP)?
   - Yes
   - No

2. What is your current year in the program?
   - 1st year
   - 2nd year
   - 3rd year
   - 4th year
   - 5th year/on internship
   - 6th year/on internship
   - Other (Free Response)

The GSAPP Clinical Department is seeking feedback from students regarding how best to assess and serve clinical wellness needs on an ongoing basis. We are interested to see how the department could be better supporting student needs. Your responses will be deidentified and anonymous.

3. The following are student social-emotional wellness supports that are being considered for clinical students. Select (2) items you would be most likely to utilize, if implemented.
   - In-House Therapist who only serves GSAPP students
   - Access to private, confidential provider at CAPS
   - Providing a vetted referral list of providers (MD, PsyD, PhD, LCSW) who accept the Rutgers United Healthcare Student Resources (UHCSR) insurance in-network ($25 copay)
   - Providing a more extensive list of GSAPP alum/psychologists who can offer deeply reduced rate therapy ($50 and below per session)
   - Access to a case manager/social work intern who can help students coordinate various personal services (e.g. medical, mental health care, insurance, leave of absence)
   - Student-led mindfulness groups
   - 8-week MBSR groups for students at deeply discounted rate
   - Student/faculty given workshops on a range of topics important to wellness (e.g. managing finances in grad school, meal prep, managing chronic illness, student mental health, activism, vicarious trauma as clinicians, life transitions)
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- Third-party ombudsman who is able to hear student complaints and concerns regarding faculty, staff, and other students
- None of the above

4. The following are **financial supports** that are being considered for clinical students. Select (2) items that you would be **most likely to utilize, if implemented**.

- Funding for student training opportunities outside of GSAPP
- Funding for internship applications
- Funding for externship travel (e.g. public transit, gas, tolls)
- Funding for increased scholarships
- Free student access to wellness program memberships (e.g. Headspace, Liberate Meditation, other)
- None of the above

5. The following are **academic supports** that are being considered for clinical students. Select (2) items that you would be most likely to utilize, if implemented.

- More extensive faculty-student mentorship with greater accountability/structure (e.g. set # of meetings/check-ins per semester)
- More structured peer mentorship program
- Faculty trainings on supporting the emotional wellness of students
- Monthly newsletter of faculty initiatives and opportunities for students
- GSAPP-hosted social gatherings which act as informal opportunities for students to unwind and connect
- None of the above

6. Below is a list of all supports previously mentioned in all 3 domains. **Select your top 3 priorities of the supports listed**:

- In-House Therapist who only serves GSAPP students
- Access to private, confidential provider at CAPS
- Providing a vetted referral list of providers (MD, PsyD, PhD, LCSW) who accept the Rutgers United Healthcare Student Resources (UHCSR) insurance in-network ($25 copay)
- Providing a more extensive list of GSAPP alum/psychologists who can offer deeply reduced rate therapy ($50 and below per session)
- Access to a case manager/social work intern who can help students coordinate various personal services (e.g. medical, mental health care, insurance, leave of absence)
- Student-led mindfulness groups
- 8-week MBSR groups for students at deeply discounted rate
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- Student/faculty given workshops on a range of topics important to wellness (e.g. managing finances in grad school, meal prep, managing chronic illness, student mental health, social justice, activism, vicarious trauma as clinicians, life transitions)
- Funding for student training opportunities outside of GSAPP
- Funding for internship applications
- Funding for externship travel (e.g. public transit, gas, tolls)
- Funding for increased scholarships
- Free student access to wellness program memberships (e.g. Headspace, Liberate Meditation, other)
- More extensive faculty-student mentorship with greater accountability/structure (e.g. set # of meetings/check-ins per semester)
- More structured peer mentorship program
- Faculty trainings on supporting the emotional wellness of students
- Monthly newsletter of faculty initiatives and opportunities for students
- GSAPP-hosted social gatherings which act as informal opportunities for students to unwind and connect
- Third-party ombudsman who is able to hear student complaints and concerns regarding faculty, staff, and other students

7. Now that you’ve seen our listed suggestions, please list any additional social-emotional, financial, or academic supports that you feel would benefit student wellness overall in the clinical department. Feel free to suggest any variations to the previously mentioned supports (Free Response)

8. Do you have any concerns or hesitations around any of the previously listed supports? If so, please describe below. (Free response)

We are now going to ask you some questions about how you feel about GSAPP. The information from this survey will help us understand what you think about your school. Your answers will be combined with other students in the Clinical program/within your cohort. No one will be able to see your individual answers to these questions.

Please rate how much you agree or disagree with the following statements, thinking about the last 6 months:
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I feel I am part of a team at GSAPP.

- Strongly Disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly Agree

Q11 I have a clear understanding of what is expected of me from clinical faculty at GSAPP and administration.

- Strongly Disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly Agree

Q12 There is open and honest two-way communication between myself and Clinical Faculty at GSAPP.

- Strongly Disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly Agree

Q13 My feelings, ideas, and suggestions matter to GSAPP clinical faculty.

- Strongly Disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly Agree
Q14 GSAPP clinical faculty deliver on promises they make to students.

• Strongly Disagree
• Disagree
• Neither agree nor disagree
• Agree
• Strongly Agree

Q15 I trust GSAPP clinical faculty and leadership to act on my behalf.

• Strongly Disagree
• Disagree
• Neither agree nor disagree
• Agree
• Strongly Agree

Q16 GSAPP clinical faculty supports my efforts to balance my work and personal life.

• Strongly Disagree
• Disagree
• Neither agree nor disagree
• Agree
• Strongly Agree
Q17 Students within my cohort treat each other with respect.

- Strongly Disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly Agree

Q18 Students are easily able to work out disagreements with other students.

- Strongly Disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly Agree

Q19 Harassment, intimidation, discrimination, microaggressions, and bullying by other students are an issue at this school.

- Strongly Disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly Agree
Q20 Sometimes I "check-out" during classes or meetings because I do not feel safe at school.

- Strongly Disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly Agree
Q21 Clinical Faculty at GSAPP…

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>....apply the same rules to all students equally.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>...are usually willing to make extra time for students who need help.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>...notice when I'm doing a good job and let me know about it.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>...provide me with assignments and coursework that is meaningful.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>...provide me with clinical training that is meaningful.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
Q41 Leadership and Administration in the Clinical Department at GSAPP (e.g. Department Chair, DCT, student services).....

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>....apply the same rules to all students equally.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>...are usually willing to make extra time for students who need help.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>...are effective at impacting systemic changes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>...are transparent about decision making processes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q22 The next set of questions will ask you about feelings about your clinical work, and its intersection with your life. When answering these questions, please consider how much you agree or disagree with the following in the last 6 months:
<table>
<thead>
<tr>
<th>Q23 I feel...</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am an incompetent clinician.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I do not have enough time to spend with friends.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I do not have enough time to spend on my personal interests.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I have little empathy for clients.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I have become callous towards clients.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I have seen clients while too distressed or exhausted to be effective.</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>○</td>
</tr>
</tbody>
</table>
Please think about how frequently you have engaged in the following behaviors over the last 6 months:

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spend time with others you enjoy</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Maintain deep interpersonal relationships</td>
<td></td>
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<tr>
<td>Seek out comforting activities</td>
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<tr>
<td>Allow yourself to laugh</td>
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<tr>
<td>Quiet time to complete tasks</td>
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<tr>
<td>Seek out projects that are exciting or rewarding</td>
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<tr>
<td>Eat healthy</td>
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<tr>
<td>Exercise or engage in physical movement</td>
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<td></td>
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<tr>
<td>Medical care</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health care</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Spend time in nature</td>
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</tr>
</tbody>
</table>
### Take vacations/time off

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Several Days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
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</thead>
<tbody>
<tr>
<td></td>
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</table>

### Pray/meditate

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Several Days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
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<tbody>
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<td></td>
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</table>

### Connect with faith/spirituality

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Several Days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
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</table>

### Advocacy/contribute to causes

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Several Days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
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</table>

**Q36 Over the last 2 weeks, how often have you been bothered by the following:**

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Several Days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
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<tbody>
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</table>

### Little interest in doing things

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Several Days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
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<tbody>
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</table>

### Feeling down, depressed, or hopeless

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Several Days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
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<tbody>
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</table>

### Feeling nervous, anxious, or on-edge

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Several Days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
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<tbody>
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</table>

### Not being able to stop or control worrying

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Several Days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
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</table>
Appendix B

Table 1.

Selected Open-Ended Responses, Categorized by Theme. “Now that you’ve seen our listed suggestions, please list any additional social-emotional, financial, or academic supports that you feel would benefit student wellness overall in the clinical department. Feel free to suggest any variations to previously mentioned supports.”

<table>
<thead>
<tr>
<th>a. Social-Emotional</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Program Culture</td>
</tr>
<tr>
<td>“Transparency and built in ‘days off’ (besides holidays) so students can take much needed time off without experiencing feelings of guilt.”</td>
</tr>
<tr>
<td>“Encouraging students to take appropriate breaks/time off.”</td>
</tr>
<tr>
<td>“Funding for parking, GSAPP Staff/Student monthly lunches, mandatory days off”</td>
</tr>
<tr>
<td>• Student Access to Resources</td>
</tr>
<tr>
<td>“According to an ODS personnel, GSAPP and The School of Social Work make it the most challenging/difficult for students to get services, and makes their students turn in a lot of required documents, whereas schools of engineering or other ones are far more lenient with this kind of accommodation (I think its pretty telling and bad that GSAPP has that kind of a reputation at ODS...)”</td>
</tr>
<tr>
<td>“More extensive vetted list of providers that are vetted [and] not GSAPP alum and take other kinds of insurances too.”</td>
</tr>
</tbody>
</table>
“Vetted list of providers that accepts UHCSR to focus on doctoral-level clinicians because these resources usually only include master’s level therapists”

“Group therapy for cohorts. There is so much conflict within cohorts that really needs some kind of group therapy intervention.”

b. Financial

- Fiscal Burden of Program

“I do think that increased funding would go a long way in allowing students to have fewer jobs and side hustles that they need to get by. Easing this financial/time burden could allow students greater opportunities to engage in their own forms of wellness.”

“We definitely need more financial support (some amount taken off for tuition cost) than the scholarships given to us in our first year. We provide a significant amount of services for the profit of the GSAPP clinic (e.g., cognitive assessment and therapeutic client cases)

“Greater support for students in the process of receiving in-state tuition.”

- Work Opportunities

“More transparent/equitable part-time job postings for the department and clinic; have been told you need to reach out to faculty to inquire about possible hirings or [that] jobs are offered to students who faculty already have relationships with. Makes it difficult to find an entry point for part-time employment at GSAPP unless you know the right people.”
c. Academic/Clinical Training

- **Timelines**

  “Adjusting timeline of significant milestones (e.g. summer classes, written comps, oral comps)- [they are often] scheduled for when burnout is most severe”

  “more conversations with staff about day-to-day life, transitioning to externships, career concerns, etc would be nice to have with supportive staff or faculty. It can be hard to understand the developmental expectations of training and feedback might help ease concerns for some students.”

- **Faculty/Departmental**

  “When concerns are raised to faculty, improving follow up and execution of proposed solutions.”

  “It would be really helpful to have at least 1 faculty member in the department who is aware of all of the responsibilities and roles that a GSAPP student has each year. It’s frustrating when faculty seem to be unaware of the time and effort that GSAPP students put into clinical work, research, academics, and possibly a part-time paid position. With this knowledge, I believe that students will consistently have an informed advocate at the faculty level.”

- **Mentorship**

  “3rd or 4th year students may be better suited for the position [of peer mentor] given their advanced standing in the program and thus greater experience.”
"Support group[s] that are "forced" - many students don't realize what they were missing out on until they talk about these things. And since conversations happen naturally, instead of being regular "check-ins with specific topics", people might not know what they are missing out on much later into the journey. For example, in my third year, I was having 5 individual cases and 3 groups to discuss and prep within 1 hour of supervision at my externship site. I didn't know this was somewhat abnormal until my second semester when someone from my cohort commented that they were receiving 1 hour of supervision for every 2-3 cases. Second example was that I received tons of supervision and guidance on my dissertation (at least one 1-hour meeting every other week, with multiple revision of manuscript), but one of my peer receive supervision like once a semester (or unless requested) and did not know that she was receiving inadequate guidance. All in all, while we may be in charge of our own social life and initiatives, talking about clinical experiences and sharing of information voluntarily can sometimes be hard (we don't know if others are willing to share). So, if there could be mandatory "let's talk about random updates" as a cohort, maybe once a month, it may be beneficial for people to share and pick-up information that were novel to them.”
Selected Open-Ended Responses, Categorized by Theme. “Do you have any concerns or hesitations around any of the previously listed supports? If so, please describe below.”

a. Social-Emotional

- **Program Culture**

  “I think wellness should also include feeling heard and valued in GSAPP. I have heard mixed reviews, with really horrible encounters with faculties, and really positive ones. So I guess the most important thing must be a completely unbiased or no-punishment policy for students to bring their concerns to the heads of the department. UNFORTUNATELY, these actions have been retaliated and the heads have not been fully friendly and supportive in such situations. The faculty SHOULD see the students as unpaid, and oppressed; so while the faculty have certainly contributed to the excellence of GSAPP, the student have too and the faculty should make more effort in treating students as equals not as subordinates whose views and opinions are relatively useless. I know I am being vague- don't want to give specific examples that may give away identifying information.”

- **Student Access to Resources**

  “Vetted list of providers — who is vetting and on what criteria?”

  “I would be slightly concerned about a therapist that exclusively serves GSAPP or a designated therapist through CAPS due to the fact that it may be difficult to talk about difficulties I am having at GSAPP with somebody who either knows or works with the person I'm having difficulties with.”
b. Financial

- Fiscal Burden of Program

  “I do not think that students have the time to read additional GSAPP materials (e.g., newsletter) or attend school-sponsored workshops. I also think that financial support is likely going to make the greatest impact. Students will be able to afford therapy, let go of part-time paid positions, and overall less stress with increased financial support.”

- Work Opportunities

  “More transparent/equitable part-time job postings for the department and clinic; have been told you need to reach out to faculty to inquire about possible hirings or [that] jobs are offered to students who faculty already have relationships with. Makes it difficult to find an entry point for part-time employment at GSAPP unless you know the right people.”

c. Academic/Clinical Training

- Faculty Mentorship

  “I think a structured faculty-student mentorship program sounds like a great idea. However, this idea rests on the assumption that the student feels supported by the relationship with their faculty advisor. There could be more flexibility to choose advisors in this kind of program.”
One concern I had was with more extensive faculty mentorship. I prioritized it because I think it could be very helpful. That being said, if faculty members are not supportive or invalidating, more meeting with them may not be helpful.”