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Valuing the Person of the Psychotherapist

There is only one recipe—to care a great deal for the cookery.
—HENRY JAMES

One fine morning, a psychotherapist meets a fellow psychotherapist on the street. The first psychotherapist says to the other, "You are fine. How am I?" That apocryphal tale highlights the ironic dilemma and the universal challenge for mental health professionals: we are so busy tending to others that we frequently neglect our own self-care.

Mental health professionals, by definition, study and modify human behavior. That is, we study and modify *other* humans. Psychological principles, methods, and research are rarely brought to bear on psychotherapists ourselves, with the probable exception of our unsolicited attempts to diagnose one another (Norcross, 2000). Carl Rogers (1961) admitted that "I have always been better at caring and looking after others than caring for myself."

Although understandable and explicable on many levels, this paucity of systematic study on psychotherapists' self-care is unsettling indeed. It is certainly less threatening, individually and collectively, to look outward rather than inward. Anna Freud once made the telling observation that becoming a psychotherapist was one of the most sophisticated defense mechanisms: granting us an aura of control and superiority and avoiding personal evaluation ourselves. In any case, this state of affairs strikes us as backward: we should be studying ourselves and *then* others.

Consider that psychotherapists are among the most highly trained and

experienced change agents. Yet, compared with the tens of thousands of studies on how our patients change, we know relatively little (at least publicly) about how we cope with our own distress or change our own behavior or struggle with the hazards of our craft. The tendency to view psychotherapists as not having lives outside the consulting room apparently afflicts us as well as our clients.

This book—and psychotherapist self-care—starts with *valuing the person of the psychotherapist*.

CONVERGENCE OF RESEARCH AND PRACTICE

The person of the psychotherapist is inextricably intertwined with treatment success. We know, scientifically and clinically, that the individual practitioner and the therapeutic relationship contribute to outcome as much as, and probably more than, the particular treatment method. So-called *therapist effects* are large and frequently exceed treatment effects (Wampold & Imel, 2015). Meta-analyses of therapist effects in psychotherapy outcome average 5–9% (Crits-Christoph et al., 1991; Wampold & Imel, 2015).

Two huge studies estimated the variability of outcomes attributable to therapists in actual practice settings, one in the United States involving 6,146 patients and 581 therapists (Wampold & Brown, 2005) and the other in the United Kingdom with 10,786 patients and 119 therapists (Saxon & Barkham, 2012). Five to seven percent of outcome was due to therapist effects; about 0% due to the specific treatment method. Despite impressive attempts to experimentally render individual practitioners as controlled variables, it is simply not possible to mask the person and the contribution of the therapist.

That contribution of the individual therapist also entails the creation of a facilitative relationship with a patient. The therapeutic relationship, as every half-conscious practitioner knows in her bones, is the indispensable soil of the treatment enterprise. Best statistical estimates are that the therapeutic relationship, including empathy, collaboration, the alliance, and so on, accounts for approximately 12% of psychotherapy success (and failure; Norcross & Lambert, 2018). That rivals or exceeds the proportion of outcome attributable to the particular treatment method.

Suppose we asked a neutral scientific panel from outside the field to review the corpus of psychotherapy research to determine what is the most powerful phenomenon we should be studying, practicing, and teaching. That panel (Henry, 1998, p. 128) "would find the answer obvious, and empirically validated. As a general trend across studies, the largest chunk of outcome variance not attributable to preexisting patient characteristics involves individual therapist differences and the emergent therapeutic relationship between patient and

therapist, regardless of technique or school of therapy." That's the main thrust of five decades of empirical research.

Here is a quick clinical exemplar to drive the point home. It derives from a thought experiment we use in our clinical workshops. We ask participants, "What accounts for the success of psychotherapy?" And then we ask, "What accounts for the success of your personal therapy?" The prototypical answer is "Many things account for success, including the patient, the therapist, their relationship, the treatment method, and the context." But when pressed, approximately 90% will answer "the relationship."

Their responses dovetail perfectly with the hundreds of published studies that have asked clients to describe what was helpful in their psychotherapy. Patients routinely identify the therapeutic relationship. Clients do not emphasize the effectiveness of particular techniques or methods; instead, they primarily attribute the effectiveness of their treatment to the relationship with their therapists (Elliott & James, 1989; Levitt et al., 2016).

Consider the clients' perspectives on the helpful aspects of their treatment in the classic National Institute of Mental Health Collaborative Treatment Study of Depression. Even among patients receiving manualized treatments in a large research study, the most common responses fell into the categories of "My therapist helped" (41%) and "I learned something new" (36%). At posttreatment, fully 32% of the patients receiving placebo plus clinical management wrote that the most helpful part of their "treatment" was their therapists (Gershefski et al., 1996).

As a final illustration, we would point to studies on the most informed consumers of psychotherapy—psychotherapists themselves. In three of our replicated studies in the United States and the United Kingdom, hundreds of psychotherapists reflected on their own psychotherapy experiences and nominated lasting lessons they acquired concerning the practice of psychotherapy (Bike et al., 2009; Norcross et al., 1988b; Norcross et al., 1992). The most frequent responses all concerned the interpersonal relationships and dynamics of psychotherapy: the centrality of warmth, empathy, reliability, and the personal relationship; the importance of transference and countertransference; the inevitable humanness of the therapist; and the need for more patience in psychotherapy. Conversely, a review of published studies that identified covariates of harmful therapies received by mental health professionals concluded that the harm was typically attributed to distant and rigid therapists, emotionally seductive therapists, and poor patient–therapist matches (Orlinsky et al., 2005).

All of this is to say that science and practice impressively converge on the conclusion that the person of the clinician is the locus of successful psychotherapy. It is neither grandiosity nor self-preoccupation that leads us to psychotherapist self-care; it is the incontrovertible science and practice that demands we pursue self-care.

Want to improve the effectiveness of psychotherapy? Then follow the evidence, the evidence that insists we select, train, and nourish the individual practitioner.

CONFLUENCE OF INDIVIDUAL AND ENVIRONMENT

A leitmotif of this book is the interdependence of the person and the environment in determining effective self-care. The self-care and burnout fields have been polarized into rival camps. One camp focuses on the individual's deficits—the "fault, dear Brutus, is in ourselves" advocates—and correspondingly recommends individualistic solutions to self-care. The other camp emphasizes systemic and organizational pressures—the "impossible profession with inhumane demands" advocates—and naturally recommends environmental and social solutions. In this book, we value both camps and adopt an interactional perspective that recognizes the reciprocal confluence of person-in-the-environment. The self is always in a system.

When conceptualizing the self-in-a-system, we repeatedly point to the unique motives, family of origins, and underlying psychodynamics of mental health professionals. What drives a person to concern herself with the dark side of the human psyche? What is it that compels certain people to elect to help those who are suffering, wounded, or dysfunctional? Assuredly they are a "special sort," since the average person prefers to downplay the psychic sufferings of fellow humans and avoid extensive contact with troubled individuals (Norcross & Guy, 1989).

The question of motivation—why did I (really) become a psychotherapist?—is obviously not a simple or entirely conscious one. To be sure, altruism "to help people" and idealism "for a better world" constitute two cornerstones of the vocational choice, but it is incomplete. It begs the deeper, selfism questions: Why is "helping people" of utmost concern for you? What makes it a deeply satisfying experience? Of all the helping careers—assisting the homeless, saving the environment, rendering public service, teaching the uneducated, tending to physical ills—why *this* career as a psychotherapist? Even the most saintly among us is moved by a complex stew of motives, some admirable and some less so, some conscious and some less so. Psychotherapists frequently report that they come to realize the reasons they chose their discipline only well into their careers or during the course of intensive personal therapy (Holt & Luborsky, 1958).

The failure to consider the individual motives, needs, and vulnerabilities of psychotherapists renders much of the well-intended practical advice on self-care hollow and general. To paraphrase Freud, it's akin to giving a starving

person a dinner menu. One-size-fits-all treatments never accommodate many people, be it our clients or ourselves. In *Leaving It at the Office,* we strive to present self-care in the context of, and responsive to, the emotional vulnerabilities and resources of the individual clinician.

RUNNING AGAINST THE TIDE

As we write this chapter, we are painfully aware that our message runs counter to the zeitgeist of the industrialization of mental health care. Managed care devalues the individuality of the practitioner, preferring instead to speak of "providers delivering interventions for ICD or DSM diagnoses." The pervasive medical model prefers manualized treatments for discrete disorders over healing relationships with unique humans. The evidence-based practice movement highlights research evidence in favor of specific treatments and downplays the evidence for the curative powers of the human clinician (and patient). Our emphasis on valuing the person of the therapist may seem a nostalgic throwback to the 1970s and 1980s.

At the same time, we detect a dawning recognition, really a reawakening, that the therapist herself is the focal process of change. "The inescapable fact of the matter is that the therapist is a person, however much he may strive to make himself an instrument of his patient's treatment" (Orlinsky & Howard, 1977, p. 567). This book stands firmly against the encroaching tide of the tyranny of technique and the myth of disembodied treatment.

The pursuit of technical competency has much to recommend it, but it may inadvertently subordinate the value of the personal formation and maturation of the psychologist (Norcross, 2005b). The ongoing march toward evidence-based practices tends to neglect the human dimensions of the practitioner, patient, and psychotherapy (Norcross et al., 2017). It has created an environment where, as Thoreau complains in *Walden* (1854, p. 25), "men have become the tools of their tools." Movements that address only, or primarily, the techniques of psychotherapy quickly become arid, disembodied, and technical enterprises.

Lest we be misunderstood on this point, let us reveal our bias, a bias rooted in years of conducting psychotherapy and research. Effective practice in mental health must embrace the treatment method, the individual therapist, the therapy relationship, the patient, and their optimal combinations (Norcross & Lambert, 2005). We value the power of the individual therapist, but not only that. As integrative therapists, we avoid the ubiquitous pull toward dichotomous and polarizing characterizations of the evidence. The evidence tells us that successful psychotherapy is a product of many components, all of which revolve around, and depend upon, the individual psychotherapist. That's good science *and* good relationships.

SELF-CARE AS ETHICAL IMPERATIVE

For those not convinced or only partially convinced by the scientific evidence on the person of the psychotherapist, we now turn to self-care's ethical imperative. Every ethical code of mental health professionals includes a provision or two about the need for self-care. The American Psychological Association's Ethical Principles and Code of Conduct (2010), for example, directs psychologists to maintain an awareness "of the possible effect of their own physical and mental health on their ability to help those with whom they work." One section (2.06) of the code instructs psychologists, when they become aware of personal problems that may interfere with performing work-related duties adequately, to "take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties."

Similarly, the National Association of Social Work Code of Ethics (2008) advises practitioners to monitor their performance, warns against practicing while impaired, and recommends "remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others." The American Counseling Association's (2014) Code of Ethics, for another example, goes further in proactively instructing counselors to "engage in self-care activities to maintain and promote their own emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities." No wonder that multiple organizations have joined the National Academy of Practice (2016) to launch an Action Collaborative on clinician well-being and resilience.

Without attending to our own care, we will not be able to help others and prevent harm to them. Psychotherapist self-care is a critical prerequisite for patient care. In other words, self-care is not only a personal matter but also an ethical necessity, a moral imperative (Barnett et al., 2006; Wise et al., 2012). Not an indulgence, not an option, but a professional responsibility. We gently urge you to challenge the morality of self-sacrifice at all costs and to embrace the indispensability of self-care.

Ethically speaking, you care best for your clients when you take sufficient care of yourself. The message is that simple yet that profound and demanding.

THE PARADOXES OF SELF-CARE

> Suppose you were to come upon a man in the woods working feverishly to saw down a tree. "What are you doing?" you ask. "Can't you see?" comes the impatient reply. "I'm sawing down this tree." You exclaim: "You look exhausted! How long have you been at it?" The man replies: "Over 5 hours, and I'm beat! This is hard work." You inquire: "Well, why

> don't you take a break for a few minutes and sharpen that saw? I'm sure it would go a lot faster." The man emphatically replies: "I don't have time to sharpen the saw. I'm too busy sawing!"

That is the first paradox of self-care: no time to sharpen the saw! The story, incidentally, comes from Stephen Covey's (1989, p. 287) *The 7 Habits of Highly Effective People*. It is *sooo* easy to see and diagnose it in other people; it is *sooo* hard to get off the treadmill ourselves.

The existential–humanistic therapists Sapienza and Bugental (2000, p. 459) put the self-care paradox bluntly: "Many of us have never really learned how to take the time to care and to nourish ourselves, having been trained to believe that this would be selfish. . . . Nor have most psychologists taken the time to develop compassion for themselves, and compassion for their wounds."

Not that psychotherapists are opposed to self-care; far from it. Instead, we are busy, multitasking professionals dedicated to helping others but who frequently cannot locate the time to help ourselves. Clients, families, paperwork, colleagues, students, and friends seem to always assume priority. The ideal balance of caring for others *and* for ourselves tends to favor the former. At the risk of redundancy, we believe it begins with prioritizing the value of yourself as a person/psychotherapist.

The point segues into another paradox of psychotherapist self-care: Not availing ourselves of what we provide or recommend to clients. We often feel hypocritical or duplicitous—suggesting to others that they work less, exercise more, renew themselves, and so forth—while we do not take our own advice. How often do we sit with patients, encouraging them to "relax and take a vacation," while calculating in our own case our lost therapy revenue and airfare and concluding that we can't afford to take the time away from the office right now (Penzer, 1984)?

A representative example from one of our workshop participants is instructive:

> "I had the ergonomic person here yesterday for an analysis in my office, thanks to back pain that signaled something negative to me. When I had to answer her questions about my amount of work, vacation, and so on, it was embarrassing! How could I possibly with a good conscience give a talk on stress management when I behave as I do?"

On a positive note, the person optimistically concluded that "I'm assuming the universe is sending me needed messages and that your reminder e-mail about self-care is yet another."

A recurrent theme of our book is the acknowledgment that it is easier to be wise and mature for others than for ourselves. If you are still feeling a little hypocritical, sheepish, or guilty about not practicing what you preach,

then join us and the crowd. We are far more adept at recommending self-care to others than practicing it ourselves, as our families and friends will readily attest. Until quite lately in our own lives, self-care was regrettably more of a research proficiency than a personal accomplishment. We are in no position to moralize.

In fact, we take seriously an early lesson of folks traveling to Esalen, the human potential center in California. Although the trainers at Esalen were teaching people how to relate to themselves and other people in optimal ways, they themselves had serious difficulties in their own lives and relationships. This led Richard Price to popularize what he called Esalen's Law: we always teach others what we most need to learn ourselves. A corollary is that each of us is our own worst student. (Thanks to Ken Pope for reminding us of the law's origins.)

Psychotherapists frequently comment on the cruel irony of giving to clients precisely what they deprive their families of. One therapist (Penzer, 1984, p. 54) notes the dissonance inherent in "spending several hours a day playing Uno, Checkers, and War in the name of play therapy and coming home in the evening and casting my children's requests aside in the name of fatigue." Another colleague was conducting psychotherapy with a harried middle-age father one evening and focusing on the father's need to spend more time with his son and daughter. Alas, the therapist was seeing patients four evenings a week and ignoring his own young children! Many therapists will candidly admit to giving more time, energy, and devotion to their practices than to their spouses, children, or themselves (Penzer, 1984). Clearly, the lesson is one of "Physician, take thine own medicine."

Just as being a lawyer does not necessarily make one more honest and being a physician does not necessarily make one healthier (Goldberg, 1992), so too being a psychotherapist does *not* make one automatically more proficient at self-care. In fact, it is frequently the converse in a profession in which people enter "to help others."

RESEARCH ON PSYCHOTHERAPIST SELF-CARE

We have been researching the self-care and self-change of mental health professionals for the past 35 years. These studies have occupied sizable portions of our professional careers and, not coincidentally, our personal lives. We and our colleagues have conducted numerous studies to identify what distinguishes the self-change of mental health professionals from that of educated laypersons, to survey practitioners about what they use and don't use to soothe themselves, to discern what change principles are particularly effective for therapist self-care, and to interview seasoned psychotherapists about their personal struggles and salvations. We have taken the Socratic dicta of "know thyself" and "heal

thyself" to heart—and to the lab. The resultant compilation of self-care strategies is clinician-recommended, research-informed, and practitioner-tested.

Some of our earliest research, including one of our doctoral dissertations (Norcross & Prochaska, 1986a, 1986b), was premised, mostly unconsciously, on the fantasy that psychotherapists' clinical skills would inoculate us from the inevitable stressors of living. But all of the research results have regrettably disabused us of this fantasy. Psychotherapists experience the same frequency of life disruptions as educationally and economically comparable laypersons. We also furtively hoped that our research would compellingly demonstrate that mental health professionals would prove better self-changers than mere mortals. But here, too, we were ruefully disappointed: this is simply not the case. In truth, we psychotherapists cope just a tad more effectively with life disruptions than laypersons with similar education, which comes as an insult to our narcissism, no doubt!

A therapist-patient of ours employed at a health maintenance organization (HMO) was treating 33 patients a week at the HMO, seeing patients 3 nights a week in private practice, and teaching a course on another night. She then complained of feeling exhausted and overwhelmed. Duh! Her complaints followed a psychotherapy session in which another of our patients, a very hard-working teacher, stayed up past midnight creating her own Christmas bows and then complaining of exhaustion. We are not so different from our patients—we are all more human than otherwise.

A question that persistently arises and that many of you may be silently asking is, "But what about our theoretical orientations? Won't our preferred systems of psychotherapy affect how we care for ourselves?" We have conducted multiple studies on this topic over the past four decades (see Norcross & Aboyoun, 1994, for a review). The results will probably surprise you, as they certainly did us.

In treating patients, psychotherapists use change principles in accordance with their theoretical orientation. Cognitive-behavioral therapists, for example, report using counterconditioning, contingency management, and stimulus control significantly more than colleagues of integrative, psychodynamic, and humanistic persuasions. On the other hand, psychodynamic therapists rely more on the therapy relationship and catharsis than do their behavioral colleagues. That the treatment of clients varies predictably with orientation is not surprising and, in fact, is quite expected.

The question then arose: Are psychotherapists equally influenced by theories in treating themselves, in their own self-care? Apparently not. We have been unable to discern any significant orientation differences in psychotherapists' self-care. This pattern of results has now been replicated in five separate studies involving different disorders and health professions. Indeed, we have been unable to discern even a few statistically significant differences expected by chance alone. In toto, these composite findings strongly argue for

a considerable similarity among psychotherapists in their own self-care, independent of their theories.

We offer three interpretations for this pattern of findings (Norcross et al, 1991). The first interpretation comes from attribution research. In their role as healers, therapists rely heavily on theories for facilitating change in others. In their role as self-changers, therapists are not as influenced by theoretical prescriptions. A second and cynical interpretation holds that mental health professionals do not avail themselves of what they offer their patients. Theoretical orientations may be for treatment-facilitated change of clients, not for self-initiated change of themselves. Negatively stated, one may *not* necessarily have to "practice what one preaches." As George Kelly (1955) noted many years ago, psychotherapists do *not* apply their theories reflexively. That is, they do not apply the same theories to their own behavior as psychotherapists that they use in understanding and treating patients.

The third and more positive explanation is that psychotherapists become more pragmatic, eclectic, and "secular" when they confront their own distress. This view is reminiscent of early psychotherapy process research that suggested experienced psychotherapists behave and think quite similarly (e.g., Fiedler, 1950a, 1950b) and also reminiscent of a "therapeutic underground" (Wachtel, 1977), an unofficial consensus of what experienced clinicians believe to be true. Psychotherapists may well value clinical strategies quite different from what they offer their clients or from what they consider to be within their professional competence. On a personal level, clinicians may be taking psychotherapy integration to heart.

George Stricker (1995), a friend and a prominent psychodynamicist, has written movingly about just such a personal integration in self-care. George and several fellow psychotherapists rented a small, puddle-jumping airplane in South America for an intimate view of the spectacular Iguazu waterfalls. George began experiencing panic symptoms as he looked over the falls to appreciate the beauty that led them there in the first place. He realized his training and proficiency in psychodynamic therapy were not particularly useful for self-management of acute panic. Ever the pragmatic integrationist, George immediately became a cognitive-behavioral therapist with the assistance of his colleagues and successfully ameliorated his anxiety. He still employs some of the cognitive-behavioral methods he was taught, when faced with similar situations. Not a cure, to be sure, but an effective way of dealing with situational anxieties.

Also consistent with this pragmatic and integrative explanation is the repeated finding that many psychotherapists choose a type of personal therapy different from what they practice themselves (see Chapter 11, and Norcross & Grunebaum, 2005). The majority of behavior therapists, in particular, choose *non*behavioral personal therapy. Practitioners, it appears, have learned that rival orientations are complimentary, not contradictory, when it comes to their own health.

Our decades of research on self-care also lead us to emphasize self-care principles or strategies, as opposed to techniques. One of the lessons from our research is that effective psychotherapist self-care is characterized by a complex, differential pattern of strategies. These strategies or principles represent an intermediate level of abstraction between concrete techniques and global theory. There are literally thousands of self-care techniques (e.g., meditation, assertion, dream analysis, vacations), and, Lord knows, we cannot agree on a single theory (e.g., psychoanalytic, cognitive, systemic, narrative); however, research increasingly reveals that we can agree on broad principles. Given the diversity of individual preferences and available resources, we recommend broad strategies as opposed to specific techniques.

If a colleague is plagued by occupational anxieties, the research suggests that the strategies of healthy escapes and helping relationships may well prove effective. Once the strategies are identified, then the individual practitioner can discover for herself the available and preferred techniques for implementing these strategies—for instance, massage, exercise, and meditation for healthy alternatives and peer support groups or clinical supervision for helping relationships. The focus should be squarely placed on broad strategies, which you then adapt to your own situation and preferences (Norcross, 2000).

Our research has additionally shown appreciable outcome differences among various psychotherapist self-care strategies, but the effect of any *single* strategy is rather modest. The different change strategies that people bring to bear on their distress do make a difference. The 13 self-care strategies recommended in this book are demonstrably more effective than the passive strategies of, say, wishful thinking, self-blame, and substance abuse (Norcross & Aboyoun, 1994). At the same time, there is no single self-care strategy so outstandingly effective that its possession alone would ensure an ability to conquer distress. These findings suggest to us, as they have to others, that possessing a particular skill in one's arsenal is less important than having a variety of self-care strategies. Seasoned practitioners have extended valuable lessons from their clinical work to their personal lives: avoid concentration on a single theory and promote cognitive and experiential growth on a broad front.

A recent meta-analysis of 17 studies on the efficacy of self-care among graduate students (Colman et al., 2017) supports the point. Many self-care strategies were associated with reductions in student distress and increases in their self-compassion and personal accomplishments. But there were not significant outcome differences due to the particular self-care strategy. Nor did student characteristics (sex, age, and ethnicity) make much of an outcome difference; that is, self-care is for all of us.

The overarching moral to be derived from the research is that psychotherapists should avail themselves of multiple self-care strategies unencumbered by theoretical dictates. Take psychotherapy integration to heart; that is, embrace multiple strategies associated with diverse theoretical traditions.

Psychotherapists should avail themselves of multiple self-care strategies unencumbered by theoretical dictates.

Be comprehensive, flexible, and secular in replenishing yourself. The self-care strategies compiled in *Leaving It at the Office* are theoretically neutral and blend psychotherapists' in-the-trenches recommendations with the research findings.

BEGIN WITH SELF-AWARENESS AND SELF-MONITORING

Quantitative studies and interview surveys alike confirm the conventional wisdom on the centrality of self-monitoring our own distress and, concomitantly, our own self-care. In one illustrative study, both program directors and professional psychologists identified "self-awareness/self-monitoring" as the top-ranked contributor to their optimal functioning (Schwebel & Coster, 1998). In a survey of 595 psychotherapists, "maintain self-awareness/self-monitoring" emerged as the second highest rated career-sustaining behavior for the entire sample, right behind "maintain sense of humor" (Rupert & Kent, 2007). In a study of master therapists, self-awareness was deeply embedded in, and routinely prized as a prerequisite for, professional conduct (Skovholt & Jennings, 2004).

Becoming aware, as we usefully remind our patients, is the key first step. In a monumental multinational study of psychotherapist development over the lifespan (Orlinsky & Rønnestad, 2005, p. 200), the authors pointedly conclude: "As a final recommendation, then, we restate how important it is that practitioners of all professions and theoretical orientations *consistently monitor and carefully attend to their sense of current professional development and their level of satisfaction with therapeutic work*." (italics in original)

Assess your own self-care as you might a student's or a patient's self-care. Be prepared to be shocked by the results. You spend most of your day in intimate contact with distressed patients, anxious parents, and insensitive administrators? You work *how* many hours per week?! Your last nonconvention vacation was when?! You never get lunch at the office?! And then you take work home with you and receive calls at night?!

Structured questionnaires can serve as convenient, empirically grounded measures in facilitating systematic self-reflection (Orlinsky & Rønnestad, 2005). Practitioners might use questionnaires to monitor their own work morale and establish benchmarks for detecting signs of stagnation or decline. Student therapists might use them privately to monitor their own clinical functioning and development and share the results with supervisors. Supervisors, in turn, might use them in parallel fashion to track supervisee's distress, self-care,

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and development. (See Appendix E in Orlinsky & Rønnestad, 2005, for sample questionnaires, scoring keys, and norms for psychotherapists; complete one of the dozen or so resiliency, compassion fatigue, or self-care instruments; or consider one of the burnout instruments, such as the Burnout Measure or the Maslach Burnout Inventory.)

Research suggests that, unfortunately, clinicians are not necessarily the best reporters of their own abilities and behaviors (Lambert, 2010; Waltman et al., 2016). We all need to supplement our self-monitoring with objective measures, peer consultation, and independent verification. Self-care begins with our own awareness, but cannot end there.

Many practitioners find it useful to track their self-care through writing, journaling, or logging (e.g., Baker, 2003; Williams-Nickelson, 2006). Some prefer structured self-monitoring on a specific behavior, such as food diaries, mood and self-talk logs, or exercise calendars. Others prefer a narrative journal of feelings and experiences. Meta-analyses on the effects of expressive writing find (small) positive effects on physical and psychological outcomes (Frattaroli, 2006; Frisina et al., 2004). In any case, a written chronicle improves adherence to a self-care regimen (DiMatteo, 2006)—of course, so long as maintaining the journal or log does not itself become yet another onerous responsibility or compulsive pursuit.

Gerald (Jerry) Corey, author of several influential textbooks on counseling, exemplifies the self-monitoring of work and play. For years, Jerry has recorded the time devoted to work and to exercise (walking and biking). Since the year 2010, he has averaged 39 hours of work weekly and an impressive 13.6 hours of exercise weekly. Jerry testifies that logging his work and exercise time keeps him more honest, balanced, and motivated.

Several of our workshop participants have taken to posting publicly their self-care plans to promote maintenance and to share their commitment with peers and patients alike. One wrote: "I have my self-care goals written out on my name tag from the workshop and tacked to my bulletin board so I can see them often. For a guilt-ridden type like me, once we commit to something in public it sticks." Another concurred, saying, "It has become more acceptable for me to discuss and overtly integrate my self-care strategies with colleagues." Your self-care can prove a contagion, spreading beyond colleagues to clients.

Self-awareness can be augmented by contracting for some honest feedback from loved ones about our workweek. Self-awareness does not imply that we go it alone, only that we must become aware of and own our behavior. For some of us, self-monitoring entails attending (nondefensively, if possible) to interpersonal feedback from significant others about our functioning.

In our case, we attend to our spouses' observations that we are looking

haggard, working longer hours, or traveling too often to supplement our own monitoring. In the early years, our defenses were immediately activated, and we quickly rationalized with such feeble protests as "Well, I have a responsible position!"; "But it's not as bad as Jim's schedule"; and the ever handy "Next week will be easier."

Awareness alone, however, is not sufficient. Self-care readily becomes one of those "healthy oughts," like flossing teeth and getting sleep, which gets discussed and then discarded. Here's how one workshop participant characterized his history of neglecting self-care:

> "Somehow my wonderful plans and desires based on my emotions did not materialize. I yet once more realize the various steps in actual life transformation. Awareness is not enough, and understanding is only the beginning of the essential first step."

In several of our studies devoted to discovering the successful self-change strategies of psychotherapists, *self-liberation*—a fancy name for choosing and self-realization—consistently emerged as an effective strategy. This strategy entails the choice of changing and the ensuing responsibility. It is the acknowledgment, the commitment, and the burden of replenishing yourself, professionally and personally.

In the prophetic words of a participant in one of our self-care workshops:

> "Your presentation was a necessary reminder to me that I cannot just advocate attention to self-care for my staff or assume that it will stay in my consciousness without some intention. I need to apply it, more consciously and intentionally, to myself. It caused me to reconsider things I was and was not doing to engage in self-care."

That, in a nutshell, is precisely our intention.

BUILDING ON YOUR SELF-CARE STRENGTHS

Part of our intention in this book is to identify what you currently do well in self-care. An unfortunate side effect of writing on the wondrous variety of self-care is that readers commonly conclude that they fall short of the self-care ideal and, in fact, are not replenishing at all. Nonsense! Let's acknowledge what you are already doing and build on those strengths.

Take a mindful moment to document existing self-care activities you desire to continue. Construct a mental list or jot them down; the research demonstrates that writing a list generally proves more effective than thinking about them, so we ask our workshop participants to take pen to paper. Perhaps

share them with peers or friends to enhance compliance. Sure, you might want to do them more regularly, but start your well-being from a position of strength and celebration about what's already working.

Some supervisors take the idea a step further: they ask their staff members to write themselves a self-care letter, seal it in an envelope, and then return it to the author 3–6 months later. Writing the letter and subsequently receiving it ideally serve as momentum and focus on self-renewal (Magaletta & Perskaudas, 2016).

MAKING SELF-CARE A PRIORITY

To reach the action stage of sustained behavior change (Prochaska , Norcross, & DiClemente, 1995), awareness and self-monitoring must beget a proactive choice. Good intentions must concretely translate into healthy behaviors. "I find that it really works to write in my exercise time on my calendar each day and make that a really important time," as one colleague told us. In other words, we must make self-care a priority.

It begins with reminding busy practitioners of the personal and professional need to tend to their own psychological health. Call it valuing, prizing, prioritizing, or another action verb, but find a way of building it into the mainstream of your life. 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.

The famous Talmudic injunction "If I am not for myself, who will be for me?" seems particularly difficult to implement for women socialized to place nurturing others above all else. And women, let us emphasize, now comprise the majority of new graduates of all mental health professions (psychology, psychiatry, social work, counseling, marital and family therapy, mental health nursing). Practicing self-care is often mistranslated as selfishness and into abandoning others. We join Carol Gilligan (1982) and other feminists in challenging such women to question the morality of self-abnegation and "to consider it moral to not only care for others but for themselves" (p. 149).

Many clinical colleagues and more than a few of our master therapists post mottos, photographs, or plaques to remind them of the self-care foundation. A few of our favorites read:

- You cannot drink from an empty cup.
- Put on your own oxygen mask before helping those around you.
- Limited self-care means limited patient care.
- You can't help others if you don't help yourself first.
- Self-care is a divine responsibility.

Self-awareness and self-monitoring should beget self-empathy and self-compassion: the capacity to notice, value, and respond to our own needs as generously as we attend to the needs of others (Murphy & Dillon, 2002). Many practitioners blame themselves for feeling drained and then, to complicate the drain, berate themselves for feeling that way. Please develop self-empathy, taking the time and space for yourself without feeling selfish, guilty, or needy.

Consider the daily life of the "successful" busy psychotherapist in independent practice. Up early and tending to family matters. Off in a rush to the office to "catch up," return telephone calls, and complete insurance forms. Confronting an avalanche of suffering patients and juggling them with the emergencies. Squeezing in a part-time teaching, supervision, or consultation commitment. Working several evenings, perhaps even a weekend day. Taking calls at nights, completing paperwork at home. The line between work and nonwork has practically disappeared.

Or consider the committed "successful" clinician working at a community mental health center. One of our workshop participants characterized her agency as one "that would chew me up and spit me out, then ask that I reassemble myself so they could have dessert. It is impossible to do what I am asked to do. I am salaried and work far more than 40 hours a week (from 45 to 50 hours)."

Or the pastoral counselor who wrote us recently about his new position at a hospital as "a chaplain, and it is mega stressful. I am on call for 104 hours per week. There are people dying of cancer and other diseases every day. This week I have been working with a young couple when doctors turned the life-support machine off on their little baby."

All are working overscheduled lives. Skimping on breakfast, probably skipping lunch, existing on snack foods during the day on the run. Running nearly on empty, subclinically exhausted. Little time for self or loved ones. In a success-driven culture hostile to rest and self-care, many psychotherapists have lost the balance, priorities, and mission they once treasured. *Quis custodiet ipsos custodies*? (Who will guard the guards?)

For those still subscribing to the myth of therapist invulnerability, longitudinal research documents the obvious. Excessive work demands of mental health professionals predict worse work-family conflict. Specifically, the more hours worked and greater emotional exhaustion lead to poorer family functioning in the future (Rupert et al., 2013).

Nor can we hide our humanness from patients. Several studies have demonstrated that our clients are sensitive to the quality of the clinician's life outside of treatment (Briggs & Munley, 2008). The higher the therapist's personal burdens, the worse the therapeutic alliance; the higher the therapist's personal satisfactions, the better the treatment alliance (Nissen-Lie et al., 2013). Our burdens—and our satisfactions—are communicated to clients and obviously impact therapeutic success.

A simple and surprisingly effective method for prioritizing self-care is to make the calendar work for you. Schedule the activities that matter most to you on your calendar (Weiss, 2004). One of our master therapists told us that "I write down the consequential before the mundane in my schedule book. My lunches with friends, exercise times, and family events are there every month." Of course, putting something *into* your schedule typically means taking something *out* of your schedule. That active choice entails both pain and freedom.

Another master therapist described this approach to us: "In training new staff, one of the top 10 points I orient them on is to never schedule anything for me between 3 P.M. and 6 P.M. on Tuesday. That is MY time to refresh and reenergize. It is when I visit my chiropractor, get a massage, and sit in the sauna."

IN CLOSING

Celebrate the person of the therapist in general, and you in particular, friend. Where others fear to tread and run away, you plunge forward into the darkness in the service of others. We ask that all mental health professionals internalize portions of Walt Whitman's *Song of Myself* (1892): "I celebrate myself, and sing myself." Later, "I am large, I contain multitudes." And, we ardently hope: "I dote on myself, there is that lot of me and all so luscious." Without resorting to grandiosity, therapists perform godly work.

The goal is not simply to survive, but to thrive—in practice and as a psychotherapist (Pope & Vasquez, 2005). Not only to keep your nose above the waterline, but to swim naturally and joyfully.

Our goal leads us, curiously enough, to barely mention how to "avoid burnout" in this book. That would be equivalent to discussing how to avoid catching a cold, how to avoid a bad marriage, or how to avoid an automobile accident. Trying to avoid burnout, while noble in intent, is avoidant as a strategy, reflective of a psychopathology orientation, and negative in purpose. As one of our workshop participants wrote, "It was important to hear you refocus self-care away from the negative of avoiding burnout toward actually living well." Exactly so.

The goal is not simply to survive, but to thrive.

Our message is that it is far more productive to promote self-care. Sure, we can temporarily alleviate the distress of clinical work; but, more optimistically and proactively, we can value and grow the person of the psychotherapist.

SELF-CARE CHECKLIST

- ✓ Adhere to the ethical imperative of engaging in self-care to maintain and promote your emotional, physical, mental, and spiritual well-being to best meet your professional responsibilities.
- ✓ Ask your patients, if you have not done so recently, what has been most helpful in their psychotherapy. Take to heart their frequent compliments about your presence, affirmation, and support.
- ✓ Resist the pressures of managed care to define yourself as a nameless and disembodied "provider"; maintain your individual identity as a distinctive practitioner of psychological healing.
- ✓ Internalize the relational crux of the work. Yes, we conduct treatments to eradicate DSM disorders, but we also offer relationships that heal and strengthen people.
- ✓ Assess your deep motives for becoming a psychotherapist beyond the altruism of "to help people" and the idealism of "to improve the world." How are the selfism motives facilitating or hindering your effective self-care?
- ✓ Take a mindful moment to identify existing self-care activities you desire to continue; start from a position of strength and celebration about what's good.
- ✓ Prioritize your self-care: put specific times in your schedule to sharpen the saw.
- ✓ Develop self-empathy and self-compassion: the capacity to notice, value, and respond to your own needs as generously as you attend to the needs of clients.
- ✓ Practice what you preach to your clients about nourishing the self: avail yourself (when applicable) of what you provide or recommend to clients with similar needs.
- ✓ Embrace an integrative mix of effective self-care strategies (as opposed to relying on a single theoretical orientation).
- ✓ Avoid concentrating on a single self-care technique, and promote cognitive and experiential growth on a broad front. Do you rely on only one or two self-care methods?
- ✓ Assess your own self-care as you might a student's or a patient's self-care—on a weekly or monthly basis.
- ✓ Track your renewal by maintaining a journal, calendar, or behavioral log of activity.

- ✓ Complete structured questionnaires on resiliency, burnout, and self-care periodically to facilitate your self-awareness.
- ✓ Consider publicly posting your action plan to bolster your compliance and to model self-care to peers and patients.
- ✓ Contract for some honest feedback from significant others about your work-week, functioning, and self-care. Let others supplement and enhance your self-monitoring.
- ✓ Track the emotional residue you're taking home from your professional work.
- ✓ Put your consequential self-care activities in your schedule/calendar first thing every month. Literally schedule your self-care.
- ✓ Celebrate mental health professionals in general and you in particular!
- ✓ Alleviate the distress of conducting psychotherapy, to be sure, but also value and grow the person of the psychotherapist.

RECOMMENDED RESOURCES

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