The COVID-19 era: How therapists can diminish burnout symptoms through self-care

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Abstract

COVID-19 is a frightening, stress-inducing, and unchartered territory for all. It is suggested that stress, loneliness, and the emotional toll of the pandemic will result in increased numbers of those who will seek psychological intervention, need support, and guidance on how to cope with a time period that none of us were prepared for. Psychologists, in general, are trained in and know how to help others. They are less effective in taking care of themselves, so that they can be their best in helping others. The article, which aims to heighten clinicians' awareness of the need for self-care, especially now in the post-pandemic era, describes the demanding nature of psychotherapy and the initial resistance by therapists to engage in self-care, and outlines the consequences of neglecting to care for themselves. We covered the demanding nature of psychotherapy and its grinding trajectory, the loneliness and isolation felt by clinicians in private practice, the professional hazards faced by those caring for others, and the creative and insightful ways that mental health practitioners can care for themselves for the good of their clients, their families, and obviously, themselves.

Keywords Psychologist · Self-care · Burnout · Occupational hazards · Competence constellation · Mindfulness

Mental health work, especially now doing the COVID-19 period, is stressful and may trigger burnout related to chronic work-related stress, resulting in emotional exhaustion and loneliness (Luther et al., 2017). Partly due to positive intentions of helping as many clients as possible, clinicians make for an especially vulnerable crowd. For example, Luther et al. (2017) conducted a study examining work experiences of 182 clinicians and showcased the tendency for clinicians to over-extend themselves with work. Another example comes from a survey of 474 psychotherapists, which indicated that 61% of clinicians meet the criteria for clinical depression (Pope & Tabachnick, 1994). While there are various positive aspects to being mental health workers, there are also others that can be frustrating for clinicians while they accommodate and adjust to the post-COVID-19 era given its especially strenuous demands (Sander & Bauman, 2020).

Self-care, defined as the deliberate and self-initiated attempt to take care of oneself, is widely accepted today as an essential tool to enhance clinician wellbeing and overall efficacy of treatment (Kottler, 2011; Norcross & VandenBos, 2018; Skovholt & Trotter-Mathison, 2016). Though research on self-care surged around the 1970s (Levin, Katz, & Holst, 1976), self-care's initial conceptualization stirred debate amongst health care workers and was not initially unanimously seen through a favorable lens. While some believed the initial implementation of self-care signals a de-professionalization in the broader health care field (Segall & Goldstein, 1989), others have long been exposed to the idea that self-care is narcissistic, self-indulgent, and unacceptable. Despite reports that self-care can heighten therapist's insight into cliental problems, thus leading to more efficacious therapy (Crowley & Gottlieb, 2012) and that a neglect of self-care translates to observed harm associated with occupational stress related to psychotherapy, this stigma is still prevalent today (Norcross & VandenBos, 2018).

Mental health practitioners, which include psychiatrists, psychologists, physicians, and social workers, are exposed to psychosocial stressors throughout their career, and if these are persistent, they can lead to burnout. Kushnir, Rabin, & Azulai, (1997) observed that occupational stress has been detrimental to the wellbeing, both psychological as well as emotional of clinicians, and has been positively correlated with anxiety, depression and anger, which in turn contributed to absenteeism and job related interpersonal conflicts. Additionally, overall stress has

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been found to be positively correlated with cardiovascular illness, lowered immune functioning, and gastrointestinal conditions, and which may result in prolonged strain and that may lead to exhaustion and depletion of personal resources, significantly affecting the quality of their care of patients (Di Martino, 1992). It is clear, that without being aware of the need for self-care, and actually practicing it, clinicians will experience burnout maybe multiple times in their careers.

The exhausting, demanding, and draining nature of psychotherapy makes clinicians an especially vulnerable crowd when it comes to the susceptibility of stress. For instance, sampling 182 clinicians, Luther et al. (2017) demonstrated that 52% of participants report working overtime hours in any given week, which resulted in feelings of alienation, symptoms of burnout, and reduced work satisfaction. Additionally, mental health work is stressful and has often been described as causing burnout, which involves chronic work-related stress, which is associated with emotional exhaustion and loneliness (Luther et al., 2017; Rupert & Morgan, 2005; Sander & Bauman, 2020).

Welch (1998), a seasoned therapist and academician, reflected on psychotherapy and noted that his "bedrock wish is that there is no need for psychotherapy. Because I have personally witnessed the good it can do, I am glad we have it. I have participated in the saving of lives literally and figuratively. I have seen the frightened conquer their fears, the tormented overthrow their torments, their timid heart asserts itself and look its doubts in the eye…. I have struggled and persevered with them because psychotherapy is not an antiseptic task. Still, the aim of any psychotherapist is to reach a place with every person who comes for help that he or she feels no further need for assistance" (p. 151).

Aside from high levels of stress and a propensity for burnout, a lack of self-care may also cause a clinician to experience loneliness which may be exacerbated when one is making decisions about clients which he or she alone will be responsible for (Rokach & Sha'ked, 2013). Stress and loneliness experienced by mental health professionals may stem from their striving to be loyal to their clients, their organization, and their commitment to their family. As a result, professionals' loneliness and self-doubt may be enhanced (Rokach, 2019; Soler-Gonzalez, San-Martín, Delgado-Bolton, & Vivanco, 2017).

In their study, which was conducted in Turkey, Karaoglu et al. (2015) explored the causes of burnout of medical students which may eventually lead to suicide. The stressors experienced by their participants included professional demands which arose from the students feeling caught between their loyalty to their patients, their responsibility towards their employer, and their desire to spend time with their family (Schernhammer & Colditz, 2004). They found that both men and women experienced loneliness similarly. Herzog (2012) wrote about the isolation felt by psychologists' psychoanalysts in private practice, whose loneliness may be an occupational hazard. Like the rest of humanity, clinicians may

experience disappointments, losses and illnesses, all of which result in the clinician's need of handling the stress in his or her private life in addition to that of their clients. It is, thus, clear—for clinicians, personal lives cannot be separated from their professional one, and the person who offers treatment, is the same person who may experiences loss and pain which must be faced and addressed, preferably proactively.

This issue is so daunting that Norcross and VandenBos (2018) stated that "we must make self-care a priority… Self-care is not a narcissistic luxury to be fulfilled as time permits; it is a human requisite, a clinical necessity, and an ethical imperative. If not us, then who will value our self-care? Certainly not our clients, who neurotically would bleed us to death if permitted. Certainly not insurance carriers, who greedily demand more of us while doling out less reimbursement and less autonomy. Hopefully our loved ones, but they understandably have their own needs and agendas, which only partially match ours. No, if anyone is to advocate for and prioritize our replenishment, it must be us" (p. 15).

This is, however, easier said than done. It is not only common for therapists to feel drained but also for therapists to add pressure and berate themselves, feel as if they have failed as therapists on the slightest mistakes, and be quick to deem themselves as incompetent. And then there are others who subscribe to the myth of therapist's invulnerability, and who disregard the potential implications of neglecting one's self-care. To them we say beware; it has been indicated, repeatedly, that excessive work demands of mental health professionals are associated with deteriorating and less than satisfactory work-family relationships, and this is increased in direct proportion to increases in the therapist's emotional exhaustion (Rupert, Hartman, & Miller, 2013a, 2013b). Neglecting self-care then, subjects oneself to a negative feedback cycle: the therapist becomes more irritable, external influences are more irritating, and the cycle continues until one faces burnout, or worse. To make matters worse, our clients are quite aware of the quality of care that is provided to them, to how we appear, and to our level of functioning (Briggs & Munley, 2008). Additionally, Nissen-Lie, Havik, Høglend, Monsen, and Rønnestad (2013) found that the more personal burdens that the therapist is facing, the worse the therapeutic alliance.

In the following pages we will highlight the consequences of not exercising self-care, and how it affects both, ourselves, and our clients. After a discussion of the occupational hazards of therapy, we will dedicate a section of this review to stress-reducing techniques which yield the most empirical backing. Mainly, we will speak about the importance of fostering and communicating within a professional network of colleagues. We will also reflect on the importance of self-awareness which we, as therapists, need to practice, and which includes the capacity to notice and address our own needs as generously as we do to others (Murphy & Dillon, 2002), before finally offering a brief review of the wonders of mindfulness.
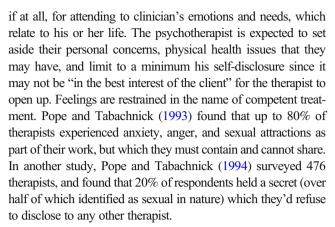
The Occupational Hazards of Psychotherapy

Physical Isolation

Psychotherapy requires privacy devoid of interruptions as a prerequisite for conducting the private journey which it is meant to be an in-depth exploration into one's self. While this isolation may be justified, it comes with a price. In contrast to the feeling of togetherness that may be experienced in clinical training, the practice of psychotherapy is a solitary task (Guy & Liaboe, 1986; Rokach & Sha'ked, 2013). While treatment teams and co-therapy are experienced by some, most clinicians go at it alone. Treatment is commonly provided by a therapist who sees clients throughout the day in consecutive sessions with minimal contact with people of the "outside world" and sometimes with very little breaks in between. Those working in hospital or clinic environments may be more fortunate in that respect as group meetings, grand rounds, and in-service workshops provide interruptions and movement. For those in private practice, even when they practice within a larger group, there are few breaks during the typical workday where they are not isolated. It is, therefore, not surprising that isolation and loneliness are leading complaints of experienced independent practitioners (Tryon, 1983; Gündoğan, 2017). While at work, the psychotherapist is unreachable by phone or personally, unless an appointment was scheduled. Moreover, the therapist is unable to be informed of daily news of local, national, and international events, which is quite unheard of in this era of immediate notification of news globally, and it may be hours before the therapist learns of a major event that may have happened locally or globally (see also Rokach, 2019).

The consulting room is isolating and together with minimal physical movement can result in environmental deprivation. It is not unusual for therapists to report sleepiness or engaging in recurrent daydreams during the times they see clients. Even the content of the sessions themselves may develop a numbing similarity, which may affect their sharpness and attention to their clients. Faced with these stressors, frustration on the part of the clinician grows, and especially for novices in the field, the ability to be authentic while properly attending to the client diminishes (Levitt & Jacques, 2005). Sitting for six or 8 h in the same room, on the same chair may also enhance boredom and monotony (Will, 1979; Misch, 2000).

Emotional Isolation

Despite the intense relational contact of psychotherapy, emotional isolation is experienced by many therapists (Rokach & Sha'ked, 2013). For example, one study found that 9% of psychologists reported significant distress related to recurrent loneliness (Thoreson, Miller, & Krauskopf, 1989). Focusing exclusively on our clients and their internal struggles leaves little room, if at all, for attending to clinician's emotions and needs, which relate to his or her life. The psychotherapist is expected to set aside their personal concerns, physical health issues that they may have, and limit to a minimum his self-disclosure since it may not be "in the best interest of the client" for the therapist to open up. Feelings are restrained in the name of competent treatment. Pope and Tabachnick (1993) found that up to 80% of therapists experienced anxiety, anger, and sexual attractions as part of their work, but which they must contain and cannot share. In another study, Pope and Tabachnick (1994) surveyed 476 therapists, and found that 20% of respondents held a secret (over half of which identified as sexual in nature) which they'd refuse to disclose to any other therapist.

Clients, naturally, react to their therapist. That may compound the psychic isolation. For instance, when clients overly idealize the therapist it may result in the clinician feeling burdened with unrealistic expectations, or alternatively accept this idealization by the client, leading to a sense of grandiosity which also removes the therapist from his or her true feelings. Clients are also known to devalue or even verbally (and rarely physically) attack their therapist. That may result in the clinician feeling discouraged, humiliated, or rejected, which the therapist must address alone, or at best with a colleague, but most cannot defend against directly communicating with the client (Del Castillo, 2010; Freudenberger, 1990a). The ethical as well as the legal requirements of confidentiality—from professionals and family or friends alike—result in psychotherapists actively splitting off the emotional impact of their work from their personal life (Nelson, Pomerantz, Howard, & Bushy, 2007; Spiegel, 1990; Tamura, Guy, Brady, & Grace, 1994). Many practitioners know quite well the change that may occur from being the empathic and caring therapist to the tired, preoccupied family member; in fact, Simpson et al. (2018), in their sample of 443 clinical and counselling psychologists found the juggling of the work-life balance to be the most distressing work related stressor amongst this crowd.

The intimacy in psychotherapy is completely one way with the client being expected to share his world and herself in great detail while the clinician is not expected to react in kind; true mutuality is lacking (Rokach, 1984). Therapists are taught to suppress intense feelings, leaving them hidden and unprocessed. Psychological treatment eventually ends, leaving psychotherapists separating from individuals they have come to value and even like. That may result in emotional losses and even mourning (Norcross, Zimmerman, Greenberg, & Swift, 2017; Rokach, 1984). No question that letting go of relationships that may have lasted for a lengthy period, where intimacy was encouraged, trust was built, and which was also a source of satisfaction is quite challenging since it cannot be shared with colleagues, family or friends (Persi, 1992). Over time, these repeated losses may result in the therapist being reluctant to allow himself to get attached and care deeply about his clients. Drawing back to Simpson et al.' (2018)

study, 79% of respondents reported experiencing a work-related stressor that impeded what therapists considered "optimal therapy", and 72% reported occasionally ruminating about this.

Since therapists were raised to believe that the theoretical school of thought that they subscribe to is more correct and appropriate for their clients than other theories, they may tend to avoid colleagues who subscribe to other theoretical orientations, and thus experience isolation and emotional alienation (Norcross & Goldfried, 2018). Male psychotherapists, more than female practitioners, experience more difficulty cultivating relationships with peers, due to their socialization. For example, one study which found that though male and female clinicians expressed their emotions with clients in equal amounts, male therapists reported being less willing and less comfortable discussing emotions in general possibly resulting in their avoidance of emotional closeness with male colleagues (Vogel, Wester, Heesacker, Boysen, & Seeman, 2006). Research found that men report greater emotional exhaustion than women in private practices and that could stem from their greater ability than men to seek support and affection in the community (Rupert & Kent, 2007). Some therapists may find it difficult to shed their interpretive observer which they are to keep in the office, and may, thus, find it difficult at home to be less detached, more spontaneous, and affectionate (Freudenberger & Robbins, 1979; Zur, Williams, Lehavot, & Knapp, 2009).

Patient Behaviors

Emotionally distressed and conflict-ridden clients are rarely seen when they are at their "best" (Guy, 1987). Therapists deal mainly with pathological populations whose perceptions of people or society-at-large are colored and skewed, such as that of victims of sexual abuse (Pearlman & Saakvitne, 1995). Being susceptible to clients' emotions may be contagious and even result in vicarious traumatization, thus making it exceedingly difficult for therapists to be what they are expected to be: empathic, kind, and wise, avoiding pejorative remarks or complaints of the client who may bring about those feelings (Schwartz, 2004). Most distressing client behaviors were found to be related to concerns about patient safety (e.g., the possibility of suicide), severely distressed clients, or clients displaying chronic and complex mental health issues (Simpson et al., 2018).

Research indicates that, as far as patient suicide is concerned, more than 30% of psychologists will have had a client commit suicide at one point in their careers (McAdams III & Foster, 2000; Gill, 2012). Upon a client's suicide, the psychotherapist who treated them will, most probably face significant negative effects their personal and professional lives, and up to 33% of them subsequently suffer from severe mental distress (Hendin, Haas, Maltsberger, Szanton, & Rabinowicz, 2004).

Another stressful client behavior is aggression, which could be exhibited through stalking, verbal or physical abuse, and in extremely rare and tragic occurrences, can involve the use of a weapon such as a knife or a firearm (Lamb, Catanzaro, & Moorman, 2006; Taylor, 2008). The literature indicates that as many as 50% of all psychotherapists are harassed or even physically attacked by a client throughout their careers (Guy, Brown, & Poelstra, 1992; Pope & Tabachnick, 1993). Thankfully, the prevalence of *physical* attacks is lower at around 20% (Pope & Vasquez, 2016). Such attacks may also increase personal vulnerability and fearfulness, decrease one's emotional wellbeing, and doubts regarding one's competence as a therapist (Hill et al., 2003).

Therapists are often unequipped when it comes to dealing with cliental anger (Maroda, 2010). In fact, client anger has been seen to elicit negative affective responses on the part of the therapist, such as submissive behavior or passive-aggressiveness in therapy, which may result in harm to the therapeutic relationship (Maroda, 2010; Walters, 2018). Client aggression has also been observed to result in clinicians' long-lasting psychological damage such as intense anxiety, depression, PTSD, anger and a fear of returning to work (Burns, 2018; Chen, Hwu, Kung, Chiu, & Wang, 2008; Figley, 2015; MacDonald, Colotla, Flamer, & Karlinsky, 2003). Client aggression could, indeed, be physical but could also include unwanted phone calls, verbal threats not only towards the therapist but their family members as well, or threats of destroying one's office or home (Carr, Goranson, & Drummond, 2014; Guy et al., 1992). Such vicarious traumatization, expressed by feeling compassion fatigue may help explain why as many as half of the psychotherapists who routinely treat traumatic clients have symptoms of secondary or acquired trauma (Reuben, 2015).

Virtually all clients who struggle with interpersonal difficulties will express those problematic patterns in therapy, particularly those suffering from a personality disorder. Taking, for example, "borderline" behaviors, it has been shown that for them the only stability is instability and drama. The affective lability of borderline patients, their self-destructive patterns, comorbid disorders, and intense anger which they often direct toward the therapist require therapeutic patience and consistency that may not easily be found, even among therapists (Norcross & VandenBos, 2018).

Clients' passive-aggressive behaviors could be problematic as well. Such behaviors may include late arrival, talking about the weather rather than themselves, and false assurances that they are well. One of the characteristics of these behaviors is that it is difficult to address them directly since they have an elusive quality. Premature termination is one such behavior which may be interpreted as occurring due to a lack of improvement in therapy, which could also be another source of
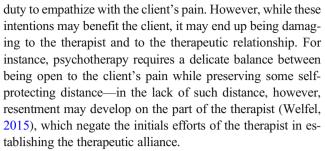
stress to therapists (Westmacott & Hunsley, 2016). Swift and Greenberg (2012) conducted a very large meta-analysis, of 669 studies representing 83,834 clients, and found that on average 20% of the clients dropped prematurely out of therapy. The threat of malpractice or an ethical complaint put forth to the governing body is a persistent threat for psychotherapists. Approximately 10–15% of mental health practitioners will face a licensing complaint during their professional careers, especially if they are male, clinicians involved in custody evaluations, or those providing services to high-risk clients. As far as malpractice suits, only two to 3 % of practitioners will actually end up facing a malpractice suit (Pope & Vasquez, 2005; Schoenfeld, Hatch, & Gonzalez, 2001; Thomas, 2005). Between 8 to 23% of psychotherapists were found to continuously worry about malpractice, either committing them or being sued by their clients about them (Knapp, VandeCreek, & Phillips, 1993; Thomas, 2005). In extreme cases clinicians may even develop litigaphobia which is expressed as an unreasonable fear of litigation by a client, and possibly not without reason. While the majority of complaints to the licensing board are unfounded, the investigation process is rough, demanding, and anxiety arousing for the psychotherapist (Thomas, 2005). Those who work with terminally ill patients and aim to support them, face during their journey with them, their own fear of death. Those who work with families may face frightening family issues, such as physical or sexual abuse, as well be triggered by issues relating to pain from their own family of origin.

Therapeutic Relationships

These relationships are, at once, capable of bringing the ecstasy and agony of therapy. It may range from hostility and anxiety that follow impaired clients' reactions, to moments where we realize that we truly helped a human being (Farber & Heifetz, 1981). There is emotional discomfort in working with suffering people (Goldberg, 1986). The very process of intimately consulting with suffering people may cause psychic comfort in the practitioner. If we are not careful, it is possible that we end up carrying around the weight and pain of every single client that we saw in our office. Countertransference is another occurrence that therapists need to be vigilant about. "Countertransference reactions could stem from the arousal of guilt due to unresolved personal struggles, inaccurate interpretations of the client's feelings caused by therapist's projection, feeling blocked and frustrated with a client, and boredom or impatience during treatment" (Norcross & VandenBos, 2018; p. 52).

Even clients who appear cooperative may indeed have a hidden agenda in therapy, causing psychotherapists to struggle with unconscious reactions, misperceptions, and possibly antagonism in relation to these clients (Kottler & Shepard, 2015). Despite this, the therapist is trained and has an ethical duty to empathize with the client's pain. However, while these intentions may benefit the client, it may end up being damaging to the therapist and to the therapeutic relationship. For instance, psychotherapy requires a delicate balance between being open to the client's pain while preserving some self-protecting distance—in the lack of such distance, however, resentment may develop on the part of the therapist (Welfel, 2015), which negate the initials efforts of the therapist in establishing the therapeutic alliance.

Achieving this balance also prevents experienced therapists from feeling overwhelmed and being sucked into the misery of their clients' lives (Greenfeld, 1985). Constant exposure to pain, conflict and pathological functioning may reactivate our own conflicts, as it brings about a great deal of self-examination and may even result in symptom overidentification (Doyle, 1987, 1987b). As Welfel (2015) puts it, "we repeatedly see the pain and destructiveness of people, and although we can usually offer help and hope to those in need, we have no magic wand to cure suffering. The cumulative effects of witnessing so much human suffering can wear down even the most competent professionals unless they are committed to self-care" (p. 100).

The therapist's Life

Some life events may cause the therapist significant distress. And to wit, research indicated that between 75 and 82% of therapists reported experiencing a distressing event in the past 3 years (Guy, Poelstra, & Stark, 1989; Norcross & Prochaska, 1986).

Pope, Tabachnick, and Keith-Spiegel, (1987) found that up to 62% of psychotherapists reported working while significantly distressed for it to be effective. These events may include dysfunctional marriages, serious illnesses, or interpersonal losses. Our profession may be taxing on marital or intimate relationships (Freudenberger, 1990b; Rupert, Stevanovic, & Hunley, 2009). Marital relationships, pregnancy, of the therapist or his partner, may bring about significant changes in roles and lifestyles and be quite stressful (Guy, Guy & Liaboe, 1986).

Female therapists may non-verbally communicate what happens in their private lives, for instance when they are noticeably pregnant, destroying anonymity and lessening boundaries (Locker-Forman, 2005; Miller & Giffin, 2019). That may result in them feeling guilty for becoming pregnant and, later, neglecting treatment of their clients due to parental obligations to the newborn, and fatigue which may impair therapist's effectiveness (Bienen, 1990; Guy et al., 1986). Changes to the quality of psychotherapy may even occur while pregnant; for instance, Locker-Forman (2005) recalls the stress she exhibited during her pregnancy when working as a clinician with children: "I had been working with the 11-year old and his family for approximately 2 years before I

became pregnant. At times, he played in an extremely destructive way, throwing objects in the room, climbing on file cabinets, and trying to destroy toys. On several occasions, I had to physically restrain him in order to prevent him from running away or hurting himself. While I never worried that he would intentionally hurt me, I was always aware of the possibility that he could lose control and harm me inadvertently" (p. 34–35).

Parenthood also comes with its set of disruptions to the therapist's work, taking form in family emergencies, ill children, elderly parents who need help, or other unexpected events. This is especially the case for first time parent therapists, as the birth of their first child constitutes a shifting identity as an individual, and also creates separation anxiety from their infant (Zackson, 2012). That increases the complexities of the therapist's professional role and requires a delicate balance to meet personal and clients' needs, which may then make them too tired to attend to family relationships (Freudenberger & Kurtz, 1990; Freudenberger & Robbins, 1979; Golden & Farber, 1998; Locker-Forman, 2005; Zackson, 2012). On top of those demands may be the family who may resent the caring and energy that are given to one's clients but not as readily to the family. Personal losses such as divorce may raise therapist's anxiety about clients finding out that their marriage failed (Guy, 1987), while the empty nest may precipitate feelings of abandonment and despair, affecting their ability to terminate therapy with their clients, wishing that termination be more gradual than it was.

Therapists undergoing a divorce were found to be more likely to maintain social contact with clients after therapy was terminated (Guy, French, Poelstra, & Brown, 1993; Kaslow & Schulman, 1987) Psychotherapists were found to engage in sexual misconduct with a client, when their personal lives were unsatisfying and non-nurturing. Loneliness, going through a divorce, enduring a parent's death, personal illnesses, and financial concerns are amongst the main causes of sexual misconduct with clients (Lamb, Catanzaro & Moorman, 2003; Norris, Gutheil, & Strasburger, 2003).

It was found that as they age, therapists are less able to keep personal concerns from affecting their practice. Going through death of one's partner, declining health and mental effects of aging may bring about a depletion of the therapist's abilities and countertransference mismanagement, all of which may cause the therapist to face, possibly their own mortality (Guy & Souder, 1986; King, 1983; Romero, 2018).

Therapists' Cognitive Musterbations

Another hazard of psychotherapy was identified by the founder of Rational Emotive Therapy, Albert Ellis. While Ellis initially explored the irrational beliefs of clients (e.g., Ellis & Grieger, 1977), he later sought to challenge the illogical and unreasonable beliefs that therapists also held. After reflecting

on his experiences, researching the literature, and recalling his time supervising other therapists, Ellis (1984) reasoned that there were five main distinct irrational beliefs that could be possibly held by therapists: 1. "I have to be successful with all my clients practically all of the time." 2. "I must be an outstanding therapist; clearly better than other therapists I know or hear about." 3. "I have to be greatly respected and loved by all my clients" 4. Since I am doing my best and working so hard as a therapist, my clients should be equally hard working and responsibly, should listen to me carefully, and should always push themselves to change." 5. "Because I am a person in my own right, I must be able to enjoy myself during therapy sessions and to use these sessions to solve my personal problems as much as to help clients their difficulties." (Ellis, 1984, pp. 206–207). Ranging from self-defeating patterns of infallible thinking and behaviours, an adherence to perfectionism, and a tendency for absolutist thinking, Ellis' musterbations suggest that therapists often find themselves behaving in the very ways they ironically teach clients to overcome. Due to these cognitive errors reflecting broader patterns in the literature, we devote a brief section to look at each of them.

I have to succeed in helping all my clients practically all of the time. From very early on, as early as clinical training even, psychotherapists have the unrealistic expectation that positive outcomes must be produced with every client they see (Efstathiou, 2017; Skovholt & Rønnestad, 2003; Szymanska, 2002) producing anxiety related to the overwhelming pressure for constant success (Efstathiou, 2017). Therapists don't need a reminder—psychotherapy is arduous. It involves vigilance, thoughtfulness, and requires profound mental exertion. Expecting results with every client is not only unrealistic but is an unwise burden to carry. Accordingly, we reiterate a statement by Norcross and VandenBos (2018) who observed that "the reality of psychotherapy, of course, is that success is neither automatic nor universal. Any therapist who assumes she [sic] has to succeed every time will eventually find great disappointment. We will not be successful with every client for multiple reasons; to say that you must always do so is completely contrary to the definition of being human" (p. 125).

I must be an outstanding therapist—the best of the lot. This pattern of thinking seems to be quite common amongst psychotherapists. For example, Walfish, SMcAlister, O'Donnell, and Lambert (2012) solicited and administered surveys to 129 mental health professionals engaged in private practice for their assessment on themselves relative to others in the profession. In this survey, *none* of the participants believed they had below-average job efficacy, while 25% of respondents believed their abilities ranked in the 90th percentile. Furthermore, a qualitative study which sought to categorize wellness and professional resilience elements in practitioners through semi-structured interviews found a major theme of professional stressors to be instances where therapists "are

stressed by issues that challenge their competency" (Mullenbach & Skovholt, 2016, b, p. 232; Skovholt & Jennings, 2004).

All my clients must greatly respect me. While psychotherapy requires constant compassion and patience, it sometimes also necessitates there being a certain level of "tough love". During such times, the best thing a client may hear is something he or she does not want to hear; while this may not win you popularity contests with your clients, one needs to be reminded—one's abilities to counsel is purely for the benefit of the client and not for seeking approval of these abilities. A therapist focusing on oneself earning the approval of clients suggests that they perhaps might have lost sight of what their work entails. Even in extreme cases, such as when one receives the "dreaded" release of information form by another therapist who the client preferred to see, practitioners need to remember that this is not indicative of a therapist's lack of ability; in fact, every so often, this is unavoidable. Certain individuals, counselor and counselee included, are just incompatible, and in such instances, this should not devalue one's perceived skillset (Kottler, 2017).

My clients should be working their hardest on their problems, since I do just that. This way of thinking suggests the depletion of empathy and a possible drift towards emotional exhaustion. It may also be suggestive of a therapist who has reached a lessened threshold for displays of anger and frustration towards a client (Norcross & VandenBos, 2018). When subject to these thoughts, counselors need to realize that only 11% of the general population with a diagnosable problem which seek psychological help (Vogel, Wade, & Hackler, 2007). Based on this statistic, it seems that the only thing we can reasonably expect from our clients is that they show up on time. We should not discount the effort they have taken to take care of themselves by seeking therapy; doing so would be dismissive of the stigma that exists around these services to begin with.

Therapy sessions must be enjoyable, and allow me an opportunity to solve my personal problems while I also help clients solve theirs. Ellis' fifth and last musterbation is multi-faceted. The component of this cognitive fallacy which believes enjoyment must be derived at all times while in the therapy room implies, similar to the 3rd musterbation, that one has forgotten about the true nature of psychotherapy in that the interests of the client are above those of the therapist. This also contradicts the notion of paid work; that is, since a client (consumer) makes the decision to purchase a service that you offer, there is no requirement for you to enjoy yourself so long as you receive compensation. The last part of this cognitive error in which therapists believe they may resolve issues in their own lives simply because of their educational background is especially problematic. Absolutistic thinking that posits that one must have all the answers to his or her own life only fuels a sense of helplessness when challenged

with the inevitable failure of doing so. And to no surprise, perceived helplessness is another common yet unique source of stress for therapists, which has been seen to manifest itself into feelings of exhaustion and incompetence (Mullenbach & Skovholt, 2016, 2016b).

Addressing Self-Care

Self-care is within us. We are our therapeutic tools. And so, observed Lasky (2005), our tools for self-care never get dull, chipped or broken. Since psychotherapy is a very demanding calling, fraught with occupational hazards, we must start our self-care by establishing realistic expectations, realizing that at times we may feel overwhelmed, tired, and even drained. We need to be aware, and protect against, what pushes our "button". It is important to *recognize* the stresses, but as essential is to realize that they are shared by most, if not all, therapists.

The stresses of therapy may lead mental health professionals to personalize their angst and subsequently abase themselves, all while not realizing, at times, that this is quite commonly experienced by all therapists. That recognition, by itself, could be therapeutic (Norcross & VandenBos, 2018). Research indicated that experienced therapists admitted experiencing many of the same doubts, confusion, and strong emotions as we encounter (Goldfried, 2001). Freud, in his early writing (1905/1933) lamented that "no one who, like me, conjures up the most evil of those half-tamed demons that inhabit the human breast, and seeks to wrestle with them, can expect to come through the struggle unscathed (p. 100)." *Accepting* that reality, accepting that we, as psychotherapists, are given to evidence various calamities and traumas, will sharpen in us the understanding that self-care is in order and is required in our profession. The Buddhist nun Chodron (1994) wrote a book entitled 'Start Where You Are', which advocates *exercising empathy* not only to our clients, but to ourselves. Understanding that we need support, nurturance, and recharging, each in whatever applies to him or to her.

As the famous Chinese proverb goes, difficulties are challenges but are also an opportunity to grow. *Resiliency* means that the practitioner responds to challenges with actions aimed to correct the situation, and moreover prevent it from recurring (Skovholt & Trotter-Mathison, 2016). Not only our clients, but we too may be broken, and as such we may join our clients on the journey to heal ourselves and function better. It should be noted that, at times, we may not overcome the challenge and that may require *teamwork*. For example, client survivors of extreme trauma, such as abuse or the loss of a loved one, requires a team of professions which can share the workload, share insight, and lighten the burden of every member involved. This team may be interdisciplinary, and may be composed by supervisors, peers, consultants, and even personal therapists (Kazak & Noll, 2004).

Self-care also needs to be *individually tailored*. That means, amongst other things, taking care of our bodies through a proper diet, ample sleep, exercise, cultivated stress outlets, and meaningful interactions with people. It is, relatively, easy for therapists who are seeing clients and are frequently overwhelmed with personal and professional responsibilities and thus do not move much, to defer to junk food and neglect their bodies. The message here is that while therapists, usually, practice from the head up, they need to be reminded to pay close attention to what is below their head as well. As Skovholt and Jennings (2004) has shown; resting, sleeping well, exercise, and a proper diet can generate and revitalize the body with energy that prepares for engagement with their clients.

The Importance of Sleep While much was written about nutrition and the importance of exercise and since a healthy mind resides in a healthy body, we would first like to highlight the importance of sleep. Many practitioners grew up being taught that sleep is, in some way, a wasted idle time. However, many research projects support the efficacy for obtaining sleep and treating insomnia, since during sleep, brain waste is being carted away, and muscle and neurological renewal take place. Thus, investing in proper rest yields returns of greater resilience and accomplishment (Irwin, Cole, & Nicassio, 2006; Smith et al., 2002).

Massage Therapy During therapy, sitting upright and keeping our posture aligned helps to give clients our full attention while preserving our energy (Bush, 2015; Rosenbaum, 1999). Being empathic includes responding viscerally to clients' suffering. Over time, however, our body takes a toll and this may lead to spasms, especially in the upper back and neck region. Massage may be very helpful in releasing that tension through increased blood flow, alleviating pain and boosting the immune system (Field, 1998), while also lifting our spirits. Additionally, meta-analyses reveal that massage therapy significantly decreases anxiety and reduces depression (Hou, Chiang, Hsu, & Yen, 2010; Moyer, Rounds, & Hannum, 2004, b).

Nutrition, Hydration and Exercise Numerous studies have reported on physical exercise's potential to improve mood and build mental stamina, while also lessening anxiety and depressive symptoms (Pope, 2017; Stathopoulou, Powers, Berry, Smits, & Otto, 2006). That could be particularly so for psychotherapists whose jobs are typically deskbound, in which prolonged hours may result in obesity, heart disease, diabetes, and a host of other bodily issues that may shorten one's lifespan. Neuhaus et al. (2014) suggested that activity-permissive workstations (e.g., a stepping device that is fitted under the desk) which allow for exercise and movement can significantly reduce sedentary time, in addition to moving some in between seeing clients.

Research has shown that ergonomic components to the office can help in supporting effectiveness (Augustin & Morelli, 2017). Office softness and orderliness, for example, improves comfort for the therapist and client and results in improved quality of services. Soft, light, and warm colours are likely to improve the office workspace (Devlin et al., 2009). The idea here, is to make the office a place that demands less respite away from it.

Additionally, and as was mentioned previously, most therapists report that they drink, during working hours, much less than the recommended amount of fluids, and frequently snack sweet, fattening, and less than healthy junk food. The foundation of any self-care imperative, thus, is to have a healthy balanced diet while also having ideal amounts of fluid intake before, during, and after therapy sessions (Korn, 2014). Together with focusing on nutrition and hydration, exercise in the form of walking, jogging, playing tennis, swimming or bicycling are not only recommended, but are reported by 71–89% of psychotherapists to be their favorite form of exercising (Barrow, English, & Pinkerton, 1987; Knapp & Sternlieb, 2012; Sherman & Thelen, 1998).

Receiving Support from our Social Support Network Therapists need support like all humans do. That may come from colleagues—if we know how to garner it—from friends or family, from mentors or from supervisors (Johnson, Barnett, Elman, Forrest, & Kaslow, 2013; Turner et al., 2005). When things do not go well, professionally, aside from reaching out for our support network, there are colleague assistance programs which are there to provide resources that may help psychotherapists address the sources of stress and promote their wellbeing (American Psychological Association, 2006). We will address the importance of professional networks more in-depth later, in our competence constellation section.

Psychotherapists will also greatly profit from personal therapy. Norcross, Dryden, & DeMichele, (1992) found that 96% of those who received personal therapy believe that it is important, to their personal and professional growth. Psychotherapists benefit from personal psychotherapy in various ways; firstly, while it is always beneficial for a physician to experience being a patient, especially in a hospital setting, the same is said about psychologists. One can only benefit from understanding what it means to be a client, to open up, to examine oneself, and to be helped to grow and gain a better self-understanding. Secondly, it may help the practitioner improve his or her emotional functioning, and that may have far-reaching positive consequences, personally and professionally. Lastly, therapists undergoing therapy can receive insight into how others conduct their therapy, perhaps inspiring new or refining existing skillsets (see also Orlinsky, Norcross, Rønnestad, & Wiseman, 2005). Personal therapy can also help the clinician address the stresses brought about by practicing

psychotherapy, and get some relief from the gnawing concerns or self-doubts that he may experience. Going through personal therapy may actually strengthen the practitioner's conviction that it is a powerful method to positively impact people's lives. And lastly, it allows the clinician, who is a client, to observe how psychotherapy actually works, and how his or her own technical skills may be used effectively. Research which has been done with practitioners who participated in personal psychotherapy, is equivocal. Some found that personal therapy had little effects on how they practiced professionally (Clark, 1986; Orlinsky et al., 2005). Other studies found several positive effects of personal therapy including heightened empathy and reducing negative perceptions of clients, if one felt that way (Gold et al., 2015). It is still recommended that personal therapy is beneficial to most therapists.

Retreats Rightfully so, taking a vacation is one the most popular forms of escapes away from the job. Expecting a vacation allows us to await with pleasure, something that promises excitement, relaxation, and experiences that will form memories in years to come. Vacations do indeed affect us positively, but it needs to be remembered that their influence evaporates as time goes on, and it is therefore important to ascertain that they are not our only healthy escape (Bloom et al., 2009).

Burnout

Interest in tracking the prevalence of burnout came to be in the mid-1970s. Freudenberger (1974) noticed a diminished desire to work to emerge as a pattern amongst himself and his staff. In the first article devoted to defining and exploring burnout, Freudenberger (1974) stated "burn-out [sic] manifests itself in many different symptomatic ways which vary in symptom and degree from person to person.… One of the chief preludes to burn-out seems to be … a feeling of exhaustion and fatigue, being unable to shake a lingering cold, suffering from frequent headaches and gastrointestinal disturbances, sleeplessness and shortness of breath.… The burn-out [sic] candidate finds it just too difficult to hold in feelings." (p. 160).

Since Freudenberger's work, there has been ample research on burnout. The American Psychological Association (APA) has devoted great attention towards the ethical imperative of preventing burnout (see Maranzan et al., 2018). Freudenberger's (1974) work, originating in New York City, even prompted the Medical Society of the State of New York (MSSNY) to dedicate a task force responsible with addressing burnout and reducing its related stressors (MSSNY, 2017). Despite the numerous research endeavors dedicated to burnout, the definition of burnout seems to vary between researchers (e.g., Freudenberger & Richelson, 1980; Maslach, 2003, 2003b; Perlman & Hartman, 1982) and between international settings, since for instance in Sweden and the

Netherlands, burnout is considered a medical prognosis (Schaufeli, Leiter, & Maslach, 2009). Despite these differences, all definitions seem to converge on its associated emotional depletion (Norcross & VandenBos, 2018).

Burnout in Psychotherapy

In relation to psychotherapists, burnout has also been characterized by exhaustion, cynicism, reduced professional efficacy, and decreased caring about one's clients (Schutte, Toppinen, Kalimo, & Schaufeli, 2000). It is said that 2–6% of psychotherapists experience "full-blown" burnout at any given time (Farber, 1990; Farber & Norcross, 2005), while as many as 25–35% of therapists experience burnout and depression to the extent that it interferes with work capabilities (Rupert & Morgan, 2005).

In one of her most notable studies, Christina Maslach, one of the first contributors to burnout research and creator of one the most widely used burnout inventories (Portoghese et al., 2018), lead a 1 year longitudinal study which tracked 466 individuals and aimed to decipher the early warning signs of burnout. The results were grouped into six domains: "workload, control, reward, community, fairness, and values" (Maslach & Leiter, 2008, p. 500). While each of these areas may be seen as belonging on a continuum, an imbalance on these domains may affect burnout related to job performance issues, social behaviour, and/or adverse affects in personal wellbeing (Maslach & Leiter, 2016). *Workload.* Workload refers to the sustainability of the tasks required; in instances where job demands exceeded one's personal limits, there is little time to rest from the demands of work, and susceptibility to burnout increases (Maslach & Leiter, 2008). More than any other work stressor, the workload psychotherapists face and the ensuing balance they must keep in order to maintain a semblance of normalcy seem to be the most distressing aspect of psychotherapy (Simpson et al., 2018).

Control Within the framework of therapy, control describes the ability and flexibility for psychotherapists to exercise professional autonomy. Control is not just limited to the capacity to manage a session but workplace hazards such as safety and verbal abuse in therapy also contribute to diminished control (Leiter, 2005). Not surprisingly, greater amounts of perceived control have been linked to workplace efficacy, while a lack of control has been seen as a catalyst of burnout within psychotherapy (Maslach & Leiter, 2008).

Reward Reward indicates the recognition received for one's work. For psychotherapists of all levels, the need to see results is related with one's own perceived competence (Skovholt & Rønnestad, 2003). Unfortunately, however, mental health professionals may lack recognition even when they do a good job. Although this may happen when disgruntled clients

failing to see the positive intentions of their therapist, it may also be observed in regard to the financial compensation of clinicians. Specifically, therapists have the tendency to reflect on their salary as an indication of professional competency, and when underpaid, they become more vulnerable to the effects of burnout (Estacio, 2019).

Community This facet relates to "the overall quality of social interaction at work, including issues of conflict, mutual support, closeness, and the capacity to work as a team" (Maslach & Leiter, 2008, p. 500). As previously alluded to in our isolation section, physical and emotional isolation may prove to be immobilizing agents with respect to the clinician's ability to feel a true bond with his or her clients. Related to a community breakdown, psychotherapists should be vigilant for the negative impact (i.e., burnout) that may arise from disputes with clients and alienation from the environment (Skovholt & Trotter-Mathison, 2016, p. 129), such as isolation.

Fairness In the therapy context, fairness relates to respect and justice (Skovholt & Trotter-Mathison, 2016). Unfortunately for psychotherapists, fairness is not always expected in the profession. Psychotherapists are often on the blunt end of hostility and cliental disrespect (Pope & Vasquez, 2016) so this source of burnout will have to be managed, rather than attempted to be prevented altogether. Treatment contracts in psychotherapy also specify that that the needs of the therapist are less important that those of the client; In other words, civil codes, professional ethics standards, and legal precedence all dictate this, either directly or indirectly, through the way with which therapists must operate (Norcross & VandenBos, 2018).

Values Maslach and Leiter's (2008) this sixth domain seems to affect psychotherapists' propensity to burnout differently depending on whether therapists are in organizational roles (e.g., hospitals) or whether they are in private practice. In other words, since therapists in private practice are given freedom to conduct therapy on the basis of their own personal judgment, they are less at-risk to suffer burnout than therapists who work in organizations. The literature seems to corroborate this assertion; for instance, Lent and Schwartz (2012) found therapists in mental health settings (e.g., inpatient and outpatient treatment rehab centres) to exhibit increased levels of emotional exhaustion compared to therapists engaged in private practice (see also Estacio, 2019).

Personality Characteristics and Burnout

While the literature has examined burnout across different therapy settings, researchers have also been interested in identifying how personality factors may come into play. With respect to the Big Five personality factors' link to burnout,

the traits most related to burnout have been identified as neuroticism, extraversion and agreeableness (Estacio, 2019; Luck, 2009; Thompson, Amatea, & Thompson, 2014), with emphasis on neuroticism as being the more significant one (Lent & Schwartz, 2012; Estacio, 2019), accounting for as much as 40% of the variability in some studies (Estacio, 2019).

As Welfel (2015) states, "In the face of all this discouraging information about the stress of professional practice, it is important to note that no counselor or therapist is doomed to experience any of these problems. Evidence also suggests that professionals who engage in career-sustaining behaviors and are committed to personal emotional wellness are better protected from feeling burnout or secondary traumatization" (p. 102–103).

Competence Constellations

When improvements to self-care and a reduction in burnout necessitates action, an effective way clinicians can attempt to accomplish both these goals is by relying on their professional support system of colleagues. Competence constellations, a term coined by Johnson, Barnett, Elman, Forrest, and Kaslow (2012), refers to "a psychologist's network or consortium of individual colleagues, consultation groups, supervisors, and professional association involvements that is deliberately constructed to ensure ongoing multisource enhancement and assessment of competence" (p. 566). This notion has recently gained traction in the literature, with some esteemed researchers believing it is only a matter of time before it becomes "infused" into training and licensing regulations, just as the psychological ethical code of conduct was (Norcross & VandenBos, 2018). Thus, this section is devoted to exploring the numerous benefits of these peer networks, including how they may help navigate delicate situations, improve the client's wellbeing, and improve the therapist's efficacy.

Navigating Ethical Dilemmas

An important impact of competence constellations is its aid to clinicians facing challenging dilemmas in the therapy room. While numerous guidelines and recommendations based on a code of ethics exist, real-life situations often blur the line between what the professional wishes to do, rather than what the recommended ethical action is most optimal to the sovereignty of the client. Simply put, "no code of ethics provides a blueprint for resolving all ethical issues, nor does the avoidance of violations always equate with ideal ethical practice, but codes represent the best judgment of one's peers about common problems and shared professional values." (Welfel, 2015, p. 10).

As the literature asserts—even in the face of colleagues acting unethically, or below thresholds of competence, psychologists don't feel comfortable directly approaching their coworkers as they feel concerned about harming their colleagues' reputation, concerned that the regulatory board may punish their colleague too harshly, or concerned that by reporting a colleague to the regulatory board they will be ostracized by their colleagues (Barnett, 2008; Bernard, Murphy, & Little, 1987; Johnson et al., 2012; Smith & Moss, 2009).

Thus, a constellation network allows a mental health professional to provide feedback without fear of these potential repercussions. Whether it is guised under friendly advice or outright anonymous, these peer networks would allow therapists to exchange information knowingly and allow for constructive criticism to be taken non-judgmentally.

Benefits to the Client

When clinicians are faced with nuanced instances that require a judgment call, professional dialogue between practitioners may be a vital part of the resolution process. This is especially important in high-risk issues (i.e., those involving the possibility of causing harm to one's client) as they may provoke intense emotions in the therapists that lead to reduced capacity to concentrate on potential resolutions (Gottlieb, Handelsman, & Knapp, 2013). Conversely, when therapists themselves are going through stressful events, clinicians may unintentionally be dismissive of their client's problems, confusion and struggles. Therefore, in the presence of minimal or total lack of professional dialogue, the client may be both minimized and marginalized, therefore further demanding a place for mental health professionals to communicate (Gottlieb et al., 2013).

Practitioners, unbeknownst to them, may also employ therapy in a manner that is too rigid in scope. For example, in psychiatric care, the dealings of sensitive issues strictly through a medical-psychiatric model (i.e., one which maintains a heavy adherence to diagnoses, symptoms and medications) may fail the client when the therapist does not balance the social and internalized conflict of the client (Koekkoek, van Meijel, & Hutschemaekers, 2006). Professional dialogue in these instances broadens the therapist's perspective and greatly enhances the client's treatment. In recalling Walfish et al.'s (2012) study, which found that none of the 129 sampled practitioners thought of themselves as having below-average abilities, this sort of overconfidence, bordering on arrogance, furthers points to the merit of what dialogue can do amongst clinicians. At its core, these constellations promote the protection of therapists from possible unknown issues of competence, such as these "blind spots".

Another such bias is in the presence of clients from different cultural backgrounds than that of the therapist; research indicates that although therapists often feel efficacious while working with these clients, they often fail to attend to their sociopolitical context, and (inadvertently) cause them harm (Johnson et al., 2012; Wilcox, Franks, Taylor, Monceaux, & Harris, 2020). Thus, speaking to a wide range of multicultural therapists would increase the finer intricacies of navigating discussions when the counselor and counselee do not share the same cultural background.

Benefits to the Therapist Wellbeing and Efficacy

Given that psychotherapists often harbour self-stigma when contemplating seeking therapy for themselves (El-Ghoroury, Galper, Sawaqdeh & Bufka, 2012; Farber, 2000), dialogues within constellation networks may also greatly benefit therapists and provide buffers to feelings of isolation, as other mental professionals may be the first and best at noticing when another therapist is feeling dejected (Norcross & VandenBos, 2018).

Competence constellations may also allow clinicians to divulge on their own self-created self-care strategies, allowing more experienced clinicians to teach the new wave of clinicians how to speed up the process they themselves had to go through. Due to the guidance that could be afforded in this scenario, growth as a result of one's competence constellation would be capable from very early on in the psychotherapist career.

The same could be said for student trainees; though only minimal research has been devoted to tracking student therapists' and trainees' improvements as a result of these networks, some studies have nonetheless found optimistic results. For example, Kois, King, Laduke, and Cook (2016) found these sorts of collaboration to increase the prevalence of mentorship and future professional opportunities. Additionally, Shen-Miller et al. (2011) found that the richness of a program's culture, along with trainees' competence, increases as a result of the integration of these sorts of models. Additionally, they advocated an entire shift in the philosophical approach to graduate school training, and a revision to the APA Ethics Code, recommending that these bodies embrace the communitarian approach of competence constellations.

Lastly, yet another feature of competence constellation which improves the quality of therapy is increases in empathy. The literature shows that when therapists reached out for help from other mental health professionals, the capacity for empathetic behaviour increased, both directed towards oneself and towards clients (Macran & Shapiro, 1998; Macran, Stiles, & Smith, 1999; Norcross, 2005). In closing of this section, we wish to reiterate Welfel (2015)'s statement in which she argues that "responsible and competent practice cannot occur consistently in isolation from the social support of other professionals (Johnson et al., 2012). Our capacity to think productively about complex ethical issues and sustain the values and ideals that brought us into this profession is dramatically enhanced by peer consultation; such consultation is essential, in fact." (p. 4).

The Importance of Self-Awareness & Mindfulness

Self-awareness, the precursor to any attempts made to reduce stress, is an integral component of a therapist's life, since it can positively impact the therapeutic relationship and one's performance, reduce burnout symptoms, and facilitate self-care (APA, 2010). When conducting our review on the different ways to reduce burnout and improve self-care, many studies seemed to highlight self-awareness, or self-monitoring, as an important tool which may achieve this. While often preached to clients during therapy, therapists need to ensure that they themselves follow this advice during, in-between, and outside of client sessions due to the associated benefits that come with this type of awareness.

Despite the seemingly conclusive work surrounding the impact and perceived importance of self-awareness (which we will discuss shortly), graduate and post-graduate programs in the United States have been seen as either lacking or underemphasizing self-awareness as an important, distinctive feature of training models (Pieterse, Lee, Ritmeester, & Collins, 2013). Additionally, the APA's (2017) code of ethics, though it strives to safeguard clients by encouraging and promoting optimal behaviour on the part of therapists, barely makes mention of the importance of self-awareness. Aside from mentioning that psychologists need to "strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work" (APA, 2017, p. 3), the topic has been left relatively unexplored.

The Benefits of Self-Awareness

Therapist self-awareness, employed during sessions, has been linked to many benefits surrounding the quality of therapy. Most notably, self-awareness has been found to relate to the ability to manage countertransference during therapy sessions (Hayes, Gelson, & Hummel, 2011). In-session self-awareness has also been associated with increased interpersonal engagement with clients and has also been a marker of perceived support on the part of clients; in fact, related to these two constructs, therapist self-awareness was seen to predict over 50% of the variance in therapist's interpersonal involvement and the perceived therapeutic alliance (Fauth & Williams, 2005). By way of it allowing therapists to be aware of any potential biases or stereotypes underlining the therapy room, self-awareness allows clinicians to better navigate discussions with clients with whom they do not share a cultural background. As Sue (2001) reports, self-awareness is the key for multicultural competency and overall improvements in therapist's communication style. It is no wonder then, that a survey of experienced therapists found self-awareness to be deemed an essential prerequisite of professional conduct (Skovholt & Jennings, 2004).

Reducing Burnout through Self-Awareness

Self-awareness' reach also extends to the lessening of burnout. In fact, numerous studies that boast impressive sampling showcase that psychologists, by and large, identify self-awareness as a valuable asset for the prevention of burnout. For instance, one study which surveyed 595 psychologists in an effort to learn about the factors related to burnout, found that maintaining self-awareness is the second highest ranked "career-sustaining behavior" (Rupert & Kent, 2007). This was also demonstrated by another study, which sampled 286 psychologists on their perceptions of the most important coping mechanisms related to optimal functioning, and which found self-awareness to rank as the 4th (out of 34) most important mechanism required (Stevanovic & Rupert, 2004). One last survey to illustrate this point comes from Coster and Schwebel (1997), who sought to question psychologists on their opinions of 1) the best ways to resolve professional impairment, and 2) what is considered most important to well-functioning. Their results, obtained through 339 psychologists, found "self-awareness/self-monitoring" to ranked as the most important item (out of 29 possibilities) across both dimensions.

Utilizing Mindfulness

While self-awareness may be achieved in a number of ways—for instance, meditation, introspection, or journaling—a practical way of achieving this cognitively is via mindfulness. Mindfulness, which can be briefly described as the deliberate and nonjudgmental focusing of thoughts and/or bodily sensation as they are in the present moment, has been linked to a myriad of beneficial effects related to resilience, wellbeing, burnout prevention and self-care for therapists (Kottler, 2011; Norcross & VandenBos, 2018; Welfel, 2015). In the last decade, mindfulness has gained wide recognition as a very effective method of self-care (Geller, 2017). Reik (1948) addressed the need to listen with our "third ear", and humanistic approaches focus on centeredness and our continuous connection with those around us, ourselves and the situation we are in.

From a biological point of view, mindfulness has been documented to produce valuable neurobiological changes. For example, reduced reactivity towards unpleasant emotions, due to increased activation in the prefrontal cortex, as result of mindfulness has been found by Chiesa and Serretti (2010). Additionally, Hatchard et al.'s (2017) neuroimaging study found mindfulness to relate to increases in attention, reflection, and emotional processing.

Another source which greatly highlights the breadth of mindfulness' positive effects is Krasner et al's. study (2009) which tracked 642 primary care physicians over a 12-months period with weekly (during the first 8 weeks) and monthly (for the remaining 10 months) mindfulness workshops. Their

results indicated that improvements in mindfulness were associated with increases in empathy, emotional stability, perspective taking, self-confidence in one's competence and conscientiousness. Additionally, participants had a reduction in burnout symptoms (related to emotional exhaustion, depersonalization and feelings of accomplishments), and also exhibited less mood disturbances.

To summarize, mindfulness is a great tool for therapists, not only because of the aforementioned benefits, but also because of its immense feasibility. That is, it can be done virtually anywhere and at any time. Whether it is done in-between clients, during lunch, or during the commute to work, mindfulness pauses even as brief as 2 min have been linked to reduced stress, increased sensitivity towards client's emotional states, greater connection between therapist and client, and increases in overall therapist effectiveness (Dunn, Callahan, Swift, & Ivanovic, 2013; Geller, 2017; Norcross & VandenBos, 2018; Ryan, Safran, Doran, & Muran, 2012).

A Mindfulness Model for Self-Care

In recognition of its large positive impact, mindfulness models have been created specifically for therapists who wish to enhance their self-care. Wise, Hersh, and Gibson (2012) created what they coined as a "mindfulness-based positive principles and practices" model that places emphasis on four components: flourishing, intentionality, reciprocity, and daily self-care practices.

The first component, in an attempt to overcome the natural tendency to ruminate about stress, emphasizes looking at the positive aspects of their occupation; mainly, the personal and professional growth that therapists undergo due to the experiences of conducting therapy are brought to attention and focused on. The second component, intentionality, is the act of accepting potential weaknesses and stressors and making the promise to oneself that an intention and an attitude change be made in order to address these issues. The third component, reciprocity, involves acknowledging the bidirectional influence of the therapy room and adhering to the notion that "human beings' locus of suffering (and the capacity for joy) [is] within the very vicissitudes of being human rather than within diagnosable psychopathology" (p. 489). The final component, daily self-care practices, stresses the importance of being consistent and creating routines which address self-care.

A Summary

To summarize, this article aims to draw attention to the dangers inherent in the profession of psychotherapy, the toll it may take on the therapist, and the price one may be required to pay if one neglects taking care of oneself. We ended this brief review of the need for self-care, and the benefits related to it, with a section on awareness and mindfulness, which in our opinion are the most salient and central characteristics of any self-care program. Mindfulness is not only related to meditation, awareness, and being present at the moment, but also signifies that we, as therapists, do what we preach and are mindful of what happens with and to us. Self-care can, thus, not only heal burnout or even prevent it from occurring, but more importantly, bring personal and professional growth, which we promote with our clients, and which we also deserve. As Welch (1998) so poignantly observed "Pray to God, but continue to swim toward shore. Whether one reads this proverb literally or metaphorically, its message reminds us that we need to rake care of ourselves. Taking care of ourselves does not mean giving up hope that others will care about us. It means, however, that we cannot be dependent totally, even minimally, on others. This, of course, is not so for children. For adults, the test of maturity is the willingness and ability to take responsibility of ourselves" (p. 151).

Compliance with Ethical Standards

Conflicts of Interest/Competing Interests   No conflict of interest.

Ethics Approval   None required.

Consent to Participate   None required.

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