Exploring Barriers to Accessing Mental Health Services Among Therapists-in-Training: A Thematic Analysis

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Abstract

Therapist well-being is widely regarded as a crucial aspect of effective therapy. Decades of research highlight the negative impacts of unmanaged distress on therapists' treatment outcomes, which has led to a focus on the ethical importance of managing challenges through self-care. However, a gap remains between the recognized importance of accessing mental health care and the actual use of these services, particularly among therapists-in-training. This presents a critical concern for both trainee well-being and client care. The purpose of this qualitative study was to explore the barriers that prevent therapists-in-training in Canada from accessing mental health services. Guided by a constructivist framework, six master's-level counselling and psychotherapy students participated in semi-structured interviews, which were analyzed using thematic analysis (Braun & Clarke, 2021). Seven overarching themes and twenty-three subthemes emerged: (1) *Internal Resistance to Help-Seeking*, (2) *Structural and Systemic Barriers*, (3) *Dual Relationships and Being Caught Between Roles*, (4) *The Demands of Training as a Barrier*, (5) *Internalized Stigma and Incongruence with the Idealized Therapist Identity*, (6) *Fear of Professional Consequences*, and (7) *Broken Trust in Therapeutic Systems*. Together, these themes reveal that barriers to help-seeking reflect individual, relational, and systemic factors. This study addresses a gap in the literature by providing insights into the unique obstacles faced by therapists-in-training. The findings contribute to the development of interventions aimed at improving access to mental health services for professionals, enhancing their long-term well-being. This, in turn, benefits clients, as well-supported therapists are better equipped to provide ethical and effective care – the profession's primary goal.

Keywords: Therapist self-care, barriers, therapists-in-training, counsellor education

Chapter 1: Introduction

In a profession devoted to fostering mental health, the irony is stark: therapists-in-training often find themselves paralyzed by the very distress they are trained to alleviate, a paradox that reveals barriers hindering their ability to seek the support they need to achieve optimal well-being and deliver effective care. According to the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, psychological distress is defined as a multifaceted array of symptoms, ranging from anxiety and depression to functional impairments and behavioural issues (American Psychiatric Association, 2013). Despite bearing the tools to guide others in improving their mental health, therapists-in-training encounter challenges of their own and may, at times, require mental health support. Indeed, high rates of psychological distress are frequently reported by therapists-in-training (Smith et al., 2007). These mental health challenges are not solely discomforting; they can pose adverse effects on student's well-being, (Andrews & Wilding, 2004; El-Ghoroury et al., 2012), which influences their clients' therapeutic outcomes (Bearse et al., 2013; Norcross & Guy, 2007). Acknowledging the impact of psychological distress on the overall functioning of these trainees and their clients, it is imperative for those facing distress to proactively seek mental health care to maintain optimal well-being.

Problem Statement

Despite the expanding accessibility of mental health services, only a minority of therapists-in-training choose to seek support (Bradley & Drapeau, 2014; Jaworska et al., 2016). Research delineating possible explanations underlying infrequent utilization of mental health services by trainees, even in the face of significant distress, unveils the existence of multiple barriers (Ciarrochi & Deane, 2001; Salaheddin & Mason, 2016). Barriers, within the context of this study, are defined as factors that deter or prevent individuals from seeking mental health care

(Shi et al., 2020). Mental health services, support, and care, refer to a spectrum of services provided by licensed individuals (e.g., psychotherapists, social workers, psychologists, etc.) aimed at improving and maintaining mental well-being, such as therapy and counselling. Due to the existence of barriers, therapists-in-training often encounter impediments in accessing mental health support. Consequently, trainees may be grappling with distress in isolation, potentially exacerbating the gravity of their challenges. Recognizing mental health as a pivotal force impacting every facet of an individual's life underscores the need to explore the barriers that prevent trainees from accessing mental health support during periods of distress, in order to better support these students' mental health needs and increase the quality of care they provide.

Contributions and Implications for Research, Education, and Practice

It is essential to conduct research to better understand the barriers therapists-in-training face in accessing mental health support for several reasons. First, by capturing the lived experiences of therapists-in-training surrounding barriers that impact their utilization of mental health services, this study will enrich the existing body of knowledge with insights that have previously been underexplored and will provide a foundational understanding that subsequent research can build upon. In terms of education, this research will amplify the voices of therapists-in-training, whose perspectives are vital for informing and improving training programs. Through exploring the specific barriers trainees encounter, institutions can develop targeted strategies to make mental health services more accessible to students. This is particularly important as therapists-in-training are in a critical period of professional development and identity formation. Establishing strong help-seeking habits during this formative time is essential, as these habits will likely persist into their professional careers, ultimately enhancing their long-term well-being and effectiveness as future therapists (Bruss &

Kopala, 1993; Foo & Green, 2023; Zahniser et al., 2017). Finally, from a practice standpoint, this study underscores the ethical responsibility of therapists and trainees to actively engage in self-care (CCPA, 2020). While all students benefit from developing healthy help-seeking habits, therapists-in-training have an ethical obligation to engage in self-care and attend to their well-being, given the demands of their training (CCPA, 2020). Engaging in self-care, such as personal therapy, not only enhances the well-being of trainees but also promotes competence and positive client outcomes (Barnett et al., 2007; Barnett & Cooper, 2009). Overall, the insights gained from this study are crucial for increasing access to mental health services, thereby fostering the wellness of future professionals and the clients they work with – the profession's primary goal (CCPA, 2020).

Overview of Current Study

The purpose of this qualitative study was to explore the perspectives of therapists-in-training in Canada regarding the barriers they perceive as impacting their access mental health services. Specifically, this study's primary objective was to gain insights into the factors that prohibit therapists-in-training from seeking mental health care when they recognize their need for support. Additionally, this research aimed to amplify the voices of therapists-in-training to gain a deeper understanding of their perspectives, with the broader goal of increasing mental health service accessibility. Accordingly, the following research question was developed: "What are the barriers that therapists-in-training identify as preventing or hindering their utilization of mental health services?" Participants included six master's-level therapists-in-training who took part in semi-structured interviews exploring their personal experiences with barriers to accessing mental health care during their training. The data were analyzed using thematic analysis.

The present thesis is divided into five overarching chapters which serve a specific

purpose. Chapter 1, the current chapter, begins by situating the study in the literature by providing an introductory discussion of therapists-in-training and barriers to seeking mental health care. Chapter 2 is a review of the literature, situating the present study within previous literature, and highlighting gaps in the literature. Chapter 3 explains the study's methodological approach to give a background on how the study was conducted, including how the data was collected and the method of analysis. Chapter 4 presents the findings and shares the results of the present study. The final chapter, Chapter 5, offers an analysis of the main research findings and discusses the implications, limitations, strengths and suggestions for future areas of research.

Chapter 2: Literature Review

Prevalence of Mental Health Difficulties Among Therapists-in-Training

While therapists-in-training develop expertise in promoting well-being through their academic studies as they prepare for careers as psychotherapists, they are not immune to mental health challenges themselves (Dearing et al., 2005). In fact, this group is particularly vulnerable, with research showing trainees experience higher rates of mental health difficulties than the general population (Kumary & Baker, 2008; Shapiro et al., 2007; Tay et al., 2018). For instance, significant levels of psychological distress, including symptoms of depression and stress, are commonly reported among therapists-in-training (Smith et al., 2007). Likewise, a nationwide survey revealed that 70% of therapists-in-training reported stressors that interfered with their functioning (El-Ghoroury et al., 2012). A survey across Canadian universities found that one-third of trainees reported clinically significant levels of depressive symptoms (Peluso et al., 2011). Additionally, over 80% of graduate students in clinical and counselling psychology programs reported experiencing a lifetime mental health difficulty/diagnosis (Victor et al., 2021). Clearly, this population faces a markedly elevated level of distress.

Sources of Distress

Studies examining the nature of psychological distress among therapists-in-training indicate that elevated levels of distress can be ascribed to the demands of their academic training, as they navigate a unique set of challenges in pursuit of a master's degree (Hyun et al., 2006). For over 30 years, theorists (e.g., Lamb et al., 1987; Schoener, 1999; Schwartz-Mette, 2009) have identified graduate training as one of the most stressful periods in the professional development of future therapists. For example, the rigorous nature of graduate school, such as demanding schedules, heavy workloads, challenging coursework, internship obligations, and

research requirements, creates a high stress environment (Andrews & Wilding, 2004; El-Ghoroury et al., 2012; Rummell, 2015). Financial constraints also contribute significantly to distress among therapists-in-training (Cahir & Morris, 1991; El-Ghoroury et al., 2012; Goplerud, 2001), with many facing substantial debt related to their education (Michalski et al., 2011). Financial pressures can also limit participation in extracurricular activities s that might alleviate distress (Shen-Miller et al., 2011).

In graduate school, therapists-in-training are tasked with managing general academic responsibilities, alongside the demands of their clinical internships, where they begin seeing clients for the first time (Shen-Miller et al., 2011). During this critical transitional phase, stressors such as performance anxiety, feelings of incompetence, evaluation in supervision, and ambiguity in their clinical work, are particularly pronounced (Jennings et al., 2003; McAlpine et al., 2012; Pica, 1998; Skovholt & Rønnestad, 2003; Thériault et al., 2015; Thériault & Gazzola, 2010). These factors can significantly exacerbate the distress experienced by trainees as they navigate their emerging professional identities as therapists. This period of training represents not only a transition in skill acquisition but also a developmental process in which trainees begin to integrate their personal and professional selves (Gibson et al., 2010). As trainees work to internalize the role of "therapist," they must reconcile ongoing self-doubt and uncertainty with expectations of competence and responsibility in clinical work. This process of identity formation may heighten sensitivity to evaluation, amplify feelings of inadequacy, and intensify the emotional impact of clinical and academic demands. (Hill et al., 2007), exacerbating the need for supervision or mental health support.

Moreover, therapists-in-training are not only stepping into an unfamiliar professional role but also must contend with repeated exposure to emotionally intense material that can contribute

to burnout and compassion fatigue (APA, 2010; Barnett et al., 2007; Kaeding et al., 2017; Smith & Moss, 2009; Sprang et al., 2007). Moreover, the confidential nature of their work may lead to professional isolation and a lack of social support, further compounding the challenges they face (American Psychological Association [APA], 2010; El-Ghoroury et al., 2012; Smith & Moss, 2009).

Overall, therapists-in-training face a range of stressors related to the academic aspects of their training (e.g., demanding coursework and research obligations), transitional and evaluation features (e.g., feelings of incompetence), and challenges inherent in clinical work (e.g., chronic exposure to distressing material). Yet, as therapists-in-training, without well-established support systems and coping strategies, trainees may struggle to manage the stress of their academic and clinical activities (Shen-Miller et al., 2011).

Impact of Distress

While clinical work can be deeply rewarding, it can exact a significant toll on the therapist (Guy, 2000; Norcross, 2000). The distress associated with this work can have far-reaching consequences on both the personal and professional lives of therapists-in-training (Andrews & Wilding, 2004; El-Ghoroury et al., 2012; Hyun et al., 2007). If not effectively managed, distress may lead to a range of severe outcomes, including depression (Mahoney, 1991), heightened stress (Shapiro et al., 2005), burnout (Smith & Moss, 2009), suicide (Deutsch, 1985; Hannigan et al., 2004), emotional exhaustion, isolation, and withdrawal (Laidig, 2007), as well as disturbed interpersonal relationships (Pope & Tabachnick, 1994).

Professional Effectiveness

Therapist well-being has emerged as a crucial aspect of effective psychotherapy, widely regarded by many theorists as the cornerstone of therapeutic practice (Baldwin, 2000; Deutsch,

1985; Hackney & Bernard, 2017; Rogers, 1992, 2007). Consequently, it is unsurprising that heightened levels of distress can have numerous negative effects on a psychotherapist's professional effectiveness (Smith & Moss, 2009). Firstly, research demonstrates that therapist's well-being directly affects their clients' therapeutic outcomes (Bearse et al., 2013; Johns et al., 2019; Norcross & Guy, 2007; Witmer & Young, 1996). When therapists experience distress, there is a risk of providing compromised (Guy et al., 1988; Kirsten & Gall, 2020; Schwartz-Mette, 2009) or ineffective care (Barnett et al., 2007; Elman & Forrest, 2007). For instance, a study by Guy et al. (1989) examined how therapists' personal distress impacted the quality of care provided to clients. Among the 318 respondents, 74.3% reported experiencing personal distress within the previous three years. Of these, 36.7% indicated that their distress had negatively affected the quality of client care, while 4.6% reported that their distress was severe enough to result in inadequate care. Furthermore, a therapist experiencing distress may engage in various inappropriate behaviours (Kirsten & Gall, 2020; Schwartz-Mette, 2009), including acting dangerously, unethically (Barnett et al., 2007; Elman & Forrest, 2007), or disrespectfully (Pope & Vasquez, 2007; Tamura, 2012; Williams et al., 2010). Distress is also associated with a higher risk of sexual involvement with clients (Remley & Herlihy, 2007).

Additionally, elevated levels of distress can make therapists more susceptible to poor clinical decision-making (Barnett et al., 2007; Elman & Forrest, 2007; Klein, 1996) and increase the likelihood of errors (Pope & Vasquez, 2007; Tamura, 2012; Williams et al., 2010). Furthermore, unmanaged distress can negatively impact declarative memory (Kirschbaum et al., 1996), diminish attention and concentration (Skosnik et al., 2000), and weaken a therapist's capacity to form strong therapeutic relationships with clients – one of the most essential components of effective therapy (Enochs & Etzbach, 2004). Distress can also lead therapists to

abandon their careers altogether, cutting short their professional journey (Thériault & Gazzola, 2008).

Experiencing distress does not inherently result in negative outcomes such as therapist impairment, nor does it mean that therapists or trainees must maintain perfect mental health to provide effective care. However, mental health difficulties often precede impairment and should be viewed as warning signs, as failure to address distress over time can increase the likelihood of impairment (Barnett et al., 2007; Barnett & Hillard, 2001; O'Connor, 2001; Sherman, 1996). Likewise, professional guidelines emphasize that neglecting one's mental health and avoiding appropriate help-seeking can worsen existing issues or lead to new problems, further compromising a therapists' functioning and fitness to practice (APA, 2010).

Ethical Responsibility

Due to the significant impact of distress on both the personal lives of therapists and the quality of care they provide, there has been increased focus on the hazards of the profession and the importance of preventing and managing distress through self-care (Barnett et al., 2007; Barnett & Cooper, 2009). As a result, self-care is now regarded as an ethical obligation within the psychotherapy profession (Norcross & Guy, 2007). For instance, the Canadian Counselling and Psychotherapy Association (CCPA; CCPA, 2020) Code of Ethics emphasizes the importance of personal care in its very first guideline under "Professional Responsibility." For example, the Code of Ethics advises that "counsellors/therapists maintain high standards of professional competence and ethical behaviour and recognize the need for continuing education and personal care in order to meet this responsibility" (CCPA, 2020, A1, p. 6). Clearly, the profession of psychotherapy has recognized self-care as essential for ethical practice, making it a mandatory aspect of professional conduct for therapists and trainees (Thériault et al., 2015).

Mental Health Support for Therapists-in-Training

The Need for Support

Given the high prevalence of distress among therapists-in-training and its impact on both their personal and professional lives, coupled with the recognition of self-care as an ethical obligation within the profession (CCPA, 2020; Norcross & Guy, 2007), it is crucial to establish accessible self-care strategies for trainees (Harris et al., 2013; Smith et al., 2007). However, concretely defining "self-care practices" and how can they be effectively integrated into one's life, can be elusive. Research-informed, practitioner-tested strategies for self-care include integrating formal instruction on self-care techniques, offering opportunities for self-care activities such as mindfulness meditation classes, incorporating self-care discussions in supervision, encouraging educators to model self-care behaviours, and promoting personal therapy (Barnett & Cooper, 2009; Norcross, 2000). Personal therapy has long been endorsed by researchers, practitioners, and trainees as a vital self-care strategy.

For much of the past century, engagement in personal therapy has been widely regarded as a fundamental component of psychotherapists' development (Fromm-Reichmann, 1949). Research spanning the last four decades indicates that many practitioners view their own therapy as essential not only for maintaining personal well-being (Mahoney, 1997; Norcross; Stevanovic & Rupert, 2004), but also for supporting their ongoing professional growth (Norcross, 2005; Pope & Tabachnick, 1994). In this sense, personal therapy has been positioned as a central element within the training and development of psychotherapists (Bike & Norcross, 2009). However, despite these endorsements, evidence regarding its impact on client outcomes remains inconclusive. Empirical findings are mixed, with some studies suggesting a positive association between therapists' personal therapy and client improvement, while others report no significant

relationship between the two (Bike & Norcross, 2009; Macran & Shapiro, 1998; Orlinsky et al., 2005).

Although empirical findings linking therapists' participation in personal therapy to improved client outcomes remain inconsistent, there is strong theoretical and clinical consensus regarding the central role of the therapist's "use of self" in effective practice. This concept broadly includes capacities such as self-awareness, emotional regulation, reflexivity, and the ability to recognize and manage one's internal responses within the therapeutic relationship (Knight, 2012). These competencies are widely regarded as foundational across psychotherapeutic modalities (Alva et al., 2025). For instance, the College of Registered Psychotherapists of Ontario (CRPO) identifies the ability to "ensure the safe and effective use of self in the therapeutic relationship" as a core requirement for entry to practice (CRPO, 2012). Training programs commonly aim to cultivate these capacities through processes of self-exploration, with personal therapy often considered a valuable avenue for fostering deeper self-understanding and working through personal experiences that may emerge in clinical contexts (Amari, 2021). In this way, personal therapy may support the development of the therapist at both personal and professional levels, encouraging a more integrated sense of self (Grimmer & Tribe, 2001; Rizq & Target, 2008) and strengthening relational competencies that are essential for effective therapeutic engagement (Merriman & Joseph, 2016).

As such, even in the absence of definitive outcome-based evidence, personal therapy may play an important role in supporting competencies that are foundational to therapeutic effectiveness. Given this, barriers that limit therapists-in-training from accessing mental health care may have implications not only for their personal well-being but also for their professional development and capacity to engage in effective use of self. Investigating these barriers is

therefore critical to understanding how to better support therapists-in-training in both their personal and professional functioning.

The Use of Support

Despite the positive attitudes toward personal therapy among seasoned therapists and therapists-in-training (Henry et al., 1971; Kaslow & Friedman, 1984; Fouad et al., 1990; Mackey & Mackey, 1993; Pope & Tabachnick, 1994; Williams et al., 1999, there is a paradoxical gap between these beliefs and actual participation in personal therapy. Although empirical evidence highlights the advantages of personal therapy, only a minority of graduate students in training programs take advantage of these services. Research examining the utilization of mental health services at various points throughout therapists' professional careers reveals a U-shaped trend, with the lowest rates of therapy engagement occurring during graduate training. For example, researchers note the high percentages of mental health professionals in America who have sought personal therapy during their career, with some indicating that approximately 80% of therapists have attended therapy (Bike et al., 2009; Neukrug et al., 2017; Orlinsky et al., 2011). Likewise, Dearing et al. (2005) found that 70% of clinical psychology trainees had attended therapy before beginning their training. Interestingly, Rummell (2015) reported that 82% of clinical and counselling psychology doctoral students had undergone therapy prior to graduate school, however, this rate dropped to 54% once the individuals in the sample entered graduate training to become therapists. Other studies have reported similar trends, with around 45% of therapists-in-training utilizing mental health services during their training (Kalkbrenner et al., 2019; Kalkbrenner & Neukrug, 2018; McCarthy et al., 2010). Clearly, while engagement in personal therapy is high before and after graduate training, there is a noticeable decline during the training

period itself. This raises a critical question: What aspects of graduate training deter students from seeking the personal therapy they clearly value?

Notably, a study by Rummell (2015) examining the psychological well-being of clinical and counselling psychology graduate students revealed alarming results. The findings showed that 81% of therapists-in-training reported experiencing significant distress on a biweekly basis. However, of these distressed individuals, only 20% were actively engaged in personal therapy at the time (Rummell, 2015). The literature reviewed suggests that therapists-in-training are not only less likely to seek personal therapy during their training but also exhibit an increased reluctance to do so in the face of significant distress. For example, in a sample of therapists and trainees, 57% acknowledged that there had been a time when they would have benefited from seeking help for their distress but had not done so (Edwards & Crisp, 2017). This finding is particularly troubling given the ethical obligation for therapists and trainees to engage in self-care to maintain high standards of professional competence, as outlined by various Codes of Ethics (American Counseling Association [ACA], 2014; CCPA, 2020; Canadian Psychological Association [CPA], 2017). Unfortunately, there is a lack of research detailing why some therapists-in-training avoid seeking personal therapy (Pakenham & Stafford-Brown, 2012). Thus, to better understand the attendance rates of personal therapy among therapists-in-training, it is crucial to explore the barriers that prevent them from accessing these services.

Barriers to Accessing Mental Health Support

In 1985, Stefl and Prosperi outlined four “universal barriers” to help seeking: availability (e.g., knowledge about available services), accessibility (e.g., transportation concerns, time), acceptability (e.g., concerns about what others would think), and affordability (e.g., cost-related concerns). Alike the “universal barriers” that are documented in the general help-seeking

literature, several have been described as barriers to the use of personal therapy among therapists-in-training (Bridgeman & Galper, 2010; Dearing et al., 2005; El-Ghoroury et al., 2012; Holzman et al., 1996) and therapists (Mahoney, 1997; Edwards & Crisp, 2017; Schwebel & Coster, 1998; Tay et al., 2018). For example, El-Ghoroury et al. (2012) surveyed therapists-in-training regarding barriers to using any coping strategy and the findings revealed that two thirds (70.6%) of participants reported that lack of time and nearly half (46.5%) reported that cost were significant barriers. However, in addition these barriers, some may be *unique* for individuals in the mental health profession, such as therapists-in-training (Klein et al., 2023).

Confidentiality

Therapists and therapists-in-training often display a heightened sensitivity to confidentiality issues compared to the public at large (Fay & Lazarus, 1984; Deutsch, 1985). Farber (2000) examined the factors affecting therapists-in-training likelihood of seeking mental health support for their distress and found that concerns about confidentiality was a significant barrier for many trainees. A more recent study by El-Ghoroury et al. (2012) surveyed therapists-in-training to assess coping strategies and common barriers to engaging in self-care or wellness activities. This study found that 29.3% of trainees reported privacy and confidentiality concerns as a barrier to seeking mental health care. Specifically, therapists-in-training may face challenges finding a therapist who is unaffiliated with their university, alongside concerns about collaborating professionally with that therapist in the future (Bearse et al., 2013; Deutsch, 1985).

Despite assurances of confidentiality, trainees may have concerns about potential connections between university clinics and their graduate departments. For instance, numerous studies have shown that both trainees and therapists are often hesitant to disclose their personal difficulties or seek personal therapy due to fears that doing so could negatively impact future

training opportunities or career prospects at the same institution (Beck, 1976; Garelick, 2012; Hassan et al., 2009). Specifically, Holzman et al. (1996) found that trainees are unlikely to seek mental health care at university counselling centers due to concerns about becoming ineligible for training opportunities at those sites in the future. More recently, Edwards and Crisp (2017) found that 68% of therapists and trainees agreed that concerns about damaging their chances when applying for jobs posed a barrier to seeking mental health treatment. Additionally, Bearse et al. (2013) highlighted that trainees may be reluctant to seek therapy due to the possibility of having to work with the therapist in a professional capacity in the future.

A common barrier to seeking therapy for therapists-in-training is the limited availability of therapists with whom they have no professional acquaintance (Deutsch, 1985; Orlinsky et al., 2011). A dual or multiple relationship occurs when a therapist has another significant relationship with a client outside the therapeutic context, such as when the client is also a colleague, student, or supervisor. Various professional Codes of Ethics underscore the importance of avoiding dual or multiple relationships, stating that therapists should make every effort to avoid such relationships (ACA, 2014; CCPA, 2020; CPA, 2017). This ethical guideline can significantly restrict the pool of available therapists from whom trainees can receive care. Additionally, trainees may find it challenging to find a local therapist because many are affiliated with their university program. For instance, students often express concerns about their supervisors and professors, who may practice as therapists in the community, creating a potential dual relationship (Bearse et al., 2013; Klein et al., 2022; Tay et al., 2018). Yet, if trainees opt for the mental health services offered on campus, they may be met with similar obstacles as in-house mental health services are often staffed by professors who teach their classes, and therapists-in-

training who are their peers. Overall, avoiding dual relationships can limit trainees access to mental health services, both within the community and at their university (Klein et al., 2022).

Consequences of Disclosure

In addition to concerns about time, finances, and confidentiality noted in El-Ghoroury et al.'s (2012) study, trainees also identified fears of potential consequences as a barrier to seeking help. Specifically, nearly one-third (32.6%) of respondents reported feeling apprehensive about what might occur if they pursued personal therapy (El-Ghoroury et al., 2012). Several studies have highlighted that fear of being judged negatively by the public, family, friends, employers, and colleagues is a significant barrier to seeking personal therapy among therapists and trainees (Corrigan, 2004; Garcia & Crocker, 2008; Garelick, 2012; Kessler et al., 2001; Tay et al., 2018). Edwards and Crisp (2017) conducted a survey of therapists and trainees to explore barriers to seeking mental health care when distressed. The survey found that 58.2% of respondents had, at some point, felt they would benefit from mental health services but chose not to pursue them, with 29.8% citing fear of colleagues discovering as a reason for not seeking treatment. The study further assessed the degree to which various factors had ever stopped or discouraged them from seeking care. It was revealed that 70.1% of participants agreed ("a little–a lot") and 14.4% strongly agreed ("a lot") that concern about what people at work might think, say, or do was a barrier to seeking help. Additionally, 67% agreed ("a little–a lot") and 10.3% strongly agreed ("a lot") that concern about being perceived as weak for having a mental health problem was a barrier. Lastly, 58.8% of respondents agreed ("a little–a lot") and 5.2% strongly agreed ("a lot") that concerns about not being taken seriously if others knew they were receiving professional care was a barrier to seeking care. These findings underscore the fear of judgment that some trainees face, which significantly impacts their willingness to seek mental health support.

Several studies have shown that therapists-in-training often avoid seeking personal therapy due to concerns about how it might affect their professional reputation. For example, Holzman et al. (1996) found that trainees may worry that undergoing therapy could cause faculty and peers to question their competence, emotional stability, and suitability for the profession. Similarly, Farber (2000) explored help-seeking attitudes among trainees and discovered that their reluctance to seek personal therapy stemmed from fears that being in therapy could be used against them. Trainees were particularly concerned about being perceived as professionally incompetent (Farber, 2000). Dearing et al. (2005) also studied help-seeking behaviours among therapists-in-training and found that trainees were hesitant to seek mental health support due to fears that it may raise doubts about their appropriateness for the profession. This apprehension extended to concerns about being viewed as professionally inadequate by employers, colleagues, and faculty members (Dearing et al., 2005; Walsh & Cormack, 1994).

Therapists-in-training may also avoid seeking mental health care due to fears of exposure and potential professional repercussions if their confidential information were to be compromised (Deutsch, 1985). For instance, a study by Edwards and Crisp (2017) surveyed mental health professionals and students about the barriers to seeking mental health support when experiencing distress. The findings revealed that 64.3% of respondents reported that a mandatory disclosure of their distress to their workplace would discourage them from revealing if they were unwell, and 57.1% stated that this requirement would also deter them from seeking treatment even in the face of significant distress. The researchers suggest that this hesitation may stem from concerns about the possible impact of self-disclosure on their professional status, such as the risk of losing their license to practice therapy (Edwards & Crisp, 2017).

Stigma

Stigma is a multifaceted concept encompassing both public stigma and self-stigma (Corrigan et al., 2004, 2005, 2009, 2011). Public stigma includes stereotypes (generalized beliefs about a group), prejudice (negative emotional reactions), and discrimination (actions that disadvantage or exclude people), while self-stigma refers to the internalization of these public stigmas by individuals within the stigmatized group (Corrigan et al., 2009, 2011). Research demonstrates that public stigma significantly influences attitudes toward seeking personal therapy, serving as a barrier and leading individuals to conceal their symptoms or use of mental health services (Chen & Mak, 2008; Hackler et al., 2010; Kessler et al., 2001; Komiti et al., 2006; Ludwikowski et al., 2009; Makenzie et al., 2004; Vogel et al., 2007). For therapists-in-training, the attitudes of faculty and peers play a crucial role in shaping their own views about therapy (Dearing et al., 2005). Studies show that perceived stigma from faculty members influences the attitudes of therapists-in-training toward seeking therapy (Dearing et al., 2005; Digiuni et al., 2013; Farber, 2000; Klein et al., 2022). Thus, negative perceptions from faculty and peers, such as the belief that those who seek therapy may be unsuitable for the profession (Holzman et al., 1996), can serve as a barrier to help-seeking among trainees.

Self-stigma, on the other hand, involves the internalization of societal attitudes, leading to negative self-perceptions about seeking personal therapy (Corrigan et al., 2009, 2011; Digiuni et al., 2013). For instance, researchers have found that perceptions of public stigma contribute to self-stigma, which subsequently impacts attitudes towards utilizing mental health services (Tay et al., 2018; Vogel et al., 2007). For example, harmful narratives that mental health difficulties reflect weakness, may lead therapists and trainees to feel that they should be resilient and capable of handling problems independently. Consequently, this stigma may become internalized,

manifesting as shame, guilt, and embarrassment if trainees do experience significant distress that feels unmanageable alone (Corrigan, 2004; Corrigan et al., 2006; Garcia & Crocker, 2008; Garelick, 2012; Kessler et al., 2001; Sirey et al., 2001; Watson et al., 2006). Indeed, El-Ghoroury et al. (2012) found that 29.6% of therapists-in-training reported feelings of embarrassment, guilt, and shame as barriers to seeking help. Similarly, research by Edwards & Crisp (2017) asked therapists and trainees the extent to which they agree that "feeling embarrassed or ashamed" is a barrier in seeking mental health treatment and 69.8% of participants agreed "a little-a lot" and 12.5% of respondents agreed "a lot." Overall, self-stigma can serve as a significant barrier for therapists-in-training, deterring them from seeking personal therapy due to internalized feelings of shame, guilt, and embarrassment associated with the idea of needing mental health care.

The Evolution of Stigma. Over the past several decades, substantial efforts have been made to shift the societal attitudes surrounding mental illness (Schomerus et al., 2022). There is a growing perception that individuals are increasingly willing to disclose their personal experiences with mental health challenges (Reavley & Jorm, 2014), and that discussing these issues has become more socially acceptable (Corrigan et al., 2024). This raises an important question: Have anti-stigma efforts translated into meaningful, population-level changes in attitudes toward individuals with mental illness?

Although public awareness initiatives have contributed to more favourable general perceptions of mental health over time, the overall landscape remains complex. Evidence suggests that reductions in stigma have been uneven, varying across specific disorders, demographic groups, and social contexts. A longitudinal analysis of stigma trends in Germany, drawing on four waves of nationally representative cross-sectional data collected between 1990 and 2020, examined changes in public attitudes toward individuals with depression and

schizophrenia (Schomerus et al., 2022). The findings indicated a modest improvement in stigma related to depression over time. In contrast, attitudes toward schizophrenia became more negative. More specifically, preferences for social distance increased in six of seven assessed scenarios involving schizophrenia, whereas modest reductions in social distance were observed in two of seven scenarios for depression. Similarly, fear and discomfort rose in relation to schizophrenia but declined for depression, and prosocial responses (e.g., willingness to help) increased for depression but decreased for schizophrenia (Schomerus et al., 2022).

Similarly, findings from a nationally representative U.S. survey spanning 1996 to 2018, indicate that changes in public attitudes toward mental illness have been uneven across diagnoses (Pescosolido et al., 2021). While stigma related to individuals with depression showed some decline, attitudes toward other diagnoses did not demonstrate the same improvement. For example, between 1996 and 2006, there was an increase in public endorsement of biomedical explanations for mental illness, reflecting greater alignment with scientific perspectives and a reduction in blame-based attributions. However, these shifts were not accompanied by decreases in social rejection. Between 2006 and 2018, modest reductions in stigma emerged, but were largely limited to individuals with depression, seen through a decreased desire for social distance. In contrast, stigma toward other diagnoses persisted or intensified, with heightened perceptions of dangerousness associated with individuals with schizophrenia and stronger moral judgments directed at those with alcohol use disorder (Pescosolido et al., 2021).

Despite evidence of modest reductions in public stigma, particularly for individuals with depression, emerging research suggests that self-stigma may be increasing (Lu et al., 2025). A cross-temporal meta-analysis of 179 studies conducted between 2005 and 2023 found a consistent rise in internalized stigma across multiple dimensions among individuals with a

diagnosed mental illness. Notably, this increase occurred alongside a rise in stigma resilience, suggesting that individuals may be developing stronger coping capacities even as they experience heightened self-stigmatizing beliefs (Lu et al., 2025).

Overall, the literature suggests that mental health stigma has not diminished so much as it has shifted in form. This shift suggests that stigma may now function less through overt societal rejection and more through internalized beliefs. For therapists-in-training, who are embedded within professional environments that emphasize competence and emotional stability, these more subtle forms of stigma may be particularly influential, shaping help-seeking behaviours in ways that are not captured by traditional conceptualizations of public stigma.

The Present Study

Research findings suggest that elevated levels of distress may have detrimental effects on therapists' well-being and professional functioning, and that therapists-in-training may be particularly susceptible to such adverse outcomes. Studies have shown that trainees often experience high levels of distress and mental health difficulties (Victor et al., 2021). However, despite experiencing significant distress, only a small number of these trainees seek mental health support due to various barriers that hinder their access (Ciarrochi & Deane, 2001; Salaheddin & Mason, 2016). While previous research has explored barriers to mental health care among the general population and experienced therapists, there is a gap in the literature concerning the specific obstacles faced by therapists-in-training, who may encounter unique barriers (Dearing et al., 2005; Klein et al., 2022; Norman & Rosvall, 1994). The current study was guided by the following research question: “What are the barriers that therapists-in-training identify as preventing or hindering their utilization of mental health services?”

Chapter 3: Methodology

Research Design

The intent of this qualitative research study was to gain a deeper understanding of the barriers that therapists-in-training face that hinder their use of mental health services. Barriers, the central phenomenon in this study, are conceptualized through a constructivist framework. From this lens, barriers are constructed by individuals based on their subjective experiences, socio-cultural influences, and beliefs. These barriers are not inherent obstacles, but rather, are shaped by the unique context within which individuals exist. As barriers are constructed through the interpretation of each individual, a comprehensive understanding of this phenomenon warrants an exploration of therapists-in-training perspectives. Thus, a thematic analysis qualitative research approach – consisting of semi-structured interviews – was used. The justification for these methods will be explained in the following sections.

Recruitment

Prior to the commencement of the study, ethical approval was sought from The Social Sciences and Humanities Research Ethics Board at the University of Ottawa. Following the receipt of approval (see Appendix A), the recruitment process was initiated. Purposeful sampling, the intentional selection of participants who possess specific characteristics or experiences relevant to the research objectives (Cresswell, 2012), was employed as the participant recruitment strategy for this study. To recruit participants, the researcher contacted professional associations such as the Canadian Psychological Association (CPA) and the CCPA, requesting that they share the recruitment text (see Appendix B). When reaching out to associations, it was requested that the study's recruitment text (see Appendix C) was shared with its student members. When interest was received, participants were asked to communicate with the

researcher using their university email address. Those who responded to the recruitment text via email correspondence and who met the study's inclusion criteria were sent a formal invitation to participate, which contained further details on the study (see Appendix D). A consent form (.pdf) accompanied each invitation, which participants were asked to electronically sign and return via email before the next phase of the study (see Appendix E).

Participants

For this qualitative study, a total of six therapists-in-training were recruited. The inclusion criteria was as follows: (1) participants must be fluent in English, (2) participants must be currently enrolled in a masters-level mental health training program (e.g., psychology, counselling psychology, social work, etc.) that leads to licensure by a recognized professional psychotherapy association/regulatory body in Canada, (3) participants must have encountered barriers that hindered or entirely blocked their ability to seek mental health support during times of distress, and (4) participants must be willing to discuss their personal experiences with navigating their mental health and their reasons for not seeking treatment.

A total of six interviews were conducted with six participants. Interview length ranged from 32 minutes to 70 minutes with an average of 50 minutes. Table 1 (see below) outlines participant characteristics with their associated pseudonym. This information was gathered by way of asking demographic questions prior to completing the interview. Participants' ages ranged from 23 to 42 with an average age of 29.83. Five out of six participants were female, and one participant was non-binary. Three participants were enrolled in a Master of Arts in Counselling Psychology, two participants were enrolled in a Master of Education in Counselling Psychology, and one participant was enrolled in a Master of Arts in Social Work. Five out of six participants

were currently practicing psychotherapy as they were in the process of completing their internship, and one participant was not seeing clients at the time of interview.

Table 1

Participant Group Profile

Participant	Gender Identity	Age	Educational Qualifications	Practicing Psychotherapy
Avery	Female	23	M.Ed. Counselling Psychology	Yes
Quinn	Female	26	M.A. Counselling Psychology	Yes
Oakley	Female	35	M.A. Counselling Psychology	Yes
Jamie	Non-Binary	27	M.A. Counselling Psychology	Yes
Sam	Female	42	M.Ed. Counselling Psychology	No
Jules	Female	26	M.A. Social Work	Yes

Procedure

Once ethical approval from The Social Sciences and Humanities Research Ethics Board was confirmed, data collection commenced. After securing informed consent, eligible participants received a link to the online interview via email. The interview, conducted at a time and date convenient for participants, was facilitated using Microsoft Teams. Prior to the interviews, a thorough review of the consent form was conducted to ensure that participants had a comprehensive understanding of the elements involved in their participation.

The interviews were conducted with a semi-structured interview protocol, predominantly comprised of pre-determined open-ended questions while also providing opportunity for improvised follow-up questions (see Appendix F). The semi-structured interview is a technique used by qualitative researchers to elicit knowledge about the phenomenon under investigation

using a series of interview questions (Mojtahed et al., 2014). Specifically, the use of semi-structured interviews allowed exploration of the meaning therapists-in-training ascribe to barriers, to gain an understanding of the experiences that have shaped the perception of barriers, as well as the impact they have. Participants were queried on a series of questions specifically related to their perspectives on barriers and their influence on the participants' capacity to seek mental health support when required. The list of interview questions was devised by the researcher and confirmed by their research supervisor. At the end of the interview, participants were provided with a debriefing form thanking them for their participation in the study, as well as information on available resources should they require additional support after the interview (see Appendix G). Finally, each interview was audio-recorded with the participants' consent and subsequently transcribed for data analysis.

Data Analysis

Once the interviews were transcribed, the transcripts were first analyzed individually, then subsequently analyzed across the data set to examine meaning and experiences of all participants. This was done using thematic analysis, as it allowed for the identification of patterns that are relevant to the research question, while also making sense of participants' shared experiences across the data set (Braun & Clarke, 2021). The thematic analysis approach was used to analyze the data from a bottom-up manner to allow the participants experiences and voices to guide the analysis (Tuckett, 2005). Thus, the themes were derived directly from participant accounts, establishing a close connection with the raw data. Aligned with the constructivist perspective, this methodology enabled the direct linkage of participants' experiences and the realities they have constructed to the research findings, ensuring that the

results mirrored shared constructions across participants (Braun & Clarke, 2021). This procedure was conducted following the six-step process outlined by Braun and Clarke (2021).

The first phase of the thematic analysis process involves immersing oneself in the data through repeated listening to recordings and thorough review of transcripts. This iterative approach persists until a profound familiarity with the data set is achieved (Braun & Clarke, 2021). In the second phase, data organization takes shape through the creation of provisional codes, identifying features deemed significant. In the third phase, a meticulous examination of codes derived from participants' responses in each interview occurs, with the aim of identifying collective and shared meanings and experiences across the entire data set. Attention is focused on emerging patterns and themes within the codes (Braun & Clarke, 2021). In the fourth phase, themes undergo a rigorous review to ensure congruency with the data set. Subsequently, they are meticulously labeled and defined for clarity in the fifth phase (Braun & Clarke, 2021). In the culminating sixth phase, the coded and analyzed data, along with organized themes and/or subthemes, are presented and disseminated in a report detailing the study's findings. Themes are systematically presented in a logical and meaningful sequence, each layer building upon the preceding one to construct a coherent narrative about the data (Braun & Clarke, 2021).

Trustworthiness

Given that research necessitates standards to establish trust, it was essential that this study employed trustworthiness criteria to ensure methodological rigor and to accurately represent the participants' individual and collective experiences. Establishing a trustworthy qualitative study, according to Lincoln and Guba (1985), involves establishing *credibility* (i.e., congruence between the respondent's views and the researcher's interpretation of them), *transferability* (i.e., evidence that the results can be generalized or transferred to other contexts), *dependability* (i.e.,

the degree to which the researcher's process was logical, traceable, and clearly documented), and *confirmability* (i.e., neutrality or evidence that the results are not shaped by the researchers bias, motivation, or interest but rather participants' own reports).

To establish credibility, it is crucial to acknowledge that people experience and interpret reality in a multitude of ways (Guba, 1981; Riege, 2003). As such, interpretations should be validated to ensure they are representative of participants' experiences. Credibility can be established using member checks, where the researcher tests empirical data and interpretations by sharing it with the research participants (Guba & Lincoln, 1989, 1981; Lincoln & Guba, 1985), and through peer debriefing, which involves sharing one's ideas and thinking with a group of peers (Guba, 1981). In this study, member checking was implemented by sharing transcripts with participants, allowing them to reflect and elaborate further on their experiences if they wished. Peer debriefing was carried out through consultations with the researchers' supervisor, Dr. Gazzola, to seek constructive feedback, to gain insight on areas to explore with future participants, and to ask questions when needed. Furthermore, transferability refers to the extent to which the findings of a study can be applied to other similar contexts, allowing readers to relate the research narrative to their own lives (Guba, 1981; Tracy, 2010). To enhance transferability, researchers can use purposive sampling and obtain detailed descriptions from participants (Guba, 1981). Thus, purposive sampling was employed to select therapists-in-training who are most likely to offer rich insights into the barriers related to accessing mental health services, such as including those who have experienced distress during their graduate studies but have not sought consultation from a mental health professional. To gather detailed and meaningful descriptions, a semi-structured interview protocol consisting of open-ended questions was utilized.

In qualitative research, dependability refers to the consistency and stability of the study's procedures (Riege, 2003). To enhance dependability, techniques such as external auditing and the creation of audit trails can be employed (Guba, 1981). In this study, the researcher's supervisor served as an external auditor, conducting a three-level audit to review the research processes and ensure that data collection methods and analysis procedures were transparent, well-documented, and free from researcher bias (Guba, 1981; Riege, 2003). Finally, a qualitative study also must include confirmability, which is the acknowledgement of the subjective nature of qualitative research and that the researcher has an active role in interpreting data in a meaningful manner (Morrow, 2005). Confirmability can be enhanced through researcher reflexivity, which involves reflecting on and being transparent about how the researcher's perspectives and decisions influence the interpretation of data (Guba, 1981). To enhance confirmability, this study actively incorporated researcher reflexivity by considering the researcher's role as the primary instrument (see Appendix H).

Chapter 4: Findings

Main Analysis

The purpose of this qualitative study was to explore the perspectives of therapists-in-training in Canada to uncover the barriers they perceive as impacting their access to mental health services. This research was guided by the following question: What are the barriers that therapists-in-training identify as preventing or hindering their utilization of mental health services? To pursue this inquiry, six participants were interviewed using a semi-structured protocol. Data were collected and analyzed using thematic analysis (Braun & Clarke, 2021).

Using an inductive approach to data analysis, seven main themes and 23 subthemes emerged, capturing therapists-in-training's perceptions and experiences of the barriers they face when seeking mental health support. The following main themes were identified: (1) Internal Resistance to Help-Seeking, (2) Structural and Systemic Barriers, (3) Dual Relationships and Being Caught Between Roles, (4) The Demands of Training as a Barrier, (5) Internalized Stigma and Incongruence With the Idealized Therapist Identity, (6) Fear of Professional Consequences, (7) Broken Trust in Therapeutic Systems. Table 2 (see below) outlines the full list of themes, subthemes, and examples of associated transcript verbatims. The following sections will include a description of each theme as well as detailed descriptions and accounts of each subtheme. Verbatims will be provided for each subtheme to provide lived examples of such experiences.

Table 2

Main Themes and Supporting Excerpts

Main Themes	Subthemes	Participant Verbatims
Theme 1: Internal Resistance to Help-Seeking	Avoidant Help-Seeking Patterns	"Things got pushed off because finding the motivation was difficult."
	Mental Loops and Anticipatory Worries	"My own head, my own thoughts. My own concoction of anxieties and irrational beliefs that I'm holding."
	The Mental Health Paradox	"It's always the irony of when you need help the most or need that support the most, that's when you're the least able to do it at that point."
	Self-Doubt and Minimization	"I always question my own experience and whether I'm making it out to be more dramatic than it needs to be, or if it's really a big deal."
	Endorsing Therapy, Neglecting Therapy	"I know I should be doing this 'cause I know, I know, it's good for me personally and professionally, and it's kind of like mandated by the college. And I'm still hesitant to go."
Theme 2: Structural and Systemic Barriers	Finances	"I think finances are huge for everyone. Finances are a huge one."
	Awareness	"I think like in the program, a lot of us are coming from other cities, and so I don't know what the resources are."
	Availability	"Just trying to find a therapist who has the time that meets my needs, you know, as a full-time student working almost full time. Yeah, it was hard to figure that out."
	Accessibility	"There's wait lists a mile long for people to see anybody really in the mental health field."

	Institutional Discrepancy and Performative Support	"It's more smoke and mirrors and it's more so just, you know, checking that off the list to say that they're doing it as opposed to, yeah, actually providing and fully trying to integrate it."
Theme 3: Dual Relationships and Being Caught Between Roles	When the Therapist is a Peer, Professor, or Future Colleague	"I maybe would have utilized services through the university just because they're accessible, had it not been people in our program that worked at them."
	Help-Seeking as a Perceived Career Risk	"I'm gonna have to apply everywhere before I find a job. I didn't wanna narrow my options too much."
Theme 4: The Demands of Training as a Barrier	Calendar Congestion	"I have enough of other obligations that feel like they're taking up all my time and energy."
	Worn Down by the Work	"There are days where I've got like four or five clients and like by the end of it, I don't wanna talk."
Theme 5: Internalized Stigma and Incongruence with the Idealized Therapist Identity	The Pressure to Appear Exceptional	"I feel like I'm supposed to be on my game all the time."
	The Myth of the All-Knowing Therapist	"This fear that like as a clinician, you have to be super healthy and well all the time and there's this expectation that like you're a rock and that you should always be okay."
	Internalized Standards and Self-Judgements	"There was a lot of internalized fears of, you know, if I seek help like maybe I'm unfit to be a therapist."
Theme 6: Fear of Professional Consequences	Fear of Being Judged by Others	"I just don't want anyone to think negatively of me."
	Fear of Being Perceived as Incompetent	"The fear of judgment and being perceived as a lesser therapist."
	Fear of Professional Repercussions	"There was this fear that I had that if I went to therapy for a specific traumatic reason or something that somehow my therapist would tell somebody and then I would be not allowed to continue this work."

Theme 7: Broken Trust in Therapeutic Systems	Damaging Therapeutic Encounters	"I had a Master of Social Work Student when I was 21 be like 'you want to die, that's fine, see you next week', you know."
	If These are the Therapists of Tomorrow…	"Therapy gets a lot scarier when you don't have as much faith in the people that you're graduating with."
	Losing Faith in the Profession	"The hardest thing that I'm kind of reflecting on now as I come out of school, is a little bit less faith in this system that obviously I had a lot of faith in coming into 'cause I wanted to be a part of it."

Theme 1: Internal Resistance to Help-Seeking (5 Subthemes)

This theme captures the internal, often paradoxical, psychological dynamics that inhibit therapists-in-training from seeking mental health support, even when they recognize its value. It summarizes the way participants describe getting in their own way, experiencing a lack of energy or motivation, questioning their own legitimacy to seek support, and ultimately deferring care – not because they don't value it, but because they're mentally or emotionally blocked. The following five subthemes capture key internal barriers: (A) delaying or avoiding the decision to seek therapy, (B) anticipatory worries and overthinking, (C) the paralyzing effect of mental health symptoms, (D) self-doubt and the minimization of one's own needs, and (E) the tension between recognizing the value of therapy and failing to act on it. These five subthemes will be explained in the next sections.

(A) Avoidant Help-Seeking Patterns

Participants express difficulty initiating or maintaining help-seeking behaviours, often due to procrastination, lack of motivation, or simply not prioritizing their own needs. These avoidant help-seeking patterns emerged across several interviews, highlighting a psychological

inertia that hindered participants from accessing care, even when they recognized its potential value. **Procrastination** was a recurring challenge, as some participants expressed a long-standing intention to seek help but admitted to delaying action. Avery reflected, "*I've had intentions pretty much the entire time and I just never pulled the trigger*," later acknowledging more directly, "*I procrastinated*." A lack of **motivation** further compounded this procrastination. Avery explained, "*Things got pushed off because finding the motivation was difficult*" and "*It's really like rooted in motivation*." These delays were not attributed to external barriers, but rather to internal avoidance that accumulated over time.

Several participants also discussed a **deprioritization** of their needs in relation to other responsibilities. Mental health was acknowledged as important, yet it was repeatedly placed on the backburner. Avery stated, "*I haven't had motivation and I just haven't made it a priority*" and "*I just never got around to it*." This sentiment was echoed by Quinn who similarly said, "*I just haven't got around to doing it*." Overall, these patterns reflect a broader theme of internal resistance, where participants' awareness of their mental health needs was outweighed by emotional and motivational barriers that stalled help-seeking efforts.

(B) Mental Loops and Anticipatory Worries

Participants described experiencing thoughts that impeded their ability to seek mental health support. These often involved anticipatory worries about potential negative outcomes, cognitive noise and overthinking, and internal debates about the value of therapy. Rather than being simple concerns, these worries represented circular mental processes that created psychological barriers to accessing care.

Fear of Negative Therapeutic Outcomes. One key pattern involved anticipatory fears of negative therapeutic outcomes, where participants imagined difficult or distressing experiences

in therapy before they even occurred. Avery reflected, "*I know therapy would be hard and it would be like kind of weird at the beginning, getting to know someone*," pointing to their perception that therapy itself is difficult to initiate. More specifically, participants worried about vulnerability being met with invalidation or conflict. "*Letting someone in, being vulnerable, and then having them maybe dismiss that or totally disagree would be in my perspective more upsetting*," Avery shared. This concern extended into professional identity, particularly for those training to be therapists themselves. "*Maybe you don't agree with what your therapist is telling you because it's not what you would do given the same situation*," Avery added, illustrating how dual perspectives, as both therapist and client, can complicate expectations in the therapeutic process.

Cognitive Noise. Several participants also highlighted the presence of cognitive noise, a buildup of internal anxieties and mental clutter that made help-seeking feel even more complex. Quinn described how "*[their] own head, [their] own thoughts, [their] own concoction of anxieties and irrational beliefs that [they're] holding*" deter them from seeking mental health support. Similarly, Avery noted, "*I think if anything, I think I've gotten in my own way the most*," emphasizing a self-perceived barrier rooted not in logistics or access, but in their own mental processing.

Questioning the Added Value of Therapy. In addition to these emotional and cognitive hurdles, participants also questioned the added value of therapy, particularly when comparing it to the insight they already possessed through their training or professional communities. "*Do I actually really need support and is it gonna actually be beneficial or is it gonna be all the same things that I know?*" Avery asked, expressing uncertainty about whether therapy could offer anything new. Quinn echoed this skepticism, stating, "*What are some other therapists going to*

give me that I don't already have myself in terms of insight from my supervisors or colleagues?" Others questioned whether therapy was any different than self-reflection or reading. "*What's the difference between me reading a book and reflecting on things that my clients are going through and another therapist who's gonna do exactly that?*" Quinn added. For some, this skepticism stemmed from their training. Jules shared,

> We now understand how mental health services work. Which makes us think we're too like cerebral for them, even though obviously we're not. But if I know all the things you're going to do to me, then I'm going to be like, wait a second.

This sentiment reflects a tension unique to therapists-in-training: some participants intellectually understood the benefits of therapy yet felt that their insider knowledge might dilute its impact. Together, these reflections showcase how anticipatory worries, cognitive noise, and questioning the added value of therapy, can stall engagement with therapy long before any session has occurred.

(C) The Mental Health Paradox

A theme across participant narratives was *The Mental Health Paradox* – the phenomenon in which the very symptoms of psychological distress act as powerful inhibitors to accessing care. Rather than lacking time or awareness, participants described an ironic contradiction: the worse their mental health became, the harder it was to initiate or maintain help-seeking. Participants shared that feelings of exhaustion, low motivation, and emotional overwhelm created a psychological impasse. As Oakley described, "*One limitation would be having the energy to just do that one more thing. When you're just exhausted and tired, even though you know you need to do it*." This statement illustrates how depleted internal resources can make the idea of seeking help feel insurmountable. They went on to articulate the paradox directly: "*It's*

always the irony of when you need help the most or need that support the most, that's when you're the least able to do it at that point." This sentiment was echoed in further reflections, where survival and day-to-day functioning took precedence over therapeutic engagement. Oakley recalled, "*I wanted to engage and go back to therapy a bit earlier or counselling services a bit earlier, but I just like was literally trying to get through each day*." Their experience underscores the emotional and cognitive load of enduring distress, where it is difficult to access the energy required to seek support in the face of overwhelming symptoms.

(D) Self Doubt and Minimization

A theme among participants was the tendency to minimize their own distress and question the legitimacy of their need for support. This internalized self-doubt often led to hesitancy around accessing therapy, despite recognizing its potential value. Participants described a persistent inner dialogue that cast doubt on whether their struggles were significant enough to warrant professional help. Avery reflected,

> I find that like the way my anxiety presents is like I question myself a lot. I think objectively, I recognize the value of therapy, that I could bring anything and that's valuable. But I always question my own experience and whether I'm making it out to be more dramatic and it needs to be, or if it's really a big deal.

Here, the participant acknowledges the rational belief in the usefulness of therapy yet simultaneously questions their need for support. This was echoed in broader concerns about whether one's struggles were "worthy enough" to justify seeking help. Avery stated that "*it probably comes back to the idea of questioning if my worries like worthy enough*" and questioned whether "*other people maybe need the support more*." Together, these reflections illustrate a tension experienced by some therapists-in-training where they understand the

importance of mental health care, but distance themselves from their needs through self-minimization and comparison to others.

(E) Endorsing Therapy, Neglecting Therapy

This theme captures the tension participants experience between valuing therapy and simultaneously choosing not to engage in it themselves. Participants expressed an awareness of the personal and professional benefits of therapy, while also disclosing hesitation, highlighting a confusion about the disconnection between their values and behaviour.

Several participants acknowledged that they believe therapy is beneficial, both as a mandate for ethical practice and as a necessary form of support yet still found themselves avoiding it. Quinn stated, "*I know I should be doing this 'cause I know it's good for me personally and professionally, and it's kind of like mandated by the college, but I'm still hesitant to go*." Similarly, another participant emphasized the contradiction between advocating for others to seek therapy while failing to do so themselves, while also highlighting the irony of being a mental health provider who is unable to access therapy for their own needs. Sam shared,

> I laugh because I tell all my friends they should be seeing a therapist or in counselling. I'm in school to do that. I know I'm going to see people when I graduate. And yet I cannot make myself look for another counsellor.

These excerpts illustrate a conflict between participants' cognitively held values regarding the importance of therapy and their inability to translate these values into action, despite personal and professional benefits.

The conflicting perspectives on therapy's role in a therapist's life were also evident in the way participants described broader professional discourses. Avery reflected on the competing views they had encountered,

> I think there's two points of view. I think there's people that recognize the value, like, of course, you carry this. You know, you carry your client's experiences, of course you need support. I think that comes from people that are closer related to the field. And then I think there is a take which is becoming less popular maybe, but that your therapist kind of has all the answers. So if they're going to therapy themselves, that maybe diminishes the value of their work.

This statement illustrates the push and pull between a compassionate, humanized view of therapists needing care, and a more rigid ideal. Moreover, some participants internalized these tensions, resulting in personal ambivalence. Jamie shared,

> I feel like I have two really, really contradicting opinions or views. Originally, I think before I got help there was a lot of internalized fears of, you know, if I seek help like maybe I'm unfit to be a therapist because I can't deal with it myself. But at the same time, I think it's really important for professionals to seek therapy to have someone that they can talk to because the job is hard.

This reflection illustrates how discourses positioning therapists as immune to mental health challenges – by virtue of their training or professional role – can become internalized, ultimately serving as a barrier to seeking care.

The result of these conflicting views was often a state of confusion or paralysis. Quinn stated, "*There's just a lot of second guessing, a lot of like confused feelings, a lot of hesitation*." Avery shared, "*I totally see the flip side in the value of it so I think it's confusing to me why I haven't sort of used services as well*." These expressions of uncertainty point to how unresolved ambivalence can result in avoidance, even when participants recognize the potential value of

therapy. Collectively, these accounts demonstrate an internal struggle where therapists-in-training both value and resist the very care they advocate for others.

Theme 2: Structural and Systemic Barriers (5 Subthemes)

This theme captures external, systemic factors that impede access to mental health services. The following five subthemes capture key systemic barriers: (A) affordability of services, (B) awareness of services, (C) availability of services, (D) accessibility of services, and (E) the issue of performative support. These five subthemes will be explained in the next sections.

(A) Finances

Participants identified financial constraints as a significant systemic barrier to accessing mental health services. These challenges were particularly salient in the context of being a therapist-in-training, where the demands of unpaid clinical placements, academic coursework, and often additional employment intersect with the rising cost of living and inconsistent access to insurance coverage. Avery shared,

> I do think finances are huge. Some peers I know they have to work a job, and then they have their placement, and then they have their courses, and so they already are working, you know, stretching themselves thin just to be able to afford the program and living expenses. You know, the increased cost of living. And depending on if people have insurance or not through their parents or whoever, that is probably a huge impact.

Jules echoed this sentiment, stating, "*I think finances are huge for everyone, especially since we're all working for free, which is kind of ridiculous, but whatever*." These quotes reflect the broader issue of financial constraints in accessing therapy, which is often compounded by the multiple demands placed on students balancing academic, clinical, and work responsibilities.

A particularly powerful moment of reflection came from Quinn, who pointed out the irony of the situation:

> Isn't that horrible that we're the ones doing this? We charge an average between $100–150, or somewhere in around that ballpark, for an hour of our time. Yet we can't even afford to put out that same money for an hour of our own therapy.

Taken together, these accounts illustrate how financial barriers operate not only at the individual level but are also structurally embedded within the design of clinical training programs.

(B) Awareness

Participants described a lack of awareness as a significant obstacle to accessing mental health care. Two key areas of difficulty emerged: uncertainty in identifying personal mental health needs and limited knowledge of existing services. Several participants expressed difficulty identifying when they were struggling or knowing what steps to take once they realized they needed support. Avery reflected, "*I think for a long time I didn't, to be transparent like, I didn't know what the indicators were that maybe I wasn't doing as good as I could be*." Jamie echoed this sense of uncertainty, stating "*I didn't know what to do*." Beyond internal uncertainty, participants also highlighted challenges in navigating the process of finding and initiating therapy, even once the need was acknowledged. As Jules noted, "*Most of the people I know recognize that like they want access to therapy, they just can't figure out how to get it or where to access it*." These experiences underscore how difficulty recognizing mental health needs and uncertainty about how to respond to their needs can act as barriers to accessing care.

In addition, participants frequently described low awareness of available services as a barrier. Oakley stated, "*I would say, like, my awareness of services isn't super, like super high*," reflecting a general uncertainty about what support options exist. Jamie noted the lack of

centralized or accessible information, saying, "*There's no like info page of like, hey, if you're a therapist-in-training that goes here, these are the services that you can use*." This highlights the absence of a clear, consolidated point of reference for services, which leaves many trainees feeling lost. The issue of low awareness was further exacerbated for students who had relocated for their training. Quinn shared, "*I think like in the program, a lot of us are coming from other cities, and so I don't know what resources are available*."

Together, these subthemes demonstrate that lack of awareness operates on multiple levels – internally, in terms of self-recognition, and externally, in relation to understanding and locating mental health services. This gap in knowledge and access infrastructure can delay or prevent therapists-in-training from receiving timely support.

(C) Availability

Participants identified availability as a core structural barrier to mental health care. In this context, availability refers to whether mental health services actually exist and are offered within a given system or geographic area, including the presence of providers, appointment slots, and types of care.

Limited Scope and Duration of Affordable Services. A number of participants shared that while university-affiliated services were more accessible financially, they were often too brief or superficial to adequately address their concerns. Oakley noted a significant reduction in session length over time,

> I had used a service through the university maybe a year and a half ago or so, and decided to reach out to them again, and with the service before it used to be the one-hour slot versus now it's 30 minutes. So, I'm finding even though it is nice to have that impartial

> ear and somebody who can have that objectivity to things, it still just is not enough time to really get into the meat and potatoes of you know what we're kind of needing.

This quote highlights the challenge of engaging in meaningful therapeutic work within increasingly constrained time limits. Another participant expressed skepticism about the effectiveness of student services due to their brevity. Quinn stated,

> The things that are made more accessible and that people are told about in terms of therapy and mental health services for students are things like those apps or three free sessions with a therapist. It's incredibly short, like three sessions. You're lucky if I've told you my middle name by session three.

These reflections suggest that while short-term interventions may offer initial support, they often fall short of addressing deeper or ongoing mental health concerns.

Lack of Specialized or Tailored Care. Beyond duration, participants also raised concerns about the lack of specialized services. Sam remarked, "*There's a lot of people that are seeking services and there's not a lot of specialized services*" and "*I would say it's a limited access to the amount of qualified professionals that are out there*," pointing to a mismatch between demand and the range of care available. Sam made a particularly telling comment likening the situation to a broader systemic issue, stating,

> What I have been noticing is that when people can get in, it's almost kind of like a doctor shortage situation. It's the same in mental health. You don't really have a choice in who you see, so you can't really pick and choose somebody that would be a good fit for you. You almost have to go to whoever you can get into see at that time. And I think that's causing a lot of concern, among especially like minority populations that need very specific things and they aren't able to get that.

This reflection underscores how the lack of choice in providers – particularly culturally competent ones or those with particular specializations – can deter help-seeking altogether.

(D) Accessibility

Accessibility emerged as a significant barrier for participants, referring not simply to the existence of services, but to the extent to which individuals could realistically access and benefit from them. Participants described a range of obstacles including long wait times, delayed intake processes, and transportation challenges, all of which limited timely access to care, particularly in moments of crisis or for those living outside urban centers.

A prominent barrier to accessibility was the extensive delay in receiving services, which created frustration and distress for participants who were often seeking immediate support. Sam remarked, "*There's wait lists a mile long for people to see anybody really in the mental health field*." Several participants described reaching out to multiple providers with little success, highlighting a disconnect between need and availability. Jamie shared, "*I felt like I was reaching out to a lot of these different places, but I couldn't get those services right away*." This was particularly challenging for those with more urgent needs, like Jamie, who shared,

> From my point of view I was getting a lot of waitlists for like a year to two years within the public sector for affordable therapy. And I was like, I need therapy now because it's just like a traumatic event. It needs to be processed immediately.

These comments highlight a mismatch between the timing of service availability and the urgency of client need, particularly when navigating trauma or acute distress.

Accessibility was also constrained by geographic location, particularly for participants living outside of city centers. Participants emphasized the difficulty of finding nearby providers, with Sam explaining,

> Within my area there's really not very many therapists, there might be two or three, but that's about it. Everything else is a drive for us, so we'd be at least half an hour to get in to see anybody in person.

This highlights the practical burden that commuting to therapy can place on individuals already managing busy schedules or limited resources. Sam also explained how "*The more rural you go, the bigger of an issue it is, the closer you get to urban centers, the more choice you have, the more availability you have of people*."

Together, these subthemes reveal that accessibility is not simply about whether services exist, but whether individuals can engage with them in a timely, convenient, and contextually appropriate way. For many therapists-in-training, the combination of long delays and geographic limitations created barriers that were difficult to overcome.

(E) Institutional Discrepancy and Performative Support

Participants voiced a strong sense of disconnect between the mental health values that institutions publicly promote and the realities of their lived experiences within those systems. This theme captures participants' perceptions of performative or surface-level commitments to mental wellness, where institutional messaging often encourages self-care and balance, while systemic pressures and demands contradict those ideals. Oakley articulated the tension between institutional rhetoric and practice:

> So, there's a lot of times where different organizations, structures, etc., will really advocate and encourage mental health and wellness and take care of yourself and, you know, make sure you're not burning out. But then they're also putting that pressure on where it's very much a lot in terms of your case work or caseload or responsibilities. It's more smoke and mirrors and it's more so just, you know, checking that off the list to say

> that they're doing it as opposed to, yeah, actually providing and fully trying to integrate it. It seems at times that it's, even though it's maybe well-intentioned that they want to be able to live out these values and encourage these different imperatives like that, it seems performative at times for some different organizations.

This quote highlights the emotional and professional burden of navigating environments that promote wellness in theory but fail to structurally support it in practice, and how the lack of tangible follow-through undermines trust and reduces the effectiveness of such efforts.

A particularly powerful expression of institutional mistrust came from a participant who felt that their worth was tied to academic productivity rather than wellbeing. Quinn stated,

> I didn't believe that universities don't like grad students until I became a grad student. And I was like, oh, you really don't like us. If we get you money and your names attached to scholarships and publications, you don't care about our mental health.

Collectively, these accounts underscore a perceived discrepancy between the values promoted by universities and organizations, and the lived experiences of therapists-in-training within the programs. Participants described the promotion of mental health as at times hollow or performative, with real support often insufficient. This mismatch contributes to a broader sense of mistrust, reducing confidence in institutional care structures and diminishing the likelihood of help-seeking.

Theme 3: Dual Relationships and Being Caught Between Roles (2 Subthemes)

Participants highlighted the ethical and interpersonal complexities that arose when available mental health services were offered by individuals who also occupied professional or academic roles within their training environment. This theme captures two interrelated concerns:

the discomfort of seeking care from peers, professors, or future colleagues, and the fear that pursuing therapy may negatively impact future career opportunities.

(A) When the Therapist is a Peer, Professor, or Future Colleague

Several participants described how the proximity of service providers, whether as fellow students, supervisors, or instructors, created a significant barrier to accessing care. This overlap between personal and professional roles generated discomfort, concerns about confidentiality, and unease with the idea of being vulnerable in front of someone who may later serve as a peer or evaluator in their professional journey.

Avery shared that although university-based mental health services were technically accessible, they ultimately chose not to use them: "*I maybe would have utilized services through the university just because they're accessible, had it not been people in our program that worked at them*." Jules echoed this discomfort, noting "*It's tough to be like, oh, I can go to this free service, but I probably can't access most of it because they're my own friends and peers in those roles*."

Participants also spoke about privacy concerns, especially around being seen or recognized by peers in clinical settings. As Jamie put it, "*There's confidentiality issues, like what if I walk in somewhere and my peer works there and they find out*?" The tension was further amplified by the multi-layered relationships within training institutions. For instance, one student noted the uncomfortable dynamic of seeing both professors and more senior trainees staffing the same clinic. Sam stated, "*The people that run the actual counselling office, they are my professors, and then the people that are counselling there would be the people that are a year ahead of me in the program*."

(B) Help-Seeking as a Perceived Career Risk

In addition to blurred boundaries, participants expressed concern that seeking therapy could limit their professional options or be perceived negatively by future employers. One participant described their hesitation to access services at clinics they admired professionally. Avery stated,

> I think knowing that I needed to apply to places to work, I feel like all the places that I would maybe want to go to for my own therapy, I was like, oh, maybe I want to apply there later. And so that was another just kind of random consideration. I felt I'm like closing the door to ever working with these people that I think are really cool.

Avery elaborated and shared, "*I had actually spent some time looking and all the places that I was like, okay, maybe I'd want to do therapy here, I was like, no, I want to apply there, so I'm not gonna*." Another participant connected these concerns directly to professional ethics. Oakley stated, "*when I wanted to seek out different mental health services, especially knowing I'm going into this field, because obviously we have to be careful of dual relationships, so if I'm a client there, then that's somewhere I wouldn't be able to ever work at type of thing*."

Overall, participants conveyed that university-based mental health services were often perceived as inaccessible due to the involvement of peers, faculty members, or others affiliated with their training program, which created discomfort and concerns around blurred professional boundaries. Additionally, some participants expressed hesitation in seeking services within the broader community, noting that doing so could potentially impact future employment opportunities. Together, these factors were described as significant barriers to accessing mental health support during training.

Theme 4: The Demands of Training as a Barrier (2 Subthemes)

Participants consistently described the structure and intensity of their training programs as a significant barrier to accessing mental health support. Rather than being limited to individual challenges, the very demands of becoming a psychotherapist, including academic workload, clinical responsibilities, and institutional expectations, were seen as creating conditions that interfered with trainees' well-being and ability to seek care.

(A) Calendar Congestion

Many participants noted that their schedules were so overburdened with coursework, practicum hours, commuting, administrative responsibilities, and sometimes paid work, that they had little time or flexibility left to explore or attend therapy. Avery stated plainly, "*I have enough of other obligations that feel like they're taking up all my time and energy*." Another described the pressure of trying to keep up during a period of heightened distress. Quinn shared,

> We had to do our mock therapy sessions, and that was so stressful for me because I wasn't in the right headspace. I just wanted a break, but I didn't feel like I had any choice or had the ability to take a pause because we're kind of in like, a mad dash to finish all the coursework and get to the practicum.

Similarly, another participant highlighted how the cumulative demands across roles left little room to prioritize therapy. Oakley stated,

> With taking on practicum, we're pretty limited in terms of our time. 'Cause we're not only doing practicum, we're also doing school and a course at the same time with lots of requirements. Many of us are also working too.

A more general sense of incompatibility between student life and mental health needs was also noted. As Jules shared, "*School is not conducive to grieving, and school's not conducive to, like, any kind of mental health stuff*."

(B) Worn Down by the Work

In addition to time constraints, participants also described a sense of emotional depletion that made the idea of attending therapy feel unrealistic or even counterproductive. The psychological toll of working with clients, especially alongside academic demands, left some trainees with little emotional capacity to invest in their own support. As Quinn explained,

> I don't wanna talk. There are days where I've got like four or five clients and like by the end of it, I don't wanna talk. I don't wanna sit there and talk and be asked questions. I want to just shut off my brain.

This sense of emotional fatigue made the idea of participating in therapy feel more like an added burden than a form of support. Similarly, one participant reflected on the emotional demands of clinical work and how it impacted their own capacity for self-care. Jamie shared, "*The job is hard and constantly giving that, you know, emotional energy and attention, sometimes we don't have that for ourselves at the end of the day, you know, after working all day with clients*."

Together, these accounts reflect how the intensive demands of psychotherapy training not only leave little time for help-seeking but also deplete the emotional resources necessary to engage in care, compounding barriers to accessing mental health support.

Theme 5: Internalized Stigma and Incongruence with the Idealized Therapist Identity (3 Subthemes)

Participants described how internalized expectations about what it means to be a therapist created barriers to seeking mental health support. These expectations were not always explicitly

imposed by others but often stemmed from cultural narratives, professional norms, and personal interpretations of what a competent or credible therapist "should" be. This theme captures how these beliefs contributed to self-judgment, hesitation, and a sense of incongruence between personal struggles and professional identity.

(A) The Pressure to Appear Exceptional

Several participants expressed a felt pressure to present themselves as consistently high-functioning and emotionally well, even when this did not reflect their internal state. This pressure was not necessarily overt or imposed by others, but rather experienced collectively within the culture of training. Quinn explained,

> You know, there's this pressure that we all kind of feel. No one really puts it on us, but we all just probably maybe feel a little bit of it as a collective, to show up and be kind of like these amazing, impressive human beings.

Quinn also shared how the "*thought in the back of [their] mind is like [they're] supposed to be on [their] A game*," highlighting how the internalized need to appear capable at all times can interfere with acknowledging personal distress or seeking help. This perceived need to always perform at a high level discouraged participants from showing vulnerability or prioritizing their own well-being.

(B) The Myth of the All-Knowing Therapist

In addition to the pressure to perform well, participants also reflected on the broader assumption, held by the public and sometimes internalized themselves, that therapists should always be mentally well. One participant noted the outdated but lingering belief that therapists should have all the answers. Avery shared, "*I think there is a take, which is becoming less popular maybe, where your therapist kind of has all the answers*." Others described a sense of

discomfort or fear around being seen as someone who also needs support. Quinn stated, "*If someone found out, they look me up, they know I'm a therapist, they [would be] questioning like why should she need this service if you're a therapist and you're supposed to help people*." This notion was reinforced by perceived public expectations. As Oakley described, "*I think the public tends to forget that therapists are human too and are still going through their own struggles and still trying to figure things out*." Similarly, Jamie shared, "*I think also this fear that, like, as a clinician, you have to be super healthy and well all the time and there's this expectation that you're a rock and that you should always be okay*." Overall, these accounts reflect how professional and public expectations contribute to the belief that therapists should not require support themselves.

(C) Internalized Standards and Self-Judgements

Participants often held themselves to high internal standards that reflected professional ideals about wellness and self-sufficiency. These internalized beliefs led to self-judgment when they struggled, as though their training should exempt them from needing help. Avery shared, "*I think there's also a part of me that's like, I know what I need to do to make myself better, so I should be able to do this*." Another echoed this sentiment, with Quinn stating, "*we get in our heads, we think, okay, we shouldn't do this because, well, we're studying this and we should know how to do it, we should know how to be mentally healthy*." Similarly, Oakley expressed "*I guess there's self-imposed judgment and kind of standards that we hold to ourselves, like, oh, I should be able to have the tools to be able to support myself through that*." This self-imposed pressure often prevented participants from accessing care, not because they lacked insight, but because they believed they *should* be able to manage without it.

Taken together, these excerpts illustrate how trainees experience both implicit and explicit pressures tied to their emerging professional identity. Many participants described feeling a persistent need to maintain competence and stability even during periods of personal difficulty. This was reinforced by the broader cultural narrative that therapists should be consistently mentally well, due to their training and role in supporting others. Over time, these messages became internalized, which for some translated into the expectation that they should not need therapy, as they already possessed the knowledge and tools to manage on their own. These internalized ideals contributed to the avoidance of care during training.

Theme 6: Fear of Professional Consequences (3 Subthemes)

This theme captures how therapists-in-training often hesitate to seek support out of concern that doing so might compromise their professional image, relationships, or future opportunities. Participants described various dimensions of this fear, including concerns about judgment, perceptions of incompetence, and potential repercussions within their training and practicum environments.

(A) Fear of Being Judged by Others

Several participants shared a generalized fear of being negatively evaluated by those around them, including peers, faculty, clients, and supervisors. This fear often led to secrecy or shame around personal mental health struggles. As Quinn explained, "*I just don't want anyone to think negatively of me*," noting a discomfort with being perceived as anything less than capable. They continued, "*The fear of judgment and being perceived as a lesser therapist*" was enough to discourage seeking help altogether. Oakley echoed this sentiment, drawing attention to how "*people are quick sometimes to judge others who are in the profession and tend to not realize*

that there's a human behind that too." This fear of judgment appeared to influence participants' willingness to seek mental health care, as they worried about how they might be perceived.

(B) Fear of Being Perceived as Incompetent

For some, the fear went beyond social judgment and into concerns about perceived competence and legitimacy as a clinician. Quinn described the pressure to maintain appearances even when they were struggling internally. They shared, "*there was a lot of pressure of I gotta keep up this façade because this person doesn't know what's actually going on and I don't want them to know because I don't want them to judge me and think I'm being a terrible therapist right now*." They elaborated further, sharing a specific worry that "*if I went to therapy for a specific traumatic reason somehow my therapist would tell somebody, and then I would not be allowed to continue this work, like it would deem me incompetent*." Jamie also reflected on how professional knowledge can ironically intensify self-judgment when seeking care. They stated, "*I think I have been using the word fear a lot, like the fear of being, I guess inadequate, or maybe not the best therapist because I was struggling and not able to just help myself*." They continued,

> We've been taught all these tools and techniques. So there's almost like imposter syndrome, like you don't need someone else to help you if you have these tools and you are a therapist. Which is silly, but sometimes you need help.

(C) Fear of Professional Repercussions

In addition to fears around image and competence, some participants expressed more concrete anxieties that seeking therapy could directly impact their standing in the program or affect career opportunities. Quinn described a scenario where accessing therapy might risk their future in the field. They shared, "*there was this fear that somehow my therapist would tell somebody, and then I would be not allowed to continue this work at a professional standpoint*."

Similarly, Jamie highlighted their fear around how seeking mental health care might impact their clinical practicum. They shared,

> And when there's a lot of different people involved, like school, the practicum site, there's so many stakes involved. I was worried about, you know, what that would mean for me and my placement.

They further clarified this fear, stating "*fear that it would jeopardize my practicum placement, my relationship with the practicum site, with the director, with my supervisor, with the people who I worked with there*."

Collectively, these subthemes illustrate how fear – of judgment, incompetence, and tangible career repercussions – creates a powerful deterrent to help-seeking among therapists-in-training. The stakes of being perceived as unwell or unfit were experienced not just as internal anxieties, but as real threats to participants' professional identities and futures.

Theme 7: Broken Trust in Therapeutic Systems (3 Subthemes)

Participants expressed a diminishing confidence in the mental health system, citing personal experiences of harm, concerns about the competence of peers, and a growing disillusionment with the field. This erosion of trust, shaped by both individual encounters and systemic reflections, appeared to impact their willingness to seek support.

(A) Damaging Therapeutic Encounters

For several participants, trust in the system was first disrupted by past therapeutic relationships that left them feeling dismissed, unsupported, or misunderstood. Sam recalled one such experience in which a counsellor minimized her experience in therapy:

> The counsellor asked the kids to leave the room and she looked at me and she was like he made a mistake I don't know what the big deal is… And I didn't go back. It was too far

> gone for me to be able to save the counselling relationship. I'd completely lost respect and interest in working with her… And I would say not only did it not sit right, it definitely wasn't a trauma informed approach. She was still fairly young, but I can't imagine anybody finishing a program where they can counsel people and that's kind of what you say to somebody… And I have not been back to counselling or therapy since.

Jules described the sharp contrast between an initially positive experience with a skilled student therapist and the subsequent disappointment with the next practitioner. Jules recalled,

> So my first experience with counselling was really incredible. She was a master's level student, and she had all the skill sets. She knew what she was doing. We talked about some really important stuff… But then the next year, she wasn't there anymore. I went back to therapy with suicidal ideation and I expressed that and the student who was talking with me was like, well, sounds like you're on the right track. And you know everything, blah, blah, blah, like, and just let me go. And I was like. Cool. I'm not OK, but that's fine.

These encounters were not only emotionally harmful but also contributed to a sense of futility about help-seeking.

(B) If These are the Therapists of Tomorrow…

Participants also voiced concerns about the quality and preparedness of their peers in training. This lack of confidence in fellow students led to doubts about the overall competence and safety of future therapists. Jules stated, "*some of the people that I will be standing up with in June, I'm like, I actually would not want to see you on the other side of therapy*," describing the discomfort of graduating alongside individuals they would not feel safe receiving therapy from. This was further compounded by witnessing peers exhibit behaviours or attitudes that seemed

ethically or clinically questionable. As Jules explained, "*therapy gets a lot scarier when you don't have as much faith in the people that you're graduating with and you know that the people who are doing counselling could be exactly those people*." This erosion of trust in fellow trainees can make the idea of seeking help from peers or future colleagues feel unsafe or unappealing, further discouraging participants from accessing mental health care themselves.

(C) Losing Faith in the Profession

This erosion of trust in individuals extended to a more systemic mistrust in the field as a whole. Some participants questioned the adequacy of training, supervision, and regulation within the profession. Sam expressed concern about how easily individuals were deemed competent despite lacking experience. They shared,

> Competency is a really big thing. I think there's a lot of people that are saying they're competent, but they're not. They might have done a course in it, or they may have taken an extra credit in it, but they haven't done the hours yet. They haven't been supervised in it yet.

Some participants shared concerns about the professional more broadly, particularly around how the field is structured and who is permitted to practice. For instance, one participant expressed discomfort with the perceived lack of readiness among new practitioners. Jules shared how "*you got a bunch of people fresh out of social work or counselling and going right into private practice counselling, which I think is wrong, I think that's not good*." Further, some participants described a noticeable shift in how they viewed the mental health profession over the course of their training. While they entered the field with hope and admiration, these sentiments were often eroded by their experiences within the system. As Jules reflected, "*the hardest thing that I'm kind*

of reflecting on now as I come out of school, is a little bit less faith in this system that obviously I had a lot of faith in coming into 'cause I wanted to be a part of it."

Altogether, this loss of faith in the profession not only shaped participants' identities as emerging therapists but also contributed to their hesitancy in seeking care. If trust in the profession is diminished, the idea of becoming a client within it may feel more threatening than helpful.

Chapter 5: Discussion

The purpose of this qualitative study was to explore the perspectives of therapists-in-training in Canada regarding the barriers they perceive as impacting their access to mental health services. Specifically, this study's primary objective was to gain insights into the factors that prohibit therapists-in-training from seeking mental health care when they are in distress and recognize their need for help. This research was guided by the following question: What are the barriers that therapists-in-training identify as preventing or hindering their utilization of mental health services?

To address this inquiry, six participants were interviewed using a semi-structured protocol, and the resulting data were analyzed following Braun and Clarke's (2021) thematic analysis. Through this data analysis technique, seven main themes and 23 subthemes emerged, capturing therapists-in-training's perceptions and experiences of the barriers they face when seeking mental health support. The following main themes were identified: (1) Internal Resistance to Help-Seeking, (2) Structural and Systemic Barriers, (3) Dual Relationships and Being Caught Between Roles, (4) The Demands of Training as a Barrier, (5) Internalized Stigma and Incongruence With the Idealized Therapist Identity, (6) Fear of Professional Consequences, (7) Broken Trust in Therapeutic Systems.

In this chapter, the results found from this study will be compared to current literature within the field regarding therapists-in-training experience of barriers to utilizing mental health services. This section's conclusion will include the study's limitations, recommendations for further research, and implications.

Main Findings and Connections with Previous Research

Structural and Systemic Barriers

The first major theme to emerge from the analysis was *Structural and Systemic Barriers*, which captures participants' experiences of external, systemic factors that impede access to mental health services. This theme had five subthemes: (A) Finances, (B) Awareness, (C) Availability, (D) Accessibility, (E) Institutional Discrepancy and Performative Support.

Finances. Affordability of services and financial constraints emerged as a universal concern, with every participant describing cost as a primary obstacle to seeking mental health care. This issue of finances was woven throughout participants' narratives, with each interview containing vivid examples of how therapy fees, insurance gaps, and limited income directly curtailed help-seeking.

This finding is not surprising as several studies have similarly found finances to be a top concern and barrier to mental health treatment amongst therapists-in-training and psychology graduate students (Dearing et al., 2005; Edwards & Crisp, 2017; El-Ghoroury et al., 2012; Hobaica et al., 2021). Dearing et al. (2005) sampled 262 clinical and counselling psychology graduate students and asked to rate 11 potential concerns in terms of how much each item was a consideration in his or her decision to enter (or not enter) personal therapy, and cost came up as the highest-ranking factor. A study conducted by El-Ghoroury et al. (2012) using a national sample of 387 psychology graduate students revealed that 46.5% of sample reported that "cannot afford/financial constraints" acted as a barrier hindering them from seeking mental health support of enacting self-care behaviours. Similarly, "not being able to afford the financial costs involved" was endorsed as a top barrier to accessing mental health care among participants in a study conducted on mental health professionals and students (Edwards & Crisp, 2017). When

graduate students were isolated from the sample in this study, 80.6% of therapists-in-training reported "not being able to afford the financial costs involved" as a barrier to seeking help. More recently, Hobaica et al. (2021) reported two-thirds of clinical psychology students (66%) cited finances as having been a barrier to seeking help from mental health services. Evidently, the proportion of individuals identifying finances as a barrier has risen over time, with higher percentages reported in the more recent studies by Edwards and Crisp (2017) and Hobaica et al. (2021) compared to El-Ghoroury et al. (2012). Perhaps this increase reflects financial constraints globally with inflation and decreased funding for universities. Interestingly, not only are finances a barrier amongst professionals and those in training, but a lack of financial resources to facilitate formal help seeking was reported as greatest for younger psychologists and those who were more junior (less experience; Bearse et al., 2013; Dearing et al., 2005; Edwards & Crisp, 2017), further highlighting the salience of financial barriers among therapists-in-training.

It is reasonable that financial constraints emerge as a primary barrier among therapists-in-training. First, many carry undergraduate or graduate student loans, heightening financial stress and prioritization of essential expenses over mental health services. Additionally, trainees carry a heavy workload, and with unpaid clinical placements, typically can only maintain part-time work. Further, some programs prohibit their students from working while in the program. Also, In Canada, private psychotherapy commonly ranges from $120-$200+ per session (Vanza, 2025), and many extended-health plans cap coverage well below what sustained therapy requires. With publicly funded mental health services often involving long waitlists or strict eligibility criteria, private therapy the only timely choice, but is not in the budget for most therapists-in-training.

Availability, Accessibility, and Awareness. In the present study, participants identified availability as a core structural barrier to seeking mental health care. Participants particularly

highlighted lack of available services that adequately address their concerns and a lack of specialized services in their geographic area. Participants also spoke to the issue of accessibility, referring not simply to the existence of services, but to the extent to which individuals could realistically access and benefit from them. Participants highlighted extensive delays in receiving services and a lack of options for those seeking immediate supports. These findings are echoed in a recent scoping review by Wang et al. (2024) investigating barriers to mental health care in Canada from the perspective of health care providers, which identified availability and accessibility as main barriers. In this study, accessibility, which included stigma, patient buy-in, awareness of services, availability of services, wait times, and ability to access, was reported across 45% of studies included in the scoping review (Wang et al., 2024). Further, availability, which included obtaining resources, restrictive intake criteria and operating hours, ambiguous intake criteria and inefficient referrals, navigational complexity, discharge planning, and funding, was reported across 75% of studies included in the scoping review (Wang et al., 2024).

Although availability and accessibility appear to be potent barriers, awareness of services was particularly salient among therapists-in-training. According to participants who expressed that awareness was a barrier, issues of awareness were twofold: they have limited knowledge of existing services, while also experiencing uncertainty in identifying mental health needs of signs of support within themselves. Previous research has outlined lack of awareness of mental services as an important barrier to the use of mental health services and self-care behaviours in professional therapists and those in training (El-Ghoroury et al., 2012; Martin et al., 2023; Quartiroli et al., 2019). For example, in a study conducted by El-Ghoroury et al. (2012), 29.2% of trainees expressed how not knowing about available resources was a barrier to seeking care and engaging in self-care. Likewise, Edwards and Crisp (2017) found that 61.3% of therapists

and trainees agreed that being unsure where to go to get professional care posed a barrier to seeking mental health treatment.

Regarding the experience of trainees not being in tune with their own mental health needs or knowing what to do when the need for support arises, less research is available. One possible explanation is that the typical markers of heightened distress of symptoms that would normally indicate that one may need external support are elevated amongst therapists-in-training due to desensitization to such experiences. For example, there may be a normalization of stress and distress, where chronic fatigue, anxiety, or mood changes can be misattributed to "just being in grad school," blurring the line between typical stress and clinical concern. Finally, perhaps the pace of graduate training leaves little opportunity for the quiet, unstructured time that fosters self-reflection. When days are filled with coursework, practicum hours, commuting, and administrative tasks, trainees have few moments to notice shifts in mood, energy, or motivation that might signal emerging mental health concerns.

Dual Relationships and Being Caught Between Roles

The second major theme to emerge from the analysis was *Dual Relationships and Being Caught Between Roles*, which highlights the ethical and interpersonal complexities that arose when available mental health services were offered by individuals who also occupied professional or academic roles within their training environment. This theme captured two subthemes: (A) When the Therapist is a Peer, Professor, or Future Colleague, and (B) Help-Seeking as a Perceived Career Risk.

When the Therapist is a Peer, Professor, or Future Colleague. Concerns about dual relationships and confidentiality emerged unanimously, with every participant describing discomfort in accessing university-based services because potential providers were classmates,

supervisors, or professors within their program. Previous research has demonstrated that a common barrier to seeking therapy for therapists-in-training is the difficulty of finding a therapist with whom they share no personal or professional ties (Deutsch, 1985; Orlinsky et al., 2011), given that dual relationships are strongly discouraged by professional mental health Codes of Ethics (ACA, 2014; CCPA, 2020; CPA, 2017). Likewise, Beck (1976) reported that despite promises of confidentiality by university counselling center therapists, students may still have concerns about a link between the clinic and the graduate department. This concern is also evidenced in a more recent study by Hobaica et al. (2021) who surveyed 912 trainees and revealed that most of the participants reported that having practicum students from their program working at the university counselling center was a barrier to utilizing university mental health services. This is particularly problematic given that finances are a primary barrier for therapists-in-training, yet many low-cost services are located within the very institutions that train their peers and future colleagues – such as university counselling or medical centers that double as internship sites. As a result, trainees reasonably fear that using these accessible services could compromise confidentiality and create uncomfortable ethical dynamics within their program (Klein et al., 2022). However, if trainees avoid on-campus mental health services, they often encounter similar obstacles in the community, where many local providers and services are affiliated with their training program (Bearse et al., 2013; Klein et al., 2022; Tay et al., 2018).

Help-Seeking as a Perceived Career Risk. In addition to the issue of dual relationships within university counselling centres and the community, a common theme amongst participants in this study was an expressed concern that seeking therapy could limit their professional options or be perceived negatively by future employers. This finding aligns with prior research showing that concerns about how seeking mental health treatment could affect future training or

employment prospects are a significant deterrent to care (Bearse et al., 2013; Deutsch, 1985). For example, Holzman et al. (1996) found that trainees are unlikely to seek mental health care at university counselling centers due to concerns about becoming ineligible for training opportunities at those sites in the future. Likewise, research by Dearing et al. (2005) highlighted the concern amongst trainees that being a client at a university counselling center may hinder future internship or training opportunities at that site. Moreover, research has highlighted how trainees also harbour the fear that seeking treatment may impact future job opportunities once they have completed the program. For example, Edwards and Crisp (2017) found that 68% of therapists and trainees agreed that concerns about damaging their chances when applying for jobs posed a barrier to seeking mental health treatment.

Taken together, the discomfort surrounding dual relationships highlights a structural conflict of interest. Universities function simultaneously as educators and mental-health service providers, which blurs professional boundaries and deters some trainees from seeking care. When an institution controls both clinical services and educational evaluation, some trainees view self-disclosure as a potential threat to their future training and career opportunities.

The Demands of Training as a Barrier

The third major theme to emerge from the analysis was *The Demands of Training as a Barrier*. This encompasses two subthemes, (A) Calendar Congestion, and (B) Worn Down by the Work, which highlight how the structure and intensity of their training programs act as a significant barrier to accessing mental health support. Here, participants expressed how the very demands of becoming a psychotherapist, including academic workload, clinical responsibilities, and institutional expectations, were seen as creating conditions that interfered with trainees' well-being and ability to seek care.

Calendar Congestion. Within this theme, participants frequently described schedules overburdened with coursework, practicum hours, commuting, and administrative responsibilities. With this workload, participants had little time or flexibility left to explore or attend therapy. This finding is unsurprising, as several studies have likewise identified lack of time as a leading barrier to seeking mental health support among therapists-in-training and psychology graduate students (Dearing et al., 2005; Edwards & Crisp, 2017; El-Ghoroury et al., 2012; Hobaica et al., 2021). For example, Dearing et al. (2005) examined predictors of psychological help-seeking among 262 clinical and counselling psychology graduate students, asking them to rate 11 potential concerns according to how much each influenced their decision to pursue – or avoid – personal therapy. The results of this analysis revealed that lack of time was the second highest ranking factor, next to cost. Similarly, Edwards and Crisp (2017) examined barriers to seeking help amongst 98 mental health professionals and trainees. Their analyses revealed that over three-quarters of mental health professionals or trainees reported that difficulties associated with taking time off work stopped or discouraged them from seeking professional care. Mirroring these findings, in other work, 74% of trainees (Hobaica et al., 2021) and 70.6% of trainees (El-Ghoroury et al. 2012) reported that they had experienced a lack of time as a barrier to seeking help or engaging in self-care.

Overall, the prominence of training demands as a barrier highlights how the structure and intensity of graduate programs can inadvertently undermine trainees' well-being. *Calendar Congestion* showcases a paradox: While intense training aims to prepare competent therapists, the very demands of coursework, clinical responsibilities, and administrative obligations leave little time for self-care or help-seeking. Unfortunately, this suggests that the scheduling and

structural design of training programs may unintentionally perpetuate stress and reduce access to mental health support.

Fear of Professional Consequences

Another theme to emerge from the analysis was *Fear of Professional Consequences*, which captures how therapists-in-training often hesitate to seek support out of concern that doing so might compromise their professional image, relationships, or future opportunities. This theme captures three subthemes: (A) Fear of Being Judged by Others, (B) Fear of Being Perceived as Incompetent, and (C) Fear of Professional Repercussions.

Fear of Being Judged by Others and Fear of Being Perceived as Incompetent. Several participants shared that they have been hesitant to seek support due to the fear of being negatively evaluated by those around them, including peers, faculty, clients, and supervisors. This finding is consistent with previous research highlighting that fear of being judged negatively by the public, family, friends, employers, and colleagues is a significant barrier to seeking personal therapy among therapists-in-training and professionals (Corrigan, 2004; Garcia & Crocker, 2008; Garelick, 2012; Kessler et al., 2001; Tay et al., 2018). Edwards and Crisp (2017) conducted a survey of therapists and trainees to explore barriers to seeking mental health care when distressed. The survey found that 58.2% of respondents had, at some point, felt they would benefit from mental health services but chose not to pursue them, with 29.8% citing fear of colleagues discovering as a reason for not seeking treatment. Additionally, their analyses revealed several other powerful barriers that participants indicated as hindering their ability to seek mental health support: 84.5% of participants reported concern about what people at work might think, say or do, 77.3% of participants reported concern that they might be seek as weak for having a mental health problem, 64% of participants reported concern that people might not

take them seriously if they found out they were having professional care, and 42.2% of participants reported concern that they might be seen as "crazy" (Edwards and Crisp, 2017).

Several participants also shared that their fear of judgement went beyond social perceptions and into concerns about perceived competence and legitimacy as a clinician, which echo's studies that have shown that therapists-in-training often avoid seeking personal therapy due to concerns about how it might affect their professional reputation. For example, Holzman et al. (1996) found that trainees may worry that undergoing therapy could cause faculty and peers to question their competence, emotional stability, and suitability for the profession. Similarly, Farber (2000) explored help-seeking attitudes among trainees and discovered that their reluctance to seek personal therapy stemmed from fears that being in therapy could be used against them as well as concerns about being perceived as professionally incompetent (Farber, 2000). Dearing et al. (2005) also studied help-seeking behaviours among therapists-in-training and found that trainees were hesitant to seek mental health support due to fears that it may raise doubts about their appropriateness for the profession. This also extended to concerns about being viewed as professionally inadequate by employers, colleagues, and faculty members (Dearing et al., 2005).

Fear of Professional Repercussions. In addition to fears around image and competence, some participants expressed more concrete anxieties that seeking therapy could directly impact their standing in the program or affect career opportunities. This concern has also been cited in the literature, with studies showcasing how therapists-in-training may also avoid seeking mental health care due to fears of exposure and potential professional repercussions if their confidential information were to be compromised (Deutsch, 1985). For instance, a study by Edwards and Crisp (2017) surveyed mental health professionals and students about the barriers to seeking

mental health support when experiencing distress. The findings revealed that 64.3% of respondents reported that a mandatory disclosure of their distress to their workplace would discourage them from revealing if they were unwell, and 57.1% stated that this requirement would also deter them from seeking treatment even in the face of significant distress. Similarly, research by El-Ghoroury et al. (2012) revealed that 32.6% of participants reported feeling apprehensive about what might occur if they pursued personal therapy, and 16.7% of respondents feared the loss of professional status if they pursued personal therapy. Taken together, the findings within this theme and the supporting literature suggest that some therapists-in-training fear being judged as less competent and worry about potential professional repercussions if their pursuit of personal therapy becomes known – fears that serve as a significant barrier to seeking mental health support when needed.

Internalized Stigma and Incongruence with the Idealized Therapist Identity

Another theme to emerge from the analysis was *Internalized Stigma and Incongruence with the Idealized Therapist Identity*. Within this theme, participants described how internalized expectations about what it means to be a therapist created barriers to seeking mental health support. These expectations were not always explicitly imposed by others but often stemmed from cultural narratives, professional norms, and personal interpretations of what a competent or credible therapist "should" be. This theme captures how these beliefs contributed to self-judgment, hesitation, and a sense of incongruence between personal struggles and professional identity.

Previous studies have emphasized the role of external stigma (e.g., stereotypes, prejudice, and discrimination) in influencing attitudes toward seeking personal therapy, serving as a barrier and leading individuals to conceal their symptoms or use of mental health services (Chen &

Mak, 2008; Hackler et al., 2010; Kessler et al., 2001; Komiti et al., 2006; Ludwikowski et al., 2009; Makenzie et al., 2004; Vogel et al., 2007). For example, studies show that perceived stigma from faculty members influences the attitudes of therapists-in-training toward seeking therapy (Dearing et al., 2005; Digiuni et al., 2013; Farber, 2000; Klein et al., 2022). Thus, negative perceptions from faculty and peers, such as the belief that those who seek therapy may be unsuitable for the profession (Holzman et al., 1996), can serve as a barrier to help-seeking among trainees. Interestingly, participants in this study did not report hearing explicit or overt messages equating the need for mental health support with weakness. This absence may signal a shift in cultural and professional attitudes towards mental health care, reflecting broader societal efforts to normalize help seeking. However, even in the absence of direct stigmatizing messages, many participants described internalized beliefs that therapists should be self-sufficient and consistently well. In this way, the external stigma documented in the earlier literature may be diminishing, but its effects endure through self-stigma, as trainees continue to measure themselves against internalized ideals of the competent, all-knowing, and resilient therapist.

Internal Resistance to Help-Seeking

Another theme to emerge from the analysis *Internal Resistance to Help-Seeking*, which captures the internal, often paradoxical, psychological dynamics that inhibit therapists-in-training from seeking mental health support. It summarizes the way participants describe getting in their own way, experiencing a lack of energy or motivation, questioning their own legitimacy to seek support, and ultimately deferring care – not because they don’t value it, but because they’re mentally or emotionally blocked. Participants described delaying or avoiding the decision to seek therapy, anticipatory worries and overthinking, the paralyzing effect of mental health symptoms,

self-doubt and the minimization of one's own needs, and the tension between recognizing the value of therapy and failing to act on it.

Previous research on barriers to seeking support amongst therapists-in-training has often emphasized *external factors* such as stigma, fears of consequences, finances, lack of time, and issues of accessibility and availability. The present study supports these findings, but also extends them by highlighting more subtle, intrapersonal, or *internal process* that trainees described as preventing them from accessing care.

Avoidant Help-Seeking Patterns. One of the main internal barriers identified by participants was procrastination. Although no previous research has examined procrastination as a barrier to seeking mental health care specifically among therapists-in-training, earlier work with Canadian undergraduate students found that higher levels of procrastination were correlated with fewer mental health-related behaviours (Stead et al., 2010). More recent literature has introduced the concept of health-related procrastination, referring to the unnecessary delay of health-related activities despite their accessibility, perceived importance, and awareness of the potential negative consequences of postponement (Rozental & Carlbring, 2014; Steel, 2010). Previous research has shown that procrastination contributes to poor management and treatment delays in various physical health conditions (Azami-Aghdash et al., 2015; Rafii et al., 2017; Shareinia et al., 2024; Sirois, 2015). The current finding that procrastination may also serve as a barrier to mental health help-seeking raises important questions about the significance of this factor and highlights the need for further investigation within the therapist-in-training population.

Self-Doubt, Minimization, and the Mental Health Paradox. Another internal barrier identified by participants was self-doubt and minimization, where individuals questioned the legitimacy of their need for treatment or downplayed the severity of their concerns. Although

there is limited research on this phenomenon among therapists-in-training, Waumans et al. (2022) found that symptom minimization similarly delayed treatment-seeking in a general adult sample from the Netherlands.

Within this theme, participants also described what could be termed a mental health paradox, in which the very symptoms that create the need for support simultaneously act as barriers to seeking it. Waumans et al. (2022) similarly noted that certain mental health characteristics may hinder help-seeking behaviours, as symptoms themselves can increase avoidance, isolation, or lack of motivation. For example, anxiety may manifest as difficulty making phone calls, leaving the house, or initiating conversations, behaviours necessary for accessing care. Consequently, the very nature of an individual's mental health difficulties may interfere with their ability to obtain the help they require. Although further research is needed to explore this dynamic within therapists-in-training, these findings highlight how self-doubt, minimization, and symptom-related barriers can delay or prevent help-seeking.

Broken Trust in Therapeutic Systems

The final theme to emerge from the analysis was *Broken Trust in Therapeutic Systems*, which captures a diminishing confidence in mental health systems and institutions. Participants cited personal experiences of harm, concerns about the competence of peers, and a growing disillusionment with the field. This erosion of trust, shaped by both individual encounters and systemic reflections, appeared to impact their willingness to seek support.

Although this is a novel finding within the literature on therapists-in-training and barriers to seeking mental health care, research from other domains can help explain this result. For example, Andrade et al. (2014) found that the most commonly reported reasons for dropping out of mental health treatment were perceived ineffectiveness of therapy (39.3%) and negative

experiences with treatment providers (26.9%). If negative experiences during treatment are associated with treatment dropout, it is reasonable to assume that individuals who have encountered such experiences would be less likely to return to therapy in the future, which is a pattern reflected in the accounts of participants in the present study. Similarly, Waumans et al. (2022) found that prior negative therapeutic experiences significantly hindered individuals' motivation to seek treatment again. Schaffler et al. (2022) also identified previous negative psychotherapy experiences as one of the most frequently reported internal barriers to seeking care. These experiences included feeling misunderstood, a poor fit with the therapist's theoretical orientation, discomfort or relational distance, feeling pre-judged, and unresolved conflict regarding issues that were important to the client.

Moreover, in a qualitative meta-analysis, Vybíral et al. (2024) further investigated clients' negative experiences in psychotherapy and found evidence that perceptions of therapist incompetence, lack of understanding, judgment, devaluation, inappropriate verbal reactions, lack of empathy, insecurity, distrust, confusion, poor interpersonal match, poor treatment fit, and unmet expectations were among the most frequently cited issues. Importantly, the authors also explored the consequences of such experiences, finding that clients often reported worsening symptoms, confusion about the therapeutic process, fear or distrust toward future therapy, and hesitancy to seek mental health care again. Collectively, these findings highlight how negative therapeutic experiences can erode trust in mental health care and discourage future help-seeking and how this effect appears to extend to therapists-in-training as observed in this study.

Ultimately, although these findings have not been previously established within the therapist-in-training literature, the present study suggests that similar mechanisms may be at play within this population. When therapists-in-training experience or witness harm, incompetence, or

ethical lapses within therapeutic settings, their trust in the broader system and in its capacity to provide effective, safe care can be compromised. This erosion of trust may lead to avoidance of therapy and reinforce a belief that seeking help within a flawed system is futile. Such findings highlight the importance of addressing not only individual-level barriers to help-seeking but also systemic and relational factors that shape therapists-in-training's perceptions of the mental health field itself.

De-Limitations

The purpose of this study was to explore the complex barriers faced by therapists-in-training that affect their access to and use of mental health services. To hone in on this phenomena, the following inclusion criteria was developed: (1) participants must be fluent in English, (2) participants must be currently enrolled in a masters-level mental health training program (e.g., psychology, counselling psychology, social work, etc.) that leads to licensure by a recognized professional psychotherapy association/regulatory body in Canada, (3) participants must have encountered barriers that hindered or entirely blocked their ability to seek mental health support during times of distress, and (4) participants must be willing to discuss their personal experiences with navigating their mental health and their reasons for not seeking treatment. To be able to focus the research on specific aspects of this phenomenon, several delimitations were established.

First, participants were required to be fluent in English, which limits the study's scope to English-speaking individuals and excludes those who might have relevant experiences but do not meet this language criterion. Second, the study was restricted to individuals currently enrolled in a masters-level mental health training program in Canada that leads to licensure by a recognized psychotherapy professional or regulatory body (e.g. the CPA and CCPA). Thus, this study

focused specifically on those in training, rather than practicing therapists or supervisors. This criterion also excluded mental health professionals from other disciplines, such as clinical psychologists and social workers, who may also encounter barriers to seeking mental health services. Moreover, this study was limited to the Canadian context, and findings may not apply to therapists-in-training in other countries with different cultural, institutional, or systemic structures. Overall, these delimitations are designed to ensure that the study's findings are relevant to the experiences of therapists-in-training while acknowledging that the focus on specific criteria inevitably excludes perspectives and experiences from broader contexts.

Limitations

Several limitations of the present study should be considered when interpreting the findings. First, the geographic representation of the sample was limited. Given Canada's considerable size and the fact that mental health care is organized and regulated by individual provinces (Gazzola & Gignac, 2025), regional variation is likely to influence training experiences. With participants residing in just three of Canada's ten provinces, the perspectives presented may not fully encompass the range of training contexts that exist across the country. Thus, the applicability of these findings should be interpreted cautiously given the narrow geographic scope of the sample. Future research would benefit from recruiting participants across more provinces and territories to better capture Canada's regional diversity. Second, the small sample size represents an additional limitation. The study included six participants, largely due to time constraints that prevented extended recruitment. As a result, data collection did not continue until saturation was achieved, which is typically recommended to include at least 12 participants to ensure that all themes are adequately explored (Guest et al., 2006). Future research with larger samples would allow for a more robust examination of barriers and

facilitators to mental health service use among therapists-in-training. Finally, the sample may not be fully representative of therapists-in-training or the broader therapist population in Canada. For example, five of the six participants identified as female. While demographic data on master's-level therapists-in-training in Canada are limited, a survey conducted by the Canadian Psychological Association found that among psychology graduate students, 73.6% identified as female, 25.6% as male, and 0.8% chose not to answer (Votta-Bleeker et al., 2016). Although the gender distribution of the current sample aligns broadly with these trends, it is important to consider how the addition of male participants would have impacted the results of this study.

This issue is particularly salient in light of well-documented gender differences in help-seeking, with a substantial body of research indicating that men are less likely to pursue mental health support across a range of cultural contexts (Staiger et al., 2020). One key explanation lies in the influence of traditional masculine norms, which prioritize emotional restraint, independence, and stoicism, and can discourage expressions of vulnerability (Mokhwelepa & Sumbane, 2025). Within this framework, seeking help is often interpreted as incompatible with masculine identity, leading some men to view it as a sign of weakness or a threat to their self-concept (Levant & Wimer, 2014; Liu & Iwamoto, 2007). These beliefs are further reinforced by broader societal expectations that position men as responsible for managing their difficulties on their own, thereby reducing the likelihood that they will reach out for support (Goodwill et al., 2020). As a result, men may be both less inclined to access psychological services and more vulnerable to experiencing stigma related to emotional expression and help-seeking (Mokhwelepa & Sumbane, 2025).

Given these gender differences, it is possible that male therapists-in-training may encounter distinct or more pronounced barriers to accessing mental health care, including greater

reluctance to disclose distress, stronger pressures toward self-reliance, or heightened concerns about professional identity and perceived competence. These factors may influence both the types of barriers experienced and the ways in which they are reported. Consequently, the themes identified in the present study may not fully capture the range of experiences across genders, and certain barriers, particularly those related to stigma and disclosure, may be underrepresented. Future research would benefit from including a more gender-diverse sample to better understand how barriers to mental health care may differ across therapists-in-training and to enhance the generalizability of findings.

Recommendations for Future Research

Given the limitations of the present study, additional research is warranted to expand and further substantiate these findings. First, future investigations would benefit from replicating the present study with a larger and more diverse participant pool to reach data saturation and enhance the transferability of findings. Recruiting therapists-in-training from multiple Canadian provinces and international contexts would allow for a richer understanding of the barriers identified. A broader geographic scope could capture differences in training structures, mental health resources, and cultural attitudes toward help-seeking, thereby improving the applicability of the results to a wider population of therapists-in-training.

Moreover, further research should also prioritize the perspectives of students with marginalized identities and those studying in Canada as international students. Graduate school environments often present significant academic and personal challenges, and these may be intensified for individuals navigating systemic discrimination, cultural adjustment, or immigration-related stressors (Clement et al., 2025). Research focused on barriers to mental health care among therapists-in-training, while intentionally sampling these groups, would

illuminate how intersecting identities shape experiences of such barriers and would assist training programs in designing more equitable support

An additional avenue for future research lies in examining how perceived barriers to mental health care evolve across the professional lifespan. While the present study focused on therapists-in-training, it remains unclear whether, and how, these barriers shift during critical career stages such as internship, early practice, mid-career, and advanced professional work. Longitudinal or comparative cross-sectional research could reveal developmental patterns, highlight changing needs, and inform interventions that remain relevant from training through established practice.

Finally, although the current findings identify the obstacles therapists-in-training face, they stop short of addressing solutions. Future studies could build on these insights by surveying students about their specific mental health needs and the supports they perceive as most helpful. Centering students' own recommendations would bring their voices to the forefront and guide institutions in designing targeted, evidence-based initiatives to reduce barriers and increase access to care.

Implications

Based on the findings of this study, recommendations for supporting therapists-in-training can be made at multiple levels: the graduate program or department, individual faculty or supervisors, and individual graduate students.

Graduate Program/Department

Graduate programs and psychology departments are uniquely positioned to promote graduate students' well-being at a broad and sustainable level as they serve as both the training ground and primary professional community for therapists-in-training. Two areas of action,

disseminating mental health resources and addressing financial obstacles, emerge as particularly important.

Disseminating Resources. Graduate programs can play a central role in equipping students with clear, accessible information about mental health care. One practical step is to integrate coping and wellness strategies directly into departmental handbooks for incoming students or to embed discussions of self-care and well-being within professional development curricula (El-Ghoroury & Hillig, 2000). As participants in this study repeatedly identified limited accessibility and availability of services as significant barriers, perhaps programs could assemble and regularly update a comprehensive list of mental health resources. Klein et al. (2022), for example, describe the development of a national resource guide to help students locate therapists and self-help materials, along with a template for program directors to adapt for their own departments.

Based on the barriers identified through this study, such a resource guide should be multifaceted. First, it should highlight location-specific services, an essential tool for students who have relocated for their training or who are seeking services for the first time. Second, it should provide options outside the university, addressing concerns about dual relationships with peers, professors, or supervisors when using on-campus counselling services. Third, the guide should feature specialized resources, including trauma-informed practitioners, crisis services, and providers with expertise in supporting marginalized communities, as participants frequently reported difficulty locating services suited to their unique needs. Fourth, it should outline hybrid and virtual service options, ensuring that students in rural or remote placements can access care. Finally, the guide should clearly identify clinics offering sliding-scale fees, given that financial strain was a universal barrier across participants.

Combating Financial Barriers. Financial concerns emerged as one of the most consistent obstacles to mental health care, echoing broader evidence that cost is a primary deterrent to treatment (Bearse et al., 2013; Crisp & Bartels, 2025; Dearing et al., 2005; Edwards & Crisp, 2017; Hobaica et al., 2021). For many therapists-in-training, the most affordable therapy option is on-campus counselling; however, fears of dual relationships and lack of confidentiality often discourage use. This dynamic leaves students with few low-cost alternatives.

Departments can begin by facilitating institutional conversations about financial compensation for clinical internships. While advocating for full minimum-wage remuneration may be ambitious in the short term, programs could explore incremental steps such as small stipends earmarked for wellness activities, grants that subsidize students' therapy costs, or enhanced student health insurance with expanded mental health coverage. Universities might also partner with community clinics to guarantee low-cost or sliding-scale services specifically for graduate students, or contract external providers to deliver confidential counselling on campus, perhaps by arranging reciprocal agreements with nearby universities so that students are not treated by students from their own department.

Individual Faculty/Supervisor

Individual faculty and supervisors play a critical role in fostering the mental health and well-being of therapists-in-training. This study highlights the importance of initiating conversations about self-care and mental health early in training, consistent with previous research suggesting that embedding self-care routines into professional habits from the outset can support long-term well-being and career sustainability (Barnett et al., 2007). Depending on available resources, these discussions could take the form of informal dialogues integrated into

core coursework, structured workshops, or even dedicated classes focused on self-care, stress management, and strategies for recognizing and responding to mental health challenges.

Early engagement with these topics has the potential to address several key barriers identified by participants. First, many trainees reported difficulty recognizing the early signs of declining mental health and uncertainty about how to access treatment once these signs were noticed. Faculty-led discussions on self-awareness, including how distress manifests cognitively, emotionally, and physically, could help students develop the capacity to identify when support is needed and the steps required to seek appropriate care.

Additionally, participants frequently described internalized self-stigma stemming from implicit and explicit messages about therapist wellness, including the expectation of serving as models of perfect mental health. This pressure contributed not only to self-judgment in response to personal mental health challenges but also to fear of negative professional evaluation. Faculty can play a vital role in deconstructing the “immune therapist” myth by normalizing the experience of mental health struggles and acknowledging the heightened susceptibility associated with the demands of therapeutic work. Research with medical residents suggests that faculty self-disclosure of personal experiences with mental health can effectively reduce stigma and encourage help-seeking behaviours (Vaa Stelling & West, 2021). Accordingly, supervisors and faculty may consider sharing their own experiences with mental health or facilitating peer discussions on self-care, early warning signs of distress, and avenues for seeking support. Such practices can help create a culture in which therapists-in-training feel supported and empowered to prioritize their well-being without fear of judgment or professional repercussions.

Individual Graduate Student

Beyond the resources provided by their department and faculty, therapists-in-training also bear the responsibility to take initiative in applying this knowledge to their personal lives. Therapists-in-training should engage in reflective practices related to self-care and mental health management, experimenting with a variety of wellness strategies to determine which are most effective and feasible for their individual circumstances. Additionally, developing a personalized self-care plan can help students proactively maintain their well-being and provide a structured approach to managing stress throughout their education and future career.

Finally, previous research indicates that social support is a highly effective coping strategy for graduate students. Accordingly, therapists-in-training are encouraged to cultivate a local support network by forming friendships within their program. Such networks can provide both emotional and practical support, while also normalizing shared experiences and fostering a sense of connection among peers.

Conclusion

This study illuminated the multifaceted barriers that therapists-in-training encounter when considering or attempting to access mental healed services. Through thematic analysis, seven overarching themes emerged, reflecting the interplay of internal, systemic, and relational factors that shape help-seeking behaviours. Addressing these barriers requires a collective effort from educational institutions, regulatory bodies, and the mental health profession to normalize help-seeking, reduce stigma, and ensure accessible, affordable, and ethically safe pathways to care. By fostering environments where therapists-in-training feel supported in prioritizing their own well-being, the profession not only enhances the development and resilience of its future practitioners, but also strengthens the quality and humanity of care they will extend to others.

References

Amari, N. (2021). The use of self in counseling psychology and Buber's "turning". *The Humanistic Psychologist, 49*(4), 543-554. https://doi.org/10.1037/hum0000174

Alva, M. H., Antony, S. P., & Kataria, K. (2025). Exploring the use of the therapist's self in therapy: A systematic review. *Indian Journal of Psychological Medicine, 47*(1), 17–24. https://doi.org/10.1177/02537176241252363

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Psychological Association. (2010). *Survey findings emphasize the importance of self-care for psychologists.* https://www.apaservices.org/practice/update/2010/08-31/survey#:~:text=According%20to%20ACCA%2C%20most%20individuals,with%20no%20impact%20on%20their

American Counseling Association. (2014). *Code of ethics.* https://www.counseling.org/docs/default-source/default-document-library/ethics/2014-aca-code-of-ethics.pdf?sfvrsn=55ab73d0_1

Andrade, L. H., Alonso, J., Mneimneh, Z., Wells, J. E., Al-Hamzawi, A., Borges, G., Bromet, E., Bruffaerts, R., de Girolamo, G., de Graaf, R., Florescu, S., Gureje, O., Hinkov, H. R., Hu, C., Huang, Y., Hwang, I., Jin, R., Karam, E. G., Kovess-Masfety, V., Kessler, R. C. (2014). Barriers to mental health treatment: results from the WHO World Mental Health surveys. *Psychological Medicine, 44*(6), 1303-17. https://doi.org/10.1017/S0033291713001943

Andrews, B., & Wilding, J. (2004). The relation of depression and anxiety to life-stress and achievement in students. *Journal of Psychology, 95*, 509-52I. https://doi.org/10.1348/0007126042369802

Azami-Aghdash, S., Ghojazadeh, M., Sheyklo, S. G., Daemi, A., Kolahdouzan, K., Mohseni, M., & Moosavi, A. (2015). Breast cancer screening barriers from the womans perspective: A meta-synthesis. *Asian Pacific Journal of Cancer Prevention*, *16*(8), 3463–3471. https://doi.org/10.7314/apjcp.2015.16.8.3463

Baldwin, M. (2000). *The use of self in therapy* (2nd ed.). Hawthorne Press.

Barnett, J. E., Baker, E. K., Elman, N. S., & Schoener, G. R. (2007). In pursuit of wellness: The self-care imperative. *Professional Psychology: Research and Practice, 38*(6), 603-612. https://doi.org/10.1037/0735-7028.38.6.603

Barnett, J. E., & Cooper, N. (2009). Creating a culture of self-care: Science and Practice. *Clinical Psychology, 16*(1), 16-20. https://doi.org/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*(2), 205-210. https://doi.org/10.1037/0735-7028.32.2.205

Bearse, J. L., McMinn, M. R., Seegobin, W., & Free, K. (2013). Barriers to psychologists seeking mental health care. *Professional Psychology: Research and Practice, 44*(3), 150-157. https://doi.org/10.1037/a0031182

Beck, D. L. (1976). A counseling program for social work students. *Social Casework, 57*(10), 651-655.

https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/scholarly-journals/counseling-program-social-work-students/docview/616199422/se-2

Berg, B. (2001). Qualitative Research Methods for the Social Sciences (4th Ed.). Allyn & Bacon

Bike, D. H., Norcross, J. C., & Schatz, D. M. (2009). Processes and outcomes of psychotherapists' personal therapy: Replication and extension 20 years later. *Psychotherapy: Theory, Research, Practice, Training*, *46*(1), 19–31. https://doi.org/10.1037/a0015139

Bradley, S., & Drapeau, M. (2014). Increasing access to mental health care through government-funded psychotherapy: The perspectives of clinicians. *Canadian Psychology, 55*(2), 80-89. https://doi.org/10.1037/a0036453

Braun, V., & Clarke, V. (2021). *Thematic analysis: A practical guide*. SAGE.

Bridgeman D, & Galper D (2010, August). *Listening to our colleagues—2009 APA practice survey results: Worries, wellness, and wisdom*. Presented at the 118th Annual Convention of the American Psychological Association, San Diego, CA: Retrieved November 9, 2018 from www.apa.org/practice/resources/assistance/acca-2010-convention.pdf

Bronfenbrenner, U. (2005). Ecological systems theory (1992). In U. Bronfenbrenner (Ed.), *Making human beings human: Bioecological perspectives on human development* (pp. 106–173). Sage Publications Ltd.

Bruss, K. V., & Kopala, M. (1993). Graduate school training in psychology: Its impact upon the development of professional identity. *Psychotherapy, 30*(4), 685-691. https://doi.org/10.1037/0033-3204.30.4.685

Cahir, N., & Morris, R. D. (1991). The Psychology Student Stress Questionnaire. *Journal of Clinical Psychology, 47*(3), 414-417. https://doi.org/10.1002/1097-4679(199105)47:3<414::AID-JCLP2270470314>3.0.CO;2-M

Canadian Counselling and Psychotherapy Association. (2020). *Code of ethics.* https://www.ccpa-accp.ca/wp-content/uploads/2021/10/CCPA-Standards-of-Practice-ENG-Sept-29-Web-file.pdf

Canadian Counselling and Psychotherapy Association. (2024a). *Certification guide.* https://www.ccpa-accp.ca/wp-content/uploads/2024/06/Certification-Guide_EN_updatedMay2024.pdf

Canadian Counselling and Psychotherapy Association. (2024b). *The profession & regulation.* https://www.ccpa-accp.ca/profession-and-regulation/

Canadian Psychological Association. (2017). *Canadian code of ethics for psychologists.* https://cpa.ca/docs/File/Ethics/CPA_Code_2017_4thEd.pdf

Chen, S. X., & Mak, W. W. S. (2008). Seeking professional help: Etiology beliefs about mental illness across cultures. *Journal of Counseling Psychology, 55*(4), 442-450. https://doi.org/10.1037/a0012898

Ciarrochi, J. V., & Deane, F. P. (2001). Emotional competence and willingness to seek help from professional and non-professional sources. *Journal of Guidance and Counselling, 29*(2), 233-246. https://doi.org/10.1080/03069880124843

Clement, D., Appleseth, H. S., Armstrong, C. M., Cole, A. B., Wingate, L. R., & Leffingwell, T. R. (2025). Minoritized graduate student identity, well-being, and mental health risks for suicidality. *Journal of Diversity in Higher Education, 18*(5), 633-644. https://doi.org/10.1037/dhe0000555

College of Registered Psychotherapists of Ontario. (2012). Entry-to-practice competency profile for registered psychotherapists. https://crpo.ca/wp-content/uploads/2024/09/Entry-to-PracticeCompetency-Profile-for-Registered-Psychotherapists-Aug1517.pdf

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist, 59*(7), 614-625. https://doi.org/10.1037/0003-066X.59.7.614

Corrigan, P. W., Kerr, A., & Knudsen, L. (2005). The stigma of mental illness: Explanatory models and methods for change. *Applied and Preventive Psychology, 11*(3), 179–190. https://doi.org/10.1016/j.appsy.2005.07.001

Corrigan, P. W., Kundert, C., & Laique, A. (2022). The impact of contact and fame on changing the public stigma of mental illness. *Community Mental Health Journal, 58*(4), 673–678. https://doi.org/10.1007/s10597-021-00870-1

Corrigan, P. W., Larson, J. E., & Rüsch, N. (2009). Self-stigma and the "why try" effect: Impact on life goals and evidence-based practices. *Official journal of the World Psychiatric Association*, *8*(2), 75–81. https://doi.org/10.1002/j.2051-5545.2009.tb00218.x

Corrigan, P. W., Rafacz, J., & Rüsch, N. (2011). Examining a progressive model of self-stigma and its impact on people with serious mental illness. *Psychiatry Research, 189*(3), 339-343. https://doi.org/10.1016/j.psychres.2011.05.024

Corrigan, P. W., Watson, A. C., & Barr, L. (2006). The self-stigma of mental illness: Implications for self-esteem and self-efficacy. *Journal of Social and Clinical Psychology, 25*(8), 875-884. https://doi.org/10.1521/jscp.2006.25.8.875

Coster, J. S., & Schwebel, M. (1997). Well-functioning in professional psychologists. *Professional Psychology: Research and Practice, 28*(1), 5-13. https://doi.org/10.1037/0735-7028.28.1.5

Cresswell, J. W. (2012). *Educational Research: Planning, conducting, and evaluating quantitative and qualitative Research* (4th ed.). Pearson.

Crisp, D., & Bartels, M. (2025). Barriers to self-care and seeking help among mental health professionals and trainees: A systematic review. *Clinical Psychology,* https://doi.org/10.1037/cps0000285

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*(3), 323-329. https://doi.org/10.1037/0735-7028.36.3.323

Deem, R., & Brehony, K. J. (2000). Doctoral students' access to research cultures-are some more unequal than others? *Studies in Higher Education, 25*(2), 149-165. https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/scholarly-journals/doctoral-students-access-research-cultures-are/docview/219567061/se-2

Deutsch, C. J. (1985). A survey of therapists' personal problems and treatment. *Professional Psychology: Research and Practice, 16*(2), 305-315. https://doi.org/10.1037/0735-7028.16.2.305

Digiuni, M., Jones, F. W., & Camic, P. M. (2013). Perceived social stigma and attitudes towards seeking therapy in training: A cross-national study. *Psychotherapy, 50*(2), 213-223. https://doi.org/10.1037/a0028784

Edwards, J. L., & Crisp, D. A. (2017). Seeking help for psychological distress: Barriers for mental health professionals. *Australian Journal of Psychology, 69*(3), 218-225. https://doi.org/10.1111/ajpy.12146

Eisenberg, D., Golberstein, E., & Gollust, S. E. (2007). Help-seeking and access to mental health care in a university student population. *Medical Care*, *45*(7), 594–601. http://www.jstor.org/stable/40221479

Elman, N. S., & Forrest, L. (2007). From trainee impairment to professional competence problems: Seeking new terminology that facilitates effective action. *Professional Psychology: Research and Practice, 38*(5), 501-509. https://doi.org/10.1037/0735-7028.38.5.501

El-Ghoroury, N. H., Galper, D. I., Sawaqdeh, A., & Bufka, L. F. (2012). Stress, coping, and barriers to wellness among psychology graduate students. *Training and Education in Professional Psychology, 6*(2), 122-134. https//doi.org/10.1037/a0028768

El-Ghoroury, N., & Hillig, J. A. (2000). Cognitive behavioral strategies to improve the graduate school experience: Applying what we have learned. *The Behavior Therapist, 23*(2), 42-44. https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/scholarly-journals/cognitive-behavioral-strategies-improve-graduate/docview/619692690/se-2

Enochs, W. K., & Etzbach, C. A. (2004). Impaired student counselors: Ethical and legal considerations for the family. *Family Journal, 12*(4), 396-400. https://doi.org/10.1177/1066480704267240

Farber, N. K. (2000). *Counseling psychology doctoral students' help seeking behavior: Factors affecting willingness to seek help for psychological problems* (Order No. 9950362). Available from ProQuest Dissertations & Theses Global; ProQuest Dissertations & Theses Global Closed Collection. (304530013). https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/dissertations-theses/counseling-psychology-doctoral-students-help/docview/304530013/se-2

Fay, A., & Lazarus, A. A. (1984). The therapist in behavioral and multi-modal therapy. In F. W. Kaslow (Ed.), *Psychotherapy with psychotherapists* (pp. 1–16). Haworth.

Foo, R. B., & Green, H. J. (2023). Investigating professional identity formation of postgraduate clinical psychology students. *Australian Psychologist, 58*(3), 198-208. https://doi.org/10.1080/00050067.2022.2095891

Fouad, N. A., Hains, A. A., & Davis, J. L. (1990). Factors in students' endorsement of counseling as a requirement for graduation from a counseling program. *Counselor Education and Supervision, 29*(4), 268-274. https://doi.org/10.1002/j.1556-6978.1990.tb01166.x

Fromm-Reichmann F. (1949). Notes on the personal and professional requirements of a psychotherapist. *Psychiatry*, *12*(4), 361–378. https://doi.org/10.1080/00332747.1949.11022748

Garcia, J. A., & Crocker, J. (2008). Coping with the stigma of depression: Egosystem and ecosystem goals. *Social Science and Medicine*, 67, 453-462.

Garelick, A. I. (2012). Doctors' health: Stigma and the professional discomfort in seeking help. *The Psychiatrist, 36*(3), 81-84. https://doi.org/10.1192/pb.bp.111.037903

Gazzola, N., & Gignac, K. (2025). Counselling regulation, education, supervision, and representation in Canada. In N. Pelling & P. Armstrong (Eds.), *The practice of clinical & counselling supervision: International applications* (3rd ed.) (pp. 324-333), Routledge.

Gibson, D. M., Dollarhide, C. T., & Moss, J. M. (2010). Professional identity development: A grounded theory of transformational tasks of new counselors. *Counselor Education and Supervision, 50*(1), 21-38. https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/scholarly-journals/professional-identity-development-grounded-theory/docview/750431739/se-2

Goodwill, J. R., Johnson, N. C., & Watkins, D. C. (2020). Adherence to masculine norms and depressive symptoms in young black men. *Social Work*, *65*(3), 235–244. https://doi.org/10.1093/sw/swaa029

Goplerud, E. N. (2001). Stress and stress mastery in graduate school. In S. Walfish & A. K. Hess (Eds.), *Succeeding in graduate school: The career guide for psychology students* (pp. 129–140). Lawrence Erlbaum Associates Publishers.

Grant, C., & Osanloo, A. (2014). Understanding, selecting, and integrating a theoretical framework in dissertation research: Creating the blueprint for your "house". *Administrative Issues Journal: Connecting Education, Practice, and Research, 4*(2), 12-26. https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/scholarly-journals/understanding-selecting-integrating-theoretical/docview/1697497308/se-2

Grimmer, A., & Tribe, R. (2001). Counseling psychologists' perceptions of the impact of mandatory personal therapy on professional development: An exploratory study. *Counselling Psychology Quarterly, 14*(4), 287–301. https://doi-org.proxy.bib.uottawa.ca/10.1080/09515070110101469

Guba. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology*, *29*(2). https://doi.org/10.1007/BF02766777

Guba, E. G., & Lincoln, Y. S. (1981). *Effective evaluation*. Jossey-Bass.

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Sage.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18*(1), 59-82. https://doi.org/10.1177/1525822X05279903

Guy, J. D. (2000). Self-care corner: Holding the holding environment together: Self-psychology and psychotherapist care. *Professional Psychology: Research and Practice, 31*(3), 351-352. https://doi.org/10.1037/0735-7028.31.3.351

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*(1), 48-50. https://doi.org/10.1037/0735-7028.20.1.48

Guy, J. D., Stark, M. J., & Poelstra, P. L. (1988). Personal therapy for psychotherapists before and after entering professional practice. *Professional Psychology: Research and Practice, 19*(4), 474-476. https://doi.org/10.1037/0735-7028.19.4.474

Hackler, A. H., Vogel, D. L., & Wade, N. G. (2010). Attitudes toward seeking professional help for an eating disorder: The role of stigma and anticipated outcomes. *Journal of Counseling & Development, 88*(4), 424–431. https://doi.org/10.1002/j.1556-6678.2010.tb00042.x

Hackney, H., & Bernard, J. M. (2017). *The professional counsellor: A process guide to helping*. Pearson.

Hannigan, B., Edwards, D., & Burnard, P. (2004). Stress and stress management in clinical psychology: Findings from a systematic review. *Journal of Mental Health, 13*(3), 235-245. https://doi.org/10.1080/09638230410001700871

Harris, M., Martin, M., & Martin, D. (2013). The relationship between psychological well-being and perceived wellness in graduate-level counseling students. *Higher Learning Research Communications, 3*(2), 14-31. http://dx.doi.org/10.18870/hlrc.v3i2.91

Hassan, T. M., Ahmed, S. O., White, A. C., & Galbraith, N. (2009). A postal survey of doctors' attitudes to becoming mentally ill. *Clinical Medicine*, *9*(4), 327–332. https://doi.org/10.7861/clinmedicine.9-4-327

Henry, W. E., Sims, J. H., & Spray, S. L. (1971). *The fifth profession: Becoming a psychotherapist.* Jossey-Bass.

Hill, C. E., Sullivan, C., Knox, S., & Schlosser, L. Z. (2007). Becoming psychotherapists: Experiences of novice trainees in a beginning graduate class. *Psychotherapy: Theory, Research, Practice, Training, 44*(4), 434-449. https://doi.org/10.1037/0033-3204.44.4.434

Hobaica, S., Szkody, E., Owens, S. A., Boland, J. K., Washburn, J. J., & Bell, D. J. (2021). Mental health concerns and barriers to care among future clinical psychologists. *Journal of Clinical Psychology, 77*(11), 2473-2490. https://doi.org/10.1002/jclp.23198

Holzman, L. A., Searight, H. R., & Hughes, H. M. (1996). Clinical psychology graduate students and personal psychotherapy: Results of an exploratory survey. *Professional Psychology: Research and Practice, 27*(1), 98-101. https://doi.org/10.1037/0735-7028.27.1.98

Hyun, J. K., Quinn, B. C., Madon, T., & Lustig, S. (2006). Graduate student mental health: Needs assessment and utilization of counseling services. *Journal of College Student Development, 47*(3), 247-266. https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/scholarly-journals/graduate-student-mental-health-needs-assessment/docview/195184450/se-2

Jaworska, N., De Somma, E., Fonseka, B., Heck, E., & MacQueen, G. M. (2016). Mental health services for students at postsecondary institutions: A national survey. *Canadian Journal of Psychiatry, 61*(12), 766-775. https://doi.org/10.1177/0706743716640752

Jennings, K. S., Cheung, J. H., Britt, T. W., Goguen, K. N., Jeffirs, S. M., Peasley, A. L., & Lee, A. C. (2015). How are perceived stigma, self-stigma, and self-reliance related to treatment-seeking? A three-path model. *Psychiatric Rehabilitation Journal, 38*(2), 109–116. https://doi.org/10.1037/prj0000138

Jennings, L., Goh, M., Skovholt, T. M., Hanson, M., & Banerjee-Stevens, D. (2003). Multiple factors in the development of the expert counselor and therapist. *Career Development of Counselors and Therapists, 30*(1), 59-72. https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/scholarly-journals/multiple-factors-development-expert-counselor/docview/220415906/se-2

Johns, R. G., Barkham, M., Kellett, S., & Saxon, D. (2019). A systematic review of therapist effects: A critical narrative update and refinement to Baldwin and Imel's (2013) review. *Clinical Psychology Review, 67*, 78-93. https://doi.org/10.1016/j.cpr.2018.08.004

Juniper, B., Walsh, E., Richardson, A., & Morley, B. (2012). A new approach to evaluating the well-being of PhD research students. *Assessment and Evaluation in Higher Education, 37*(5), 563. https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/scholarly-journals/new-approach-evaluating-well-being-phd-research/docview/1024131467/se-2

Kaeding, A., Sougleris, C., Reid, C., van Vreeswijk, M. F., Hayes, C., Dorrian, J., & Simpson, S. (2017). Professional burnout, early maladaptive schemas, and physical health in clinical and counselling psychology trainees. *Journal of Clinical Psychology, 73*(12), 1782-1796. https://doi.org/10.1002/jclp.22485

Kalkbrenner, M. T., & Neukrug, E. S. (2018). Identifying barriers to attendance in counseling among adults in the United States: Confirming the factor structure of the revised fit,

stigma, & value scale. *Professional Counselor, 8*(4), 299-313. https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/scholarly-journals/identifying-barriers-attendance-counseling-among/docview/2228690097/se-2

Kalkbrenner, M. T., Neukrug, E. S., & Griffith, S. M. (2019). Appraising counselor attendance in counseling: The validation and application of the revised Fit, Stigma, and Value Scale. *Journal of Mental Health Counseling, 41*(1), 21-35. https://doi.org/10.17744/mehc.41.1.03

Kaslow, N. J., & Friedman, D. (1984). The interface of personal treatment and clinical training for psychotherapist trainees. In F. W. Kaslow (Ed.), *Psychotherapy with psychotherapists* (pp. 33–57). Haworth.

Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., & al, e. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research, 36*(6), 987-1007. https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/scholarly-journals/prevalence-correlates-untreated-serious-mental/docview/211713858/se-2

Kirschbaum, C., Wolf, O. T., May, M., Wippich, W., & Hellhammer, D. H. (1996). Stress and treatment induced elevations of cortisol levels associated with impaired declarative memory in healthy adults. *Life Sciences, 58*(17), 1475-1483. https://doi.org/10.1016/0024-3205(96)00118-X

Kirsten, P., & Gall, T. L. (2020). Dear mental health practitioners, take care of yourselves: a literature review on self-care. *International Journal for the Advancement of Counselling, 42*(1), 1-20. https://doi.org/10.1007/s10447-019-09382-w

Kivunja, C. (2018). Distinguishing between theory, theoretical framework, and conceptual framework: A systematic review of lessons from the field. *International Journal of*

Higher Education, 7(6), 44-53. https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/scholarly-journals/distinguishing-between-theory-theoretical/docview/2461140517/se-2

Klein, A. B., Barnes Horowitz, N. M., Tran, I., Rabasco, A., Steele, E. H., & Breaux, R. (2023). Perceived barriers to seeking mental health treatment among clinical psychology graduate students. *Training and Education in Professional Psychology, 17*(2), 208-212. https://doi.org/10.1037/tep0000413

Klein, G. (1996). The effect of acute stressors on decision making. In J. E. Driskell, & E. Salas (Eds.), *Stress and human performance* (pp. 49-88, 314 Pages). Lawrence Erlbaum.

Knight, C. (2012). Therapeutic use of self: Theoretical and evidence-based considerations for clinical practice and supervision. *The Clinical Supervisor, 31*(1), 1. https://doi.org/10.1080/07325223.2012.676370

Komiti, A., Judd, F., & Jackson, H. (2006). The influence of stigma and attitudes on seeking help from a GP for mental health problems: A rural context. *Social Psychiatry and Psychiatric Epidemiology: The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services, 41*(9), 738-745. https://doi.org/10.1007/s00127-006-0089-4

Kumary, A., & Baker, M. (2008). Stresses reported by UK trainee counselling psychologists. *Counselling Psychology Quarterly, 21*(1), 19-28. https://doi.org/10.1080/09515070801895626

Laidig, J. (2007). Recognizing the hazards. In J. C. Norcross & J. D. Guy, Jr. (Eds.), *Leaving it at the office: A guide to psychotherapist self-care*. Guilford.

Lamb, D. H., Presser, N. R., Pfost, K. S., Baum, M. C., Jackson, V. R., & Jarvis, P. A. (1987). Confronting professional impairment during the internship: Identification, due process, and remediation. *Professional Psychology: Research and Practice, 18*(6), 597-603. https://doi.org/10.1037/0735-7028.18.6.597

Lederman, N. G., & Lederman, J. S. (2015). What is a theoretical framework? A practical answer. *Journal of Science Teacher Education, 26*(7), 593-597. https://doi.org/10.1007/s10972-015-9443-2

Levant, R. F., & Wimer, D. J. (2014). The relationship between conformity to masculine norms and men's health behaviors: Testing a multiple mediator model. *International Journal of Men's Health, 13*(1), 22–41. https://doi-org.proxy.bib.uottawa.ca/10.3149/jmh.1301.22

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage Publications.

Liu, W. M., & Iwamoto, D. K. (2007). Conformity to masculine norms, Asian values, coping strategies, peer group influences and substance use among Asian American men. *Psychology of Men & Masculinity, 8*(1), 25–39. https://doi-org.proxy.bib.uottawa.ca/10.1037/1524-9220.8.1.25

Lu, X., Chen, H., Bai, D., Chen, X., Ji, W., Gao, H., Yuan, Y., Hou, C., & Gao, J. (2025). Worldwide changes in self-stigma among people with mental illness from 2005 to 2023: A cross-temporal meta-analysis and systematic review. *International Psychogeriatrics*, 100106. Advance online publication. https://doi.org/10.1016/j.inpsyc.2025.100106

Ludwikowski, W. M. A., Vogel, D., & Armstrong, P. I. (2009). Attitudes toward career counseling: The role of public and self-stigma. *Journal of Counseling Psychology, 56*(3), 408–416. https://doi.org/10.1037/a0016180

MacKenzie, C. S., Knox, V. J., Gekoski, W. L., & MacAulay, H. L. (2004). An adaptation and extension of the attitudes toward seeking professional psychological help scale. *Journal of Applied Social Psychology, 34*(11), 2410-2435. https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/scholarly-journals/adaptation-extension-attitudes-toward-seeking/docview/37745787/se-2

Mackey, R. A., & Mackey, E. F. (1993). The value of personal psychotherapy to clinical practice. *Clinical Social Work Journal, 21*(1), 97. https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/scholarly-journals/value-personal-psychotherapy-clinical-practice/docview/227766690/se-2

Macran, S., & Shapiro, D. A. (1998). The role of personal therapy for therapists: A review. *The British Journal of Medical Psychology*, *71*(1), 13–25. https://doi.org/10.1111/j.2044-8341.1998.tb01364.x

Mahoney, M. J. (1991). *Human change processes: The scientific foundations of psychotherapy*. Basic.

Mahoney, M. J. (1997). Psychotherapists' personal problems and self-care patterns. *Professional Psychology: Research and Practice, 28*(1), 14-16. https://doi.org/10.1037/0735-7028.28.1.14

Martin, D. R., Quartiroli, A., & Wagstaff, C. R. (2023). A qualitative exploration of neophyte sport psychology practitioners' self-care experiences and perceptions. *Journal of Applied Sport Psychology, 35*(5), 874–896. https://doi.org/10.1080/10413200.2022.2046659

McAlpine, L., Paulson, J., Gonsalves, A., & Jazvac-Martek, M. (2012). 'Untold' doctoral stories: Can we move beyond cultural narratives of neglect? *Higher Education Research & Development, 31*(4), 511-523. https://doi.org/10.1080/07294360.2011.559199

McCarthy, J. T., Bruno, M. L., & Sherman, C. A. (2010). Exploring the help-seeking attitudes of graduate students at an off-campus site. *Canadian Journal of Counselling, 44*(2) Retrieved from https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/scholarly-journals/exploring-help-seeking-attitudes-graduate/docview/754911692/se-2

Merriman, O., & Joseph, S. (2018). Therapeutic implications of counselling psychologists' responses to client trauma: An interpretative phenomenological analysis. *Counselling Psychology Quarterly*, *31*(1), 117–136. https://doi.org/10.1080/09515070.2016.1266601

Michalski, D., Kohout, J., Wicherski, M., & Hart, B. (2011). *2009 doctorate employment survey.* American Psychological Association. Retrieved from https://www.apa.org/workforce/publications/09-doc-empl/report.pdf

Mojtahed, R., Nunes, M. B., Martins, J. T., & Peng, A. (2014). Equipping the constructivist researcher: The combined use of semi-structured interviews and decision-making maps. *Electronic Journal of Business Research Methods, 12*(2), 87-95. https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/scholarly-journals/equipping-constructivist-researcher-combined-use/docview/1627119511/se-2

Mokhwelepa, L. W., & Sumbane, G. O. (2025). Men's Mental Health Matters: The impact of traditional masculinity norms on men's willingness to seek mental health support A systematic review of literature. *American Journal of Men's Health*, *19*(3), 15579883251321670. https://doi.org/10.1177/15579883251321670

Neukrug, E. S., Kalkbrenner, M. T., & Griffith, S. A. M. (2017). Barriers to counseling among human service professionals: The development and validation of the Fit, Stigma, & Value Scale. *Journal of Human Services, 37*(1), 27-40.

https://www.researchgate.net/publication/322207888_Barriers_to_counseling_among_human_service_professionals_The_development_and_validation_of_the_fit_stigma_value_FSV_scale

Norcross, J. C. (2000). Psychotherapist self-care: Practitioner-tested, research-informed strategies. *Professional Psychology: Research and Practice, 31*(6), 710-713. https://doi.org/10.1037/0735-7028.31.6.710

Norcross J. C. (2005). The psychotherapist's own psychotherapy: Educating and developing psychologists. *The American Psychologist*, *60*(8), 840–850. https://doi.org/10.1037/0003-066X.60.8.840

Norcross, J. C., & Guy, J. D. (2007). *Leaving It at the Office: A Guide to Psychotherapist Self-Care*. Guilford.

Norman, J., & Rosvall, S. B. (1994). Help-seeking behavior among mental health practitioners. *Clinical Social Work Journal, 22*(4), 449-460. https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/scholarly-journals/help-seeking-behavior-among-mental-health/docview/57758056/se-2

O'Connor, M. F. (2001). On the etiology and effective management of professional distress and impairment among psychologists. *Professional Psychology: Research and Practice, 32*(4), 345-350. https://doi.org/10.1037/0735-7028.32.4.345

Orlinsky, D. E., Norcross, J. C., Rønnestad, M. H., & Wiseman, H. (2005). Outcomes and impacts of the psychotherapists' own psychotherapy: A research review. In J. D. Geller, J. C. Norcross, & D. E. Orlinsky (Eds.), *The psychotherapist's own psychotherapy* (pp. 214–230). Oxford University Press.

Orlinsky, D. E., Schofield, M. J., Schroder, T., & Kazantzis, N. (2011). Utilization of personal therapy by psychotherapists: A practice-friendly review and a new study. *Journal of Clinical Psychology, 67*(8), 828-842. https://doi.org/10.1002/jclp.20821

Pakenham, K. I., & Stafford-Brown, J. (2012). Stress in clinical psychology trainees: A review of current research and future directions. *Australian Psychologist, 47*(3), 147-155. https://doi.org/10.1111/j.1742-9544.2012.00070.x

Peluso, D. L., Carleton, R. N., & Asmundson, G. J. G. (2011). Depression symptoms in Canadian psychology graduate students: Do research productivity, funding, and the academic advisory relationship play a role? *Canadian Journal of Behavioural Science, 43*(2), 119–127. https://doi.org/10.1037/a0022624

Pescosolido, B. A., Halpern-Manners, A., Luo, L., & Perry, B. (2021). Trends in public stigma of mental illness in the US, 1996-2018. *JAMA, 4*(12). https://doi.org/10.1001/jamanetworkopen.2021.40202

Pica, M. (1998). The ambiguous nature of clinical training and its impact on the development of student clinicians. *Psychotherapy, 35*(3), 361-365. https://doi.org/10.1037/h0087840

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*(3), 247-258. https://doi.org/10.1037/0735-7028.25.3.247

Pope, K. S., & Vasquez, M. J. (2007). *Ethics in psychotherapy and counseling: A practical guide* (3rd ed.). Jossey-Bass.

Quartiroli, A., Etzel, E. F., Knight, S. M., & Zakrajsek, R. A. (2019). Self-care as key to others' care: The perspectives of globally situated experienced senior-level sport psychology

practitioners. *Journal of Applied Sport Psychology, 31*(2), 147–167. https://doi.org/10.1080/10413200.2018.1460420

Rafii, F., Rahimparvar, S. F. V., Mehrdad, N., & Keramat, A. (2017). Barriers to postpartum screening for type 2 diabetes: A qualitative study of women with previous gestational diabetes. *The Pan African medical journal*, *26*, 54. https://doi.org/10.11604/pamj.2017.26.54.11433

Reavley, N. J., & Jorm, A. F. (2014). The Australian public's beliefs about the causes of schizophrenia: Associated factors and change over 16 years. *Psychiatry Pesearch, 220*(1-2), 609–614. https://doi.org/10.1016/j.psychres.2014.07.016

Remley, T. P., & Herlihy, B. (2007). *Ethical, legal, and professional issues in counseling* (2nd ed.). Pearson Prentice Hall.

Riege, A. M. (2003). Validity and reliability tests in case study research: A literature review with "hands-on" applications for each research phase. *Qualitative Market Research: An International Journal, 6*(2), 75-86. https://doi-org.proxy.bib.uottawa.ca/10.1108/13522750310470055

Rizq, R., & Target, M. (2008). "The power of being seen": An interpretative phenomenological analysis of how experienced counselling psychologists describe the meaning and significance of personal therapy in clinical practice. *British Journal of Guidance & Counselling, 36*(2), 131–153. https://doi-org.proxy.bib.uottawa.ca/10.1080/03069880801926418

Rogers, C. R. (2007). The basic condition of the facilitative therapeutic relationship. In M. Cooper, M. O'Hara, P. Schmid, & G. Wyatt (Eds.), *The handbook of person centered psychotherapy and counselling* (pp. 1–7). Palgrave Macmillan

Rogers, C. R. (1992). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting and Clinical Psychology, 60*(6), 827-832. https://doi.org/10.1037/0022-006X.60.6.827

Rozental, A., & Carlbring, P. (2014). Understanding and treating procrastination: A review of a common self-regulatory failure. *Psychology, 5*(13), 1488. https://doi.org/10.4236/psych.2014.513160

Rummell, C. M. (2015). An exploratory study of psychology graduate student workload, health, and program satisfaction. *Professional Psychology: Research and Practice, 46*(6), 391-399. http://doi.org/10.1037/pro0000056

Salaheddin, K., & Mason, B. (2016). Identifying barriers to mental health help seeking among young adults in the UK: A cross-sectional survey. *British Journal of General Practice, 66*, 686–692. http://doi.org/10.3399/bjgp16X687313

Schaffler, Y., Probst, T., Jesser, A., Humer, E., Pieh, C., Stippl, P., Haid, B., & Schigl, B. (2022). Perceived barriers and facilitators to psychotherapy utilisation and how they relate to patient's psychotherapeutic goals. *Healthcare*, *10*(11), 2228. https://doi.org/10.3390/healthcare10112228)

Schoener, G. R. (1999). Practicing what we preach. *The Counseling Psychologist, 27*(5) 693-701. https://doi.org/10.1177/0011000099275003

Schomerus, G., Schindler, S., Sander, C., Baumann, E., & Angermeyer, M. C. (2022). Changes in mental illness stigma over 30 years: Improvement, persistence, or deterioration? *European Psychiatry, 65*(1), e78. https://doi.org/10.1192/j.eurpsy.2022.2337

Schwandt, T. (1994). Constructivist, interpretivist approaches to human inquiry. In *Handbook of qualitative research* (pp. 221–259). Sage.

Schwandt, T., Lincoln, Y., Guba, E., & Mathison, S. (2007). Judging interpretations: But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New Directions for Evaluation*, *114*, 11-25. doi: 10.1002/ev.223

Schwartz-Mette, R. A. (2009). Challenges in addressing graduate student impairment in academic professional psychology programs. *Ethics & Behavior, 19*(2), 91-102. https://doi.org/10.1080/10508420902768973

Schwebel, M., & Coster, J. (1998). Well-functioning in professional psychologists: As program heads see it. *Professional Psychology: Research and Practice, 29*(3), 284-292. https://doi.org/10.1037/0735-7028.29.3.284

Shapiro, S. L., Astin, J. A., Bishop, S. R., & Cordova, M. (2005). Mindfulness-Based Stress Reduction for Health Care Professionals: Results from a randomized trial. *International Journal of Stress Management, 12*(2), 164-176. https://doi.org/10.1037/1072-5245.12.2.164

Shapiro, S. L., Brown, K. W., & Biegel, G. M. (2007). Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology, 1*(2), 105–115. https://doi.org/10.1037/1931-3918.1.2.105

Shareinia, H., Ghiyasvandian, S., Rooddehghan, Z., & Esteghamati, A. (2024). The formation of health-related procrastination in patients with type-2 diabetes: A grounded theory research. *Frontiers in Psychology, 14*, 1196717. https://doi.org/10.3389/fpsyg.2023.1196717

Shen-Miller, D., Grus, C. L., Van Sickle, K. S., Schwartz-Mette, R., Cage, E. A., Elman, N. S., Jacobs, S. C., & Kaslow, N. J. (2011). Trainees' experiences with peers having

competence problems: A national survey. *Training and Education in Professional Psychology, 5*(2), 112-121. https://doi.org/10.1037/a0023824

Sherman, M. D. (1996). Distress and professional impairment due to mental health problems among psychotherapists. *Clinical Psychology Review, 16*(4), 299-315. https://doi.org/10.1016/0272-7358(96)00016-5

Shi, W., Shen, Z., Wang, S., & Hall, B. J. (2020). Barriers to professional mental health help-seeking among chinese adults: A systematic review. *Frontiers in Psychiatry*, *11*, 442. https://doi.org/10.3389/fpsyt.2020.00442

Sirey, J. A., Bruce, M. L., Alexopoulos, G. S., Perlick, D. A., Friedman, S. J., & Meyers, B. S. (2001). Stigma as a barrier to recovery: Perceived stigma and patient-rated severity of illness as predictors of antidepressant drug adherence. *Psychiatric Services, 52*(12), 1615-1620. https://doi.org/10.1176/appi.ps.52.12.1615

Sirois F. M. (2015). Is procrastination a vulnerability factor for hypertension and cardiovascular disease? Testing an extension of the procrastination-health model. *Journal of Behavioral Medicine*, *38*(3), 578–589. https://doi.org/10.1007/s10865-015-9629-2

Skosnik, P. D., Chatterton, R. T., Jr., Swisher, T., & Park, S. (2000). Modulation of attentional inhibition by norepinephrine and cortisol after psychological stress. *International Journal of Psychophysiology, 36*(1), 59-68. https://doi.org/10.1016/S0167-8760(99)00100-2

Skovholt, T. M., & Ronnestad, M. H. (2003). Struggles of the novice counselor and therapist. *Career Development of Counselors and Therapists, 30*(1), 45-58. https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/scholarly-journals/struggles-novice-counselor-therapist/docview/220398749/se-2

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, 16*(1), 1-15. https://doi.org/10.1111/j.1468-2850.2009.01137.x

Smith, H. L., Robinson, E. H., & Young, M. E. (2007). The relationship among wellness psychological distress, and social desirability of entering master's-level counseling trainees. *Counselor Education and Supervision, 47*(2), 96-109. https://doi.org/10.1002/j.1556-6978.2007.tb00041.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*(3), 259-280. https://doi.org/10.1080/15325020701238093

Staiger, T., Stiawa, M., Mueller-Stierlin, A. S., Kilian, R., Beschoner, P., Gündel, H., Becker, T., Frasch, K., Panzirsch, M., Schmauß, M., & Krumm, S. (2020). Masculinity and help-seeking among men with depression: A qualitative study. *Frontiers in Psychiatry*, *11*, 599039. https://doi.org/10.3389/fpsyt.2020.599039

Stead, R., Shanahan, M. J., & Neufeld, R. W. J. (2010). 'I'll go to therapy, eventually': Procrastination, stress and mental health. *Personality and Individual Differences, 49*(3), 175-180. https://doi.org/10.1016/j.paid.2010.03.028

Steel, P. (2010). Arousal, avoidant and decisional procrastinators: Do they exist? *Personality and Individual Differences, 48*(8), 926-934. https://doi.org/10.1016/j.paid.2010.02.025

Stefl, M. E., & Prosperi, D. C. (1985). Barriers to mental health service utilization. *Community Mental Health Journal, 21*, 167–177. https://doi.org/10.1007/BF00754732

Stevanovic, P., & Rupert, P. A. (2004). Career-Sustaining Behaviors, Satisfactions, and Stresses of Professional Psychologists. *Psychotherapy: Theory, Research, Practice, Training, 41*(3), 301–309. https://doi-org.proxy.bib.uottawa.ca/10.1037/0033-3204.41.3.301

Tamura, L. (2012). Emotional competence and well-being. In S. J. Knapp, M. C. Gottlieb, M. M. Handelsman, & L. D. VandeCreek (Eds.), *American psychological association handbook of ethics in psychology* (pp. 175–215). American Psychological Association.

Tay, S., Alcock, K., & Scior, K. (2018). Mental health problems among clinical psychologists: Stigma and its impact on disclosure and help seeking. *Journal of Clinical Psychology, 74*(9), 1545–1555. https://doi.org/10.1002/jclp.22614

Thériault, A., & Gazzola, N. (2010). Therapist feelings of incompetence and suboptimal processes in psychotherapy. *Journal of Contemporary Psychotherapy*, *40*(4), 233–243. https://doi.org/10.1007/s10879-010-9147-z

Thériault, A., Gazzola, N., Isenor, J., & Pascal, L. (2015). Imparting self-care practices to therapists: What the experts recommend. *Canadian Journal of Counselling and Psychotherapy, 49*(4), 379–400. https://cjc-rcc.ucalgary.ca/article/view/61031/2765-R

Tracy, S. J. (2010). Qualitative quality: Eight "Big-Tent" criteria for excellent qualitative research. *Qualitative Inquiry, 16*(10), 837-851. https://doi-org.proxy.bib.uottawa.ca/10.1177/1077800410383121

Tribe, R. (2001). Counselling psychologists’ perceptions of the impact of mandatory personal therapy on professional development--an exploratory study. *Counselling Psychology Quarterly, 14*(4), 287-301. https://doi.org/10.1080/09515070110101469

Tuckett, A. G. (2005). Applying thematic analysis theory to practice: A researcher’s experience. *Contemporary Nurse, 19*(1), 75–87. https://doi.org/10.5172/conu.19.1-2.75

Vaa Stelling, B. E., & West, C. P. (2021). Faculty disclosure of personal mental health history and resident physician perceptions of stigma surrounding mental illness. *Academic Medicine: Journal of the Association of American Medical Colleges*, *96*(5), 682–685. https://doi.org/10.1097/ACM.0000000000003941

Vanza, R. (2025, April 28). *How much does therapy cost in Canada*. Cedarway Therapy. https://cedarwaytherapy.com/how-much-does-therapy-cost-in-canada/#:~:text=How%20Much%20Do%20Counselling%20Sessions,charge%20more%20for%20their%20services.

Victor, S. E., Devendorf, A. R., Lewis, S. P., Rottenberg, J., Muehlenkamp, J. J., Stage, D. L., & Miller, R. H. (2022). Only human: Mental-health difficulties among clinical, counseling, and school psychology faculty and trainees. *Perspectives on Psychological Science, 17*(6), 1576-1590. https://doi.org/10.1177/17456916211071079

Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology, 54*(1), 40-50. https://doi.org/10.1037/0022-0167.54.1.40

Votta-Bleeker, L., Tiessen, M., & Murdoch, M. (2016). A snapshot of Canada’s psychology graduates: Initial analysis of the 2015 Psychology Graduates Survey. *Canadian Psychology, 57*(3), 172-180. https://doi.org/10.1037/cap0000059

Vybíral, Z., Ogles, B. M., Řiháček, T., Urbancová, B., & Gocieková, V. (2024). Negative experiences in psychotherapy from clients’ perspective: A qualitative meta-analysis. *Psychotherapy Research, 34*(3), 279-292. https://doi.org/10.1080/10503307.2023.2226813

Walsh, S. and Cormack, M. (1994), "Do as we say but not as we do": Organizational, professional and personal barriers to the receipt of support at work. *Clinical Psychology and Psychotherapy*, *1*, 101-110. https://doi.org/10.1002/cpp.5640010207

Wang, J., Pasyk, S. P., Slavin-Stewart, C., & Olagunju, A. T. (2024). Barriers to mental mealth care in Canada identified by healthcare providers: A scoping review. *Administration and Policy in Mental Health and Mental Health Services Research, 51*(5), 826-838. https://doi.org/10.1007/s10488-024-01366-2

Watson, A. C., Corrigan, P., Larson, J. E., & Sells, M. (2007). Self-stigma in people with mental illness. *Schizophrenia Bulletin*, *33*(6), 1312–1318. https://doi.org/10.1093/schbul/sbl076

Waumans, R. C., Muntingh, A. D. T., Draisma, S., Huijbregts, K. M., van Balkom, Anton J. L. M., & Batelaan, N. M. (2022). Barriers and facilitators for treatment-seeking in adults with a depressive or anxiety disorder in a Western-European health care setting: A qualitative study. *BMC Psychiatry, 22*, 15. https://doi.org/10.1186/s12888-022-03806-5

Williams, B. E., Pomerantz, A. M., Segrist, D. J., & Pettibone, J. C. (2010). How impaired is too impaired? Ratings of Psychologist impairment by psychologists in independent practice. *Ethics & Behavior, 20*(2), 149. https://doi.org/10.1080/10508421003595968

Williams, F., Coyle, A., & Lyons, E. (1999). How counselling psychologists view their personal therapy. *British Journal of Medical Psychology, 72*(4), 545-555. https://doi.org/10.1348/000711299160112

Witmer, J. M., & Young, M. E. (1996). Preventing counselor impairment: A wellness approach. *Journal of Humanistic Education and Development, 34*(3), 141-155. https://doi.org/10.1002/j.2164-4683.1996.tb00338.x

Yilmaz, K. (2008). Constructivism: Its theoretical underpinnings, variations, and implications for classroom instruction. *Educational Horizons, 86*(3), 161–172. https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/scholarly-journals/constructivism-theoretical-underpinnings/docview/61983197/se-2

Zahniser, E., Rupert, P. A., & Dorociak, K. E. (2017). Self-care in clinical psychology graduate training. *Training and Education in Professional Psychology, 11*(4), 283-289. https://doi.org/10.1037/tep0000172

Appendix A

Ethics Approval

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE I CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	S-01-25-11102
Titre du projet / Project Title	Exploring Barriers to Accessing Mental Health Services Among Therapists-in-Training: A Thematic Analysis
Type de projet / Project Type	Thèse de maîtrise / Master's thesis
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	13/02/2025
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	12/02/2026

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
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Conditions spéciales ou commentaires / Special conditions or comments

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Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Le Comité d'éthique de la recherche (CÉR) de l'Université d'Ottawa, opérant conformément à l'*Énoncé de politique des Trois conseils* (2014) et toutes autres lois et tous règlements applicables, a examiné et approuvé la demande d'éthique du projet de recherche ci-nommé.

L'approbation est valide pour la durée indiquée plus haut et est sujette aux conditions énumérées dans la section intitulée "Conditions Spéciales ou Commentaires". Le formulaire « Renouvellement ou Fermeture de Projet » doit être complété quatre semaines avant la date d'échéance indiquée ci-haut afin de demander un renouvellement de cette approbation éthique ou afin de fermer le dossier.

Toutes modifications apportées au projet doivent être approuvées par le CÉR avant leur mise en place, sauf si le participant doit être retiré en raison d'un danger immédiat ou s'il s'agit d'un changement ayant trait à des éléments administratifs ou logistiques du projet. Les chercheurs doivent aviser le CÉR dans les plus brefs délais de tout changement pouvant augmenter le niveau de risque aux participants ou pouvant affecter considérablement le déroulement du projet, rapporter tout évènement imprévu ou indésirable et soumettre toute nouvelle information pouvant nuire à la conduite du projet ou à la sécurité des participants.

The University of Ottawa Research Ethics Board, which operates in accordance with the *Tri-Council Policy Statement* (2014) and other applicable laws and regulations, has examined and approved the ethics application for the above-named research project.

Ethics approval is valid for the period indicated above and is subject to the conditions listed in the section entitled "Special Conditions or Comments". The "Renewal/Project Closure" form must be completedfour weeks before the above-referenced expiry date to request a renewal of this ethics approval or closure of the file.

Any changes made to the project must be approved by the REB before being implemented, except when necessary to remove participants from immediate endangerment or when the modification(s) only pertain to administrative or logistical components of the project. Investigators must also promptly alert the REB of any changes that increase the risk to participant(s), any changes that considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project or the safety of the participant(s).

Mathieu LAFLAMME
Responsable d'éthique en recherche / Protocol Officer
Pour/For **Barbara GRAVES** Président(e) du/ Chair of the **Comité d'éthique de la recherche en sciences sociales et humanités / Social Sciences and Humanities Research Ethics Board**

550, rue Cumberland, pièce 154 550 Cumberland Street, Room 154
Ottawa (Ontario) K1N 6N5 Canada Ottawa, Ontario K1N 6N5 Canada

613-562-5387 • 613-562-5338 • ethique@uOttawa.ca / ethics@uOttawa.ca
www.recherche.uottawa.ca/deontologie | www.recherche.uottawa.ca/ethics

Appendix B

Email to Professional Psychotherapy Associations and Regulatory Bodies

To whom it may concern,

My name is Mackenzie Mayled, and the purpose of this email is to invite you to share the recruitment text of a study I am conducting with your professional members. Conducting this study is one of my requirements to complete a master's degree within the department of Counselling Psychology at the University of Ottawa. My research will be supervised by Dr. Nicola Gazzola.

The purpose of this study is to explore the intricate set of barriers encountered by therapists-in-training that impact their access to and utilization of mental health services. Participants will be asked to share their perspectives on the obstacles they perceive as hindering their use of these services.

Please find the recruitment text attached to this email (see Appendix C).

Thank you for your time and consideration,

Mackenzie Mayled, M.A.[Ed] Candidate, Counselling Psychology
University of Ottawa

Appendix C

Recruitment Text

To whom it may concern,

My name is Mackenzie Mayled, and the purpose of this email is to invite you to participate in a study I am conducting, as part of my requirements to complete a master's degree within the department of Counselling Psychology at the University of Ottawa. My research will be supervised by Dr. Nicola Gazzola, professor, and research supervisor.

The purpose of this study is to explore the intricate set of barriers encountered by therapists-in-training that impact their access to and utilization of mental health services. Participants will be asked to share their perspectives on the obstacles they perceive as hindering their use of these services.

The criteria for participation are as follows: (1) participants must be fluent in English, (2) participants must be currently enrolled in a masters-level mental health training program (e.g., psychology, counselling psychology, social work, etc.) that leads to licensure by a recognized professional psychotherapy association/regulatory body in Canada, (3) participants must have experienced distress during their graduate studies but have not sought consultation from a mental health professional, and (4) participants must be willing to discuss their personal experiences with navigating their mental health and their reasons for not seeking treatment.

The interview will be conducted in English and will take place virtually using platform Microsoft Teams, unless the participant requests an in-person interview within the Ottawa region. It will be audio recorded and later transcribed to ensure that data used for the study is accurate. Please note that all identifying information will be removed during the transcription stage and that the primary researcher (who is also a student completing their Counselling Psychology program placement) and her thesis supervisor will be the only individuals with access to the data. To ensure complete confidentiality for participants, all identifying information will be removed from

the data that is collected. The data will only be accessible to the primary researcher, Mackenzie Mayled, and her thesis supervisor, Dr. Nicola Gazzola.

If you are interested in participating in the study, believe you might benefit from an opportunity to reflect on how barriers play a role in your access and use of mental health services, or would like more information, please feel free to contact me at [email redacted] or my supervisor at gazzola@uottawa.ca. Please note that participants will be selected on a first-come, first-serve basis depending on whether they meet the inclusion criteria. Priority will be given to students of varying theoretical backgrounds to ensure diversity within the study.

Thank you for your time and consideration,

Mackenzie Mayled, M.A.[Ed] Candidate, Counselling Psychology
University of Ottawa

Appendix D

Formal Invitation

To whom it may concern,

In our previous email correspondence, you expressed an interest in participating in a qualitative study I am conducting on therapists-in-training perception of barriers. I am pleased to inform you that you have been selected to participate in the study. This email is your formal invitation. Attached to this email you will find an informed consent form which further discusses the details of the study. Please review this consent form, and electronically sign, date, and return it to me via email at your earliest convenience. The interview will take place virtually, unless requested otherwise (if you reside in the Ottawa area). Please confirm whether you are comfortable using Microsoft Teams for the interview. Please also let me know when you will be available to conduct your interview for the study so that we may schedule the meeting as soon as possible.

As a reminder, the purpose of this study is to explore the intricate set of barriers encountered by therapists-in-training that impact their access to and utilization of mental health services. Participants will be asked to share their perspectives on the obstacles they perceive as hindering their use of these services.

The criteria for participation are as follows: (1) participants must be fluent in English, (2) participants must be currently enrolled in a masters-level mental health training program (e.g., psychology, counselling psychology, social work, etc.) that leads to licensure by a recognized professional psychotherapy association/regulatory body in Canada, (3) participants must have experienced distress during their graduate studies but have not sought consultation from a mental health professional, and (4) participants must be willing to discuss their personal experiences with navigating their mental health and their reasons for not seeking treatment.

The interview will be conducted in English. It will be audio recorded and later transcribed to ensure that data used for the study is accurate. Please note that all identifying information will be removed during the transcription stage and that the primary researcher (who is also a student

completing their Counselling Psychology program placement) and her thesis supervisor will be the only individuals with access to the data. To ensure complete confidentiality for participants, all identifying information will be removed from the data that is collected. The data will only be accessible to the primary researcher, Mackenzie Mayled, and her thesis supervisor, Dr. Nicola Gazzola.

If you are still interested in participating in the study, please email [email redacted] with the signed and dated consent form, as well as please indicate your preferred interview modality (in person or online), and when you are available for the interview with the researcher.

Thank you for your time and consideration,

Mackenzie Mayled, M.A.[Ed] Candidate, Counselling Psychology
University of Ottawa

Appendix E

Informed Consent Form

Researchers:

Mackenzie Mayled
M.A. Candidate
Counselling Psychology
University of Ottawa
Email: [email redacted]

Dr. Nicola Gazzola
Professor, Thesis Supervisor
Counselling Psychology
University of Ottawa
Email: gazzola@uottawa.ca
Telephone: 613-562-5800 ext. 4030

You have been invited to participate in a study called Exploring Barriers to Accessing Mental Health Services Among Therapists-in-Training: A Thematic Analysis. This research will be conducted by Mackenzie Mayled as part of her requirements to complete an M.A.[Ed] degree within the department of Counselling Psychology at the University of Ottawa. The research will be supervised by Dr. Nicola Gazzola.

Purpose of Study

The purpose of this study is to explore the intricate set of barriers encountered by therapists-in-training that impact their access to and utilization of mental health services. Participants will be asked to share their perspectives on the obstacles they perceive as hindering their use of these services.

Procedures

If you agree to participate in this study, you will be interviewed about your experience with and perception of barriers that impact your access and use of mental health services. The interview will last approximately 45-60 minutes and will be conducted in English using the online videoconferencing platform Microsoft Teams. This interview will be audio recorded and later transcribed to ensure that data used for the study is accurate. Please note that all identifying information will be removed during the transcription stage. The researcher will also take objective notes during the interview. Data from the study will be used to write a research report

that will be shared with the public. The direct quotations of participants may be used in the report, provided they do not include any identifying information.

Potential Risks and Discomforts

Speaking about experiences of barriers that inhibit your use of mental health services may lead to feelings of discomfort. Although there is minimal risk associated to this, you can inform the researcher of any discomfort you experience at any time during the interview. Breaks are encouraged if you would like a minute to reflect or pause from answering questions. The researcher has the priority of ensuring your comfort. At the end of the interview, you will be provided with a debriefing form that contains services you can access if the interview causes you any discomfort. To mitigate any social risks, participant identities will be protected by assigning pseudonyms, and all data will be will be kept in a password encrypted Word document, saved on an external hard drive, as well as backup USB key owned by the primary researcher, that are both kept in a secure location in the researcher's home office, throughout the duration of the study and ten years after the study is completed. After ten years, all data will be destroyed by secure file deletion.

Potential Benefits of Participation

Participation in this study will help shed light on the barriers that therapists-in-training identify as hindering their access to and use of mental health services. Discussions on this topic may allow participants to expand their understanding of their own experiences and barriers related to accessing mental health services which can be a valuable personal growth opportunity. Additionally, discussing and recognizing barriers will help normalize therapists-in-training experience of them, potentially reducing stigma and encouraging more open discussions about mental health within the profession. Finally, results from the study will inform prospective training programs and encourage more support and resources for trainees

Confidentiality and Anonymity

To ensure complete confidentiality for participants, all identifying information will be removed from the interview transcripts. As well, any information obtained that could compromise the confidentiality of participants will not be shared with anyone other than the primary researcher

and the thesis supervisor. To maintain anonymity, all identifying information will be removed from the interview transcripts and each participant will be assigned an interviewee number (and pseudonym). Only the primary researcher, Mackenzie Mayled, and her supervisor, Dr. Nicola Gazzola, will know the identities of participants in this study. The primary researcher will also take objective notes during the interview. Data from the study will ultimately be used to write a research report that will be shared with the public. The direct quotations of participants may be used in the report, provided they do not include any identifying information.

Data Collection and Storage

Data collected for the study will consist of audio recordings and transcripts of interviews, as well as any notes taken by the primary researcher while conducting interviews. All original data will be stored in a password encrypted Word document, saved on an external hard drive, as well as backup USB key owned by the primary researcher, that are both kept in a secure location in the researcher's home office. The data files, including the audio recordings and their transcriptions from each interview will also be stored on this external hard drive and USB key, when not in use. Dr. Nicola Gazzola, the researcher's supervisor, will store all research data under lock and key in his office for a period of 10 years. After ten years, all data will be destroyed by secure file deletion. The data will only be accessible to Mackenzie Mayled and Dr. Nicola Gazzola.

Participation and Withdrawal

Your participation in the study is completely voluntary and can be withdrawn at any time. If you choose to withdraw your participation, your data will not be used in the study, and it will be destroyed and disposed of immediately. At any time during the interview, you may ask questions of the researcher, refuse to answer any questions, and/or request to take a break. None of these actions will result in any negative consequence.

Two copies of the consent form have been provided, one for the researcher's records and one for your own. If you have any questions, you may contact either the researcher or her supervisor. Any questions or complaints about ethical conduct of the research study can be forwarded to the Office of Research Ethics and Integrity at Tabaret Hall, 550 Cumberland Street, Room 154, at 613-562-5387.

I, ___________________________, understand all information contained in this form and agree to participate in this study.

Participant's Signature: ______________________ Date: ______________________

Researcher's Signature: ______________________ Date: ______________________

Appendix F
Interview Protocol

Date: ________ (M/D/Y) Time of Interview: ________ Interviewee #: ________

Information for Participants

The purpose of this study is to explore the intricate set of barriers encountered by therapists-in-training that impact their access to and utilization of mental health services. Participants will be asked to share their perspectives on the obstacles they perceive as hindering their use of these services.

Review Consent Procedures

Before beginning the interview, we will review the informed consent document and sign the document if this has not already been done. Please let me know if you have any questions or concerns. We can address your questions now and as they come up during the interview. You can also feel free to contact me after our meeting today with any additional questions you may have.

Collect Demographic Information

To begin our interview, I am going to ask you some demographic questions that will help me describe my participant sample when interpreting the results.

1. What is your age? ________
2. What is your gender? Woman________ Man________ Nonbinary________ Prefer to self-describe as ________ Rather not say________
3. What are your educational qualifications? ________
4. Which accredited masters-level mental health training program (e.g., psychology, counselling psychology, social work, etc.) are you currently enrolled? ________
5. How far into your program are you currently? ________
6. Are you currently practicing counselling or psychotherapy? ________

Contextual Interview Questions

The next step is to go through questions that will explore your perspective on barriers that you perceive as hindering your use of mental health services during periods of elevated distress. If you are experiencing any discomfort while you are being asked or answering these questions, please let me know. We can take a break or stop the interview at any time. This interview will be audio recorded and later transcribed to ensure that data used for the study is accurate. All identifying information will be removed during the transcription stage. Ensuring your confidentiality is my priority. At the end of the interview, you will be provided with a debriefing form (see Appendix G) that contains services you can access should the interview cause you any discomfort.

Research Question: What barriers do therapists-in-training identify as hindering their access and use of mental health services?

Personal Experience with Mental Health Difficulties

1. Can you define what "mental health difficulties" means to you?
    a. How do you recognize when you're experiencing a decline in your mental health?
2. Has there been a time when you experienced mental health challenges during your training or related to your training/professional role?
    a. What were the main contributing factors?
    b. What do you believe were the impacts (e.g., well-being, academics, or clinical work)?
    c. How did you manage or cope with this?

Use of Mental Health Services

1. Could you start by sharing whether or not you have ever accessed any mental health services during your lifetime?
2. Have you ever utilized any mental health services throughout your training program?
    a. Can you describe the types of services you've accessed (e.g., personal psychotherapy, distress lines, etc.)?

Barriers

1. Can you recall a time when you felt you needed mental health support but found it challenging to seek help?
    a. What factors made it difficult to seek mental health support, even though you recognized the need?
    b. Were you able to access mental health services despite these challenges? If so, what steps did you take to overcome or navigate these barriers?
2. Can you recount a time when you felt you needed mental health support but decided not to seek it at all?
    a. What were the main factors behind your decision not to pursue mental health services, despite feeling that you needed them?
    a. Can you walk me through your thought process when you made the decision to not seek mental health support? What factors did you consider?
    b. What actions, if any, did you take instead of seeking mental health services?
3. Can you think of any factors that you believe might make it difficult, or fully prevent, other therapists-in-training from seeking mental health care when they feel they need it?

Macrosystem: Societal and Structural Factors

Stigma:

1. How would you describe societal attitudes towards mental health professionals seeking mental health services?
2. How do you think others in the mental health profession (e.g., professors, peers, practitioners) feel about therapists-in-training needing and accessing mental health services?
    a. Have these perceptions ever influenced your own decisions about pursuing or avoiding mental health care when it was needed? If so, can you share an experience that stands out?

Mesosystem: Institutional and Community Factors

Awareness and Availability:

1. How aware are you of the mental health services available to students within your academic institution and surrounding community?
    a. What are your thoughts on how accessible these services are?
    b. Do you feel the available mental health services meet the needs of therapists-in-training? Why or why not?
2. Has a lack of awareness or availability of mental health services ever impacted your ability or decision to seek help? Could you provide an example?

Microsystem: Individual and Psychological Factors

Self-Stigma:

1. What are your personal thoughts, feelings, and attitudes about therapists-in-training seeking mental health services during their training?
    a. Where do these thoughts/feelings/attitudes originate from?
2. Have your personal beliefs about needing or using mental health care ever prevented or completely blocked you from seeking support when needed? If so, can you provide an example?

Consequences:

1. How do you feel others (e.g., peers, supervisors, or the public) might respond to you for needing or seeking mental health support as a therapist-in-training?
2. What are the potential impacts (e.g., positive and/or negative), if any, do you think could arise from seeking mental health support as a therapist-in-training, either now or in the future?
    a. Have these potential responses or impacts ever influenced your ability or decision to seek mental health support? Can you think of a specific instance where this has happened?

Confidentiality/Dual Relationships:

1. What has your experience been like finding therapists who aren't connected to your training program?
    a. Have privacy or confidentiality concerns influenced your decision to seek or avoid mental health services? If so, can you share an example?

Wrap Up / Check In

1. Are there any other barriers you can think of that we missed?
2. Based on all of the barriers the discussed today, can you tell me what top three barriers have the strongest impact on your decision to seek mental health services?
3. Is there anything else you would like to share about your experiences or perspectives on this topic?
4. How did this interview go for you?
   a. Does anything stand out?
   b. Did anything surprise you?
   c. Any final words?

Mention Appendix G (Debriefing): Available resources to aid with any discomfort caused by the interview.

Appendix G
Debriefing

Thank you for participating in this study. We greatly appreciate the time and energy you put into it.

If you have any further questions, please feel free to contact me, Mackenzie Mayled, by email at [email redacted] or my supervisor, Dr. Nicola Gazzola, by email at gazzola@uottawa.ca or by telephone at 613-562-5800 ext. 4030. As noted on the Consent Form, any questions or complaints about ethical conduct of the research study can be forwarded to the Office of Research Ethics and Integrity at Tabaret Hall, 550 Cumberland Street, Room 154, at 613-562-5387.

Below are some services you can access in the case that the interview caused you any discomfort:

Distress Centre of Ottawa and Region

Offers 24/7 phone-line services to individuals needing help due to crisis or distress. Further information can be found on the Distress Centre Ottawa and Region website.

Distress Line Telephone: 613-238-3311

Crisis Line Telephone: 613.722.6914

Website: https://www.dcottawa.on.ca

The Walk-In Counselling Clinic

Offers free, single-session counselling services to community members. Counselling sessions last approximately 1.5 hours. The location and times for this service varies and can be found on the Walk-In Counselling Clinic website.

Website: https://walkincounselling.com/

Services for those who reside outside of Ottawa will be forwarded upon request. As such, please feel free to contact me at [email redacted] if you require information on additional services available within Canada.

Appendix H

Positionality Statement

In the process of conducting qualitative research, the researcher is the primary instrument in the collection and analysis of the data (Berg, 2001). As the primary researcher, I will be heavily involved in the procedures associated with the study (e.g., inviting participants, providing informed consent, conducting, transcribing, and analyzing the data). In a qualitative research study, inquiry is inevitably a value-laden process and remaining absolutely objective is nearly impossible (Schwandt et al., 2007). As such, I would like to acknowledge that I hold several axiological biases and that my positionality has been deeply influenced by my cultural background, personal experiences, and professional roles.

Growing up in South-Eastern Ontario, I was exposed to a diverse cultural environment that heightened my awareness of disparities in access to mental health services. This exposure inspired a core belief in the importance of equitable access to mental health resources for everyone. For example, I have witnessed a range of barriers, including time constraints, financial limitations, lack of information about available resources, and inadequate advertising of mental health services, that have impacted mine, and others, ability to access mental health care. These experiences highlighted the complexities and systemic issues that can obstruct individuals from obtaining mental health support.

Currently, as a masters-level counselling psychology graduate student and therapist-in-training, I have encountered and reflected on additional barriers unique to navigating this role. Both my conversations with peers and my personal experiences have illuminated several challenges, including fears of disclosure, concerns about professional judgment, and anxieties that seeking mental health support might undermine others' perceptions of our competence as future mental health professionals. These experiences have contributed to the understanding that, beyond the common barriers encountered by some individuals seeking mental health care, there may be distinct obstacles that are unique to the therapist-in-training role. Moreover, through my coursework in ethics at both the undergraduate and graduate levels, I have developed a profound appreciation for the ethical imperative to prioritize our own psychological well-being as a means to provide effective and empathetic services to clients. This foundational ethical principle underscores the importance of self-care for mental health professionals, yet I have observed a conspicuous lack of practical support and structured discussions on self-care within my

educational experience. This observed disparity between ethical standards and the practical support available to therapists-in-training has significantly fueled my interest in this research project. My aim is to bridge this gap by exploring the specific barriers faced by therapists-in-training in seeking mental health services. By addressing these issues, I seek to contribute to a deeper understanding of the challenges inherent in this role and to advocate for more effective strategies that align ethical standards with practical support.

Finally, acknowledging my positionality is crucial to the integrity and effectiveness of my research. My background, experiences, and personal beliefs inevitably influence my approach to this study, informing both the research questions I ask, the methodologies I choose, and the interpretations I make. By recognizing these influences, I strive to maintain an awareness of how my perspective and position as a therapist-in-training may impact my interactions with participants and my interpretation of their experiences. To remain reflexive, I will engage in regular self-reflection and seek feedback from my colleagues and supervisor who can offer diverse viewpoints and challenge my assumptions. I will also keep a reflexive journal throughout the research process to document my thoughts, biases, and evolving understandings. This ongoing self-awareness will help mitigate potential biases and enhance the credibility and depth of my research findings. Additionally, I will continue to prioritize transparency in how my positionality shapes the research process and outcomes, recognizing that my experiences are one of many perspectives and striving to amplify the voices of the participants in my study.