Imparting Self-Care Practices to Therapists: What the Experts Recommend
Entrainer des pratiques d'auto-soin chez les thérapeutes : Recommandations des experts

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ABSTRACT

Therapist self-care has been lauded as a professional and ethical imperative. However, in education and in supervision, self-care themes are relegated to the realm of optional topics. Our objective was to discover what experts believed were the core hardships that should be brought forward in training courses or supervision, and how trainees or supervisees could be coached to develop self-care strategies in response to these challenges. The 26 experts sampled provided detailed responses to structured and open questions. Results indicate that there is agreement regarding the hazards involved in the profession of psychotherapy, that supervisors and educators address hazards through various mechanisms, but that the quest to incorporate self-care into standard academic programs is not unequivocal.

RÉSUMÉ

L'auto-soin est promu comme un impératif professionnel et déontologique pour les conseillers. Cependant, dans les activités d'éducation et de supervision, la thématique d'auto-soin demeure facultative. Le but de cette étude est d'identifier les difficultés clés, d'après les experts, qui doivent être incluses dans la formation et la supervision et d'explorer comment entrainer les stagiaires et les étudiants supervisés à développer des stratégies d'auto-soin pour répondre à ces défis. Vingt-six experts ont répondu en détail à un sondage comportant des questions structurées et ouvertes. Les résultats révèlent un consensus sur les difficultés typiques dans la profession de la psychothérapie et la variété de mécanismes employés par les superviseurs et les éducateurs pour les aborder. Toutefois, la mission d'intégrer l'auto-soin dans les programmes académiques traditionnels reste équivoque.

From unwanted intrusion to central agent of change, the appreciation for the role of the person of the psychotherapist in psychotherapy has shifted radically since the early 1900s. Whereas traditional psychoanalysis aimed for "optimal abstinence and relative anonymity" (Wolitzky, 2003, p. 48) in an effort to cleanse the therapy hour from therapist countertransference and sentiment (Freud, 1910), many current theoretical conceptualizations have come to value the working alliance and real relationship and encourage therapists to be transparent, self-

disclosing, spontaneous, and authentic (Lambert & Ogles, 2004; Rowan & Jacobs, 2002; Sussman, 2007).

Theoretical perspectives, such as social-constructivism, relational psychotherapy, and intersubjective models, view the therapist as a coparticipant in psychotherapy; therapist subjectivity, "including his or her assumptions, biases, concerns, motivations, and emotional conflicts" (Sussman, 2007, p. xviii), is consequential. In fact, we now estimate that the magnitude of therapeutic impact that is attributable to the therapist as a person is eight times greater than treatment technique (Lambert, 1989). Indeed, it is understood that therapist characteristics and the emergent therapeutic relationship are second only to client characteristics in terms of impact on psychotherapy process and outcome (Duncan, Miller, Wampold, & Hubble, 2010). It is no longer possible to mask the person and the contribution of the therapist: "Science and practice impressively converge on the conclusion that the person of the clinician is the locus of successful psychotherapy" (Norcross & Guy, 2007, p. 3).

Therapist well-being has thus emerged as a critical component of psychotherapy; it is considered by many theorists to be the foundation of their craft (Baldwin, 2000; Deutsch, 1985; Hackney & Cormier, 2005; Mahoney, 1991; Rogers, 1992, 2007). For example, Beutler, Machado, and Neufeldt (1994) reviewed 15 studies published between 1968 and 1991 and concluded that therapist emotional well-being was positively correlated with treatment benefit. Other studies have confirmed the link between therapist ways of being and positive outcome. A study of therapist effects in patient change reports that 28% of growth on scores relating to Global Assessment of Functioning (GAF) and 21% of changes measured by the Inventory of Personal Problems are attributable to therapist differences, including therapist difficulties in practice, interpersonal style, and relational skills (Nissen-Lie, Monsen, Ulleberg, & Ronnestad, 2013). Therapist difficulties would be a predictor of patient outcome.

It is not uncommon for therapists to suffer from emotional distress. Studies reveal that levels of self-reported personal distress among therapists can reach 74.3% (Guy, Poelstra, & Stark, 1989). Furthermore, 90% of therapists report that their emotional problems are directly related to their role as therapist (Guy, 1987). Clearly, while clinical work is rewarding, it extorts a high cost from the personal and professional functioning of the therapist (Guy, 2000; Mahoney, 1991; Norcross, 2000). Work-related distress has a range of consequences on the personal life of the therapist. Depression (Mahoney, 1991), stress (Shapiro, Astin, Bishop, & Cordova, 2005), burnout (Skovholt, Grier, & Hanson, 2001), suicide (Deutsch, 1985; Hannigan, Edwards, & Burnard, 2004), alcoholism, emotional depletion, physical isolation and psychic withdrawal (Laidig, 2007), and disturbed interpersonal relationships have been underscored among hazards that are related to the exercise of the "impossible profession" (Freud, 1937). On a professional level, therapist distress is linked to sexual involvement with clients (Remley & Herlihy, 2007), and can cause therapists to abandon their career prematurely (Thériault & Gazzola, 2008a).

Therapist distress is also thought to have an impact on therapeutic process; it can lead to alterations in the length of therapy and the timing of interventions (Strean, 1993), emotional detachment, loss of authenticity (Norcross, 2007), referrals (Loganbill, Hardy, & Delworth, 1982), disengagement and withdrawal in seasoned therapists (Thériault & Gazzola, 2006), and early terminations (Brady, Guy, Poelstra, & Brown, 1996; Piselli, Halgin, & MacEwan, 2011). Although distress does not necessarily lead to therapist impairment, a lack of attention to distress over time appears to make the link more likely (Barnett, Baker, Elman, & Schoener, 2007). Because therapist distress is linked to serious repercussions on therapists' personal lives and on the quality of the therapy they conduct, increased attention has been placed on the hazards and pitfalls of the profession and on the prevention of decline in therapist functioning. Consequently, self-care has become an ethical and educational imperative.

Therapist self-care is not merely a lofty ideal but is recognized in the psychotherapy profession as an ethical responsibility (Norcross & Guy, 2007); it behooves practitioners to recognize their struggles and to proactively take measures to prevent their struggles from contaminating their work. If the therapist's self is among the most important instruments for the work of therapy (Corey, 2005; Satir, 2000), then therapists must acknowledge and intervene when work-related experiences threaten to render this tool anything less than sharp. For example, the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 2000) explicitly requires that psychologists "engage in self-care activities that help to avoid conditions (e.g., burnout, addictions) that could result in impaired judgment and interfere with their ability to benefit and not harm others" (CPA, 2000, II.12, p. 16). Similarly, the Canadian Counselling and Psychotherapy Association (CCPA, 2007) Code of Ethics addresses personal care in its very first guideline under the heading of Professional Responsibility:

> *A1. General Responsibility:* Counsellors maintain high standards of professional competence and ethical behaviour, and recognize the need for continuing education and personal care in order to meet this responsibility. (CCPA, 2007, A1, p. 5)

The profession of psychotherapy has embraced therapist self-care as a valuable therapist activity, and it has become mandatory for ethical practice. Likewise, an impressive body of empirical literature has endorsed self-care as a legitimate enterprise for trainees, novices, and experienced psychotherapists. A plethora of accessible and practical documentation and recommendations have proliferated to guide therapists and trainees who are being (re)initiated to the hazards of our profession and are becoming cognizant of their self-care (Alves de Oliveira & Vandenberghe, 2009; Baird, 2014; Dryden & Reeves, 2008; Guy, 2000; Kottler, 2010, 2012; Norcross & Guy, 2007; Skovholt & Jennings, 2004; Skovholt & Trotter-Mathison, 2011; Yalom, 2009).

In sum, a convincing body of empirical, practical, and anecdotal literature endorses the assertion that there is "no real controversy over the importance of

maintaining one's health and mental health if one is to be an ethical practitioner" (Barnett et al., 2007, p. 611). What is conspicuously absent from the collective literary effort to put self-care at the forefront of counsellors' professional agendas are models for teaching about impairments and self-care to students and trainees. Despite longstanding calls for programmatic reform (Barnett et al., 2007; Brady et al., 1996; Elman, 2007; Farber & Heifetz, 1982; Mahoney, 1997; Schwebel & Coster, 1998), it appears that few training programs systematically address self-care issues in their curriculum, leaving most psychotherapists unprepared for the emotional demands and difficulties inherent in the work. For example, Munsey (2006) reported that 83% of graduate students of psychology disclosed that their training program offered no written materials on self-care. Likewise, in a study of emotional well-being and professional resiliency with 10 master therapists, Jennings and Skovholt (1999) revealed that participants retrospectively identified having felt hindered in their work by a lack of training and ensuing lack of awareness of the emotional demands of their work. Generally, self-care is left in the hands of the individual practitioner or trainee and at the discretion of professors and supervisors.

Our study begins at the juncture of the ethical, personal, and professional imperative of self-care and the relative unresponsiveness of training institutions to the need to prepare counsellors for the hazards of our profession. Our research question was as follows: *How can we impart self-care practices through education and supervision?* In order to contribute to the empirical base and to expand this underdeveloped domain, we sought the input of experts in the field of therapist self-care, education, and supervision. Our objective was to discover what experts believed were the core hardships that should be brought forward in training courses or supervision and how trainees or supervisees could be coached to develop self-care strategies in response to these in educational contexts and in supervision.

METHODOLOGY

Because our objective was to begin to establish self-care content areas that were deemed to be priorities by knowledgeable stakeholders as well as to introduce some mechanisms by which these self-care themes could be broached in courses and in supervision, we utilized a mixed-method approach. Using different methods for different inquiry components increased the scope of the inquiry and expanded the study's potential to respond to the research question (Greene, Caracelli, & Graham, 1989). To further enhance the program development aspect of our study, we utilized strategies inspired by Delphi poll methodology. The Delphi method was designed to capitalize on existing expertise and to develop future events or directions (Norcross, Hedges, & Prochaska, 2002) and, from a pragmatic standpoint, was a useful framework to help address our research question concisely. It was developed in the 1950s to conduct military research and, since then, well over 1,000 studies have utilized this method in a variety of fields, including mental health and psychotherapy (Neimeyer & Diamond, 2001). In addition to being economical

in terms of time and expense, the Delphi method is advantageous because it is an accurate means of gathering expert opinions that is critical in seminal work and program development. The Delphi method usually entails the construction of a questionnaire that is administered, interpreted, and then readministered to participants (in its interpreted form) for consensus. In our case, the findings were redistributed for confirmation and/or specification (member check) rather than for consensus. Because of this fundamental difference, we consider our study to fall under the rubric of mixed-methods rather than being a pure Delphi study. The mixed-method was a better prospect for the desired depth and nuance.

Mixed-Method Approach Inspired by the Delphi Poll Method

The study was conducted using a parallel mixed design (Teddlie & Tashakkori, 2012) that borrowed some strategies from the *double* Delphi method. A parallel mixed design is a mixed-method where both quantitative and qualitative data are collected simultaneously. We incorporated some key elements of the Delphi method into our mixed-method approach, namely, the use of an expert panel to craft the questionnaire, the use of an expert panel to respond to the questionnaire, and the use of questions that are oriented toward program development. Although these discrete elements of the Delphi method were retained, the traditional Delphi requires experts to revise their rankings in light of the aggregate response from other experts. The final response set then reflects the consensual ranking. Because we deliberately sought input from stakeholders with multiple perspectives and also performed a thematic analysis on the open-ended questions, we felt that seeking consensus was counterproductive and we opted to forego a second round of polling of this nature.

A web-based questionnaire with quantitative and qualitative questions was constructed with the help of a group of experts and conducted with another group of experts (the participants). The aim of the questionnaire was to elicit opinions regarding the priority of a variety of self-care issues and to obtain recommendations from selected experts regarding how to address them in education and supervision. Our second exchange with participants consisted of a member check, where the analyzed responses from the first questionnaire were mirrored and levels of agreement with the accuracy and representativeness of findings were determined.

Participants and Experts

Panel for the development of the questionnaire: Expert Group 1. Four counselling psychology researchers who teach and supervise students in a graduate counselling program were recruited to brainstorm, comment on, and rank in order of importance a series of questions that were drawn from an extensive literature review on the topics of therapist self-care and the challenges inherent in the psychotherapy profession. These were four professors with Ph.D.s in counselling psychology with an average of 6.25 years of tenured or tenure-track employment in a university setting (all from the same setting). In addition to being counsellor educators and supervisors themselves, all four were involved in research projects

pertaining to counsellor development (e.g., supervision, identity, and self-care). These experts gave feedback and recommendations based on their knowledge of the extant literature and their experience as counsellor educators and supervisors. The literature that we drew upon to propose potential questions and items for the questionnaire was practical, empirical, and theoretical and pertained to counsellor supervision, development, education, and self-care. The questionnaire was subsequently modified to reflect a consensus between the first two authors regarding how to integrate the feedback received from the four experts on this panel. The questionnaire was then piloted by a single administration of the instrument to a group of six graduate students who provided feedback on user friendliness and suggested modifications. Questions were also adapted for a web-based delivery model. In order to fine-tune the instrument, the web-based questionnaire was then piloted with five experts who were not part of the study's sample.

The respondent group: Expert Group 2. The sampling method used was purposive sampling: Respondents selected were those who could best provide meaningful input on the issues of psychotherapist self-care and hazards of the profession, as well as training and supervisory needs as they relate to these. To recruit respondents, invitations were sent to selected experts in counsellor supervision, education, and self-care drawn from the research, practice, and theoretical literature. The criteria for inclusion were (a) to have published books or peer-reviewed articles on counsellor self-care, education, or supervision; (b) to be actively involved in counsellor education at the graduate level or beyond; and (c) to be actively involved in counsellor supervision at the graduate level or beyond. It was felt that those immersed in the research, the literature, and the practice of educating and supervising counsellors would be the most knowledgeable regarding their self-care needs and the role of education and supervision in addressing these.

The list was drawn up by the first author after extensive research of related publications (i.e., supervision, education, and self-care) and public information found on counsellor and psychotherapy training institutions. A total of 160 invitations were electronically mailed to potential participants to addresses found in the public domain (e.g., online websites, noted in research articles). A reminder was sent to all invited participants approximately one month after the initial invitation was made. A total of 26 people responded to the first round (14 from Canada, 11 from the United States, and 1 from New Zealand). There were 13 female participants, 12 male participants, and 1 participant's gender was undeclared.

EDUCATIONAL BACKGROUND

Seventeen of the 26 participants reported that their highest level of education was a Ph.D., three indicated that it was an Ed. D., one held a Psy.D., two indicated having a M.Ed. degree, two had an M.D. degree, and one participant had an M.A.

EXPERIENCE/EMPLOYMENT

Participants' mean years of counselling experience was 21.77 (*SD* = 10.44), with 16 participants reporting that they had more than 20 years of counselling

experience. Additionally, 10 participants had more than 20 years of experience in teaching or training counselling students, 9 participants had more than 20 years of experience in supervising counselling students, 6 participants had more than 20 years of experience supervising counsellors, and 9 participants had more than 20 years of experience in conducting research in counsellor education, supervision, or self-care. Of the 26 respondents, 16 worked within a university department setting, 3 in private practice, 3 in medical settings, and 6 indicated other professional settings.

Questionnaire

Based on an extensive review of the literature and in consultancy with Expert Group 1, a questionnaire was constructed for web-based administration. The questionnaire comprised 10 sections that addressed the topic of self-care in education and supervision and included both scaled and open-ended items. All questions are described sequentially along with the results in the Results section.

Data Analysis

The scaled items were analyzed using measures of central tendency and standard deviations. Open questions were analyzed using structured thematic analysis as described by Braun and Clarke (2006).

Scaled item data analysis. The results of the online poll were analyzed by calculating the means and standard deviations for the scaled items (questions 1, 3, and 6). In questions 2 and 5, relative weights were assigned to items; overall ranks of items were assessed by assigning points to the items selected (three points for a first-ranked item, two points for a second-place item, and one point for a third-place item) and then taking the sum total for each item across all 26 completed questionnaires to determine overall ranks.

Qualitative data analysis. Questions 7 to 10 were open questions that invited a spontaneous verbal response. These verbatim were analyzed for thematic content using systematic thematic analysis (Braun & Clarke, 2006) that consisted of six steps:

1. The researcher becomes familiar with the data by transcribing and compiling verbal data.
2. The researcher identifies the most basic elemental codes, which are at a higher level of abstraction than the raw data and involve some interpretative and inductive work. The codes are then organized into meaningful groups called subcategories and categories.
3. Categories are grouped together under overarching themes.
4. Themes are then reviewed and amalgamated under grander themes that have a higher level of abstraction if this fits.
5. Themes and subthemes are defined and refined.
6. The thematic structure is crystallized and a report is written outlining the conceptual ordering along with examples.

TRUSTWORTHINESS

Measures were adopted to ensure the results were not reflective of bias stemming from the authors' own preconceived notions or expectations regarding the nature and valence of self-care issues. These measures were applied to increase the trustworthiness of our findings.

Auditor. An extra step was utilized in the analytic process. A complete audit was conducted by the second author who reviewed the verbatim, the codes, and the thematic tags ascribed during Steps 2, 3, and 4 for fit and parsimony.

Member check. A member-checking questionnaire was created, comprising the original questionnaire, the results found for each question, and a request for feedback. All of the original participants (respondents) were sent an e-mail inviting them to review the findings and to indicate their level of agreement with the results found for each question via a 5-point Likert scale (1 = *completely disagree* to 5 = *completely agree*). Participants were also provided space to write comments in response to each question's findings in order to expand upon their numerical feedback. Five of the 26 participants responded with feedback, which was used to clarify some contradictory findings (this will be elaborated in the summary section).

RESULTS

Results are presented on the 10 sections of the questionnaire. We will present the quantitative results first (questions 1 through 6), followed by the qualitative results.

Quantitative Results

The first question pertained to 10 difficulties identified in the literature as critical for both novice and experienced therapists. The experts were asked to indicate the level of importance of these difficulties on a 5-point Likert scale (1 = *unimportant* to 5 = *very important*) and were given space to include three additional difficulty items based upon their experience. The experts indicated that all 10 difficulties were important but these assigned them various degrees of importance (see Table 1). Nine of the 26 participants proposed original difficulties. The difficulties identified by experts over and above those provided in the questionnaire included professional identity (individual and collective), boundary violations/assertiveness, burnout, organizational stress, problems with consultations and referrals, administrative interference with clinical work, ethical dilemmas, competency, perfectionism, financial concerns, lack of mentor, and emotional intensity of the work.

In question 2, the participants were asked to select three difficulty items from the list provided in question 1 that they considered to be the most critical for novice and experienced therapists. They were then asked to rank them in order of importance from most important (1st rank) to least (3rd rank) (see Table 1).

Table 1

Mean Ratings and Ranked Level of Importance of Difficulties for Both Novice and Experienced Therapists (Questions 1 and 2)

Difficulty item	M	SD	Voted first	Voted second	Voted third	Total votes[a]	Relative weight
Feeling of incompetence and self-doubts about effectiveness	4.08	.845	7	4	3	14	32
Isolation	4.08	.891	4	3	2	9	20
Stress	3.92	.628	3	1	4	8	15
Emotional depletion	3.88	.993	3	1	2	6	13
Compassion fatigue	3.85	.967	1	4	2	7	13
Concerns about caseload	3.73	.667	0	2	2	4	6
Secondary trauma	3.46	1.174	2	2	3	7	13
Role ambiguity/role diffusion	3.46	.989	1	1	3	5	8
Disillusionment about work	3.46	.948	1	0	0	4	3
Disrupted personal relationships	3.35	1.056	0	3	1	6	7

Note. Mean response: 1 = *unimportant*, 3 = *moderately important*, 5 = *very important*.
[a]A first rank was given a weight of three points, a second rank vote two points, and a third rank vote one point.

The expert participants were then asked in question 3 to refer to their chosen top three difficulties, as determined in question 2, and to indicate the prevalence of these difficulties on a scale of 1 to 5 (1 = *not prevalent* to 5 = *very prevalent*). Means and standard deviations were calculated for the top three ranked items: Feeling of Incompetence and Self-Doubts about Effectiveness (M = 3.94, SD = .929), Isolation (M = 3.78, SD = .833), and Stress (M = 4.13, SD = 1.126). The high standard deviation values suggest that there were considerable differences of opinion in regard to the prevalence of each of these items. However, the data also suggest that while Feelings of Incompetence (FOI), Self-Doubts, and Isolation may be considered more important difficulties that novice and experienced therapists face, they are not considered as prevalent as Stress in the therapist population.

In the next set of items (question 4), the group of experts indicated their level of agreement with 12 statements on a scale of 1 (*strongly disagree*) to 4 (*strongly agree*). These questions covered the participants' level of comfort and their intentions to address role-related difficulties (as covered in the previous questions) in educational and supervision contexts. As can be seen in Table 2, the participants' responses tended to agree with the 12 statements, all reporting a mean of 3.15 or above (3 =

agree). However, the standard deviations indicate that there is some variability in the responses, particularly with regards to whether (a) self-care is one of the most important topics to cover in counsellor training, (b) the participants frequently observe students or supervisees struggling with FOI, (c) the participants regularly address FOI in their classes or in supervision, and (d) Isolation or Stress should be systematically addressed in supervision. It should be noted that the means and standard deviations for items 4.7 to 4.12 were calculated using a subsample of the Delphi participants. For these items we used only the responses from those participants that had identified FOI (*n* = 14), Isolation (*n* = 9), or Stress (*n* = 8) among the top three difficulties experienced by therapists (from question 2).

Table 2

Experts' Level of Agreement with Incorporating FOI and Self-Care into Their Educational and Supervision Practice (Question 4)

Statements	M	SD
In view of the theoretical course work and internship experience that students will have, I believe self-care is among the most important topics to cover	3.15	.675
I frequently observe students or supervisees struggling with feelings of incompetence	3.31	.618
I frequently observe students or supervisees struggling with #1, 2, or 3 as selected in previous section[a]	3.15	.881
I regularly address FOI in class or supervision	3.15	.613
I am mindful of both the rewards and the hazards of the counselling and psychotherapy profession	3.65	.485
I am comfortable processing issues related to FOI and self-care with students and supervisees	3.73	.533
I think #1 selected in the previous section (FOI) should be included in a therapist self-care teaching module[b]	3.69	.480
I think #2 above (Isolation) should be included in a therapist self-care teaching module[b]	3.50	.480
I think #3 above (Stress) should be included in a therapist self-care teaching module[b]	3.62	.463
I think #1 above (FOI) should be systematically addressed during supervision[b]	3.57	.514
I think #2 above (Isolation) should systematically addressed during supervision[b]	3.25	.886
I think #3 above (Stress) should systematically addressed during supervision	3.62	.744

Note: Mean response: 1 = *strongly disagree*, 4 = *strongly agree*.
[a]Score represents an overall mean for all participants, with no differentiation between responses for #1, 2, or 3. [b]Scores are calculated from subsamples within our group of participants, FOI (*n* = 14), Isolation (*n* = 9), and Stress (*n* = 8).

Similar to the item "I frequently observe students or supervisees struggling with feelings of incompetence," the next item asked participants to comment on whether "I frequently observe students or supervisees struggling with item number 1, 2, or 3 as selected in previous section." For this item we calculated a mean response of 3.15 (SD = .881) for the entire participant sample. Because each participant brought forward a different set of three difficulties that they had identified as top priorities in question 2, the participants did not evaluate the same three difficulties in this item; however, the results here suggest that some of the participants did perceive their students and supervisees as struggling.

Clearer agreement was found for the statements "I am mindful of both the rewards and the hazards of the counselling and psychotherapy profession" (M = 3.65, SD = .485) and "I am comfortable processing issues related to FOI and self-care with students and supervisees" (M = 3.72, SD = .533). Both of these items had a full participant response sample. These and the above results suggest that while not all participants are actively teaching or bringing up topics of FOI and self-care, they do feel able to assist students and supervisees if these topics arise.

Question 5 included 10 items that outlined possible coping mechanisms to deal with the stresses of counselling that were distilled from a review of the literature. Similar to question 1, participants were asked to rank the level of importance on a 5-point Likert scale (see Table 3).

Table 3

Mean Ratings and Ranked Level of Importance/Usefulness of Coping Mechanisms for Counsellors' Facing Daily Challenges Related to Self-Care or Feelings of Incompetence (Question 5)

Coping mechanism	M	SD	Voted first	Voted second	Voted third	Total votes[a]	Relative weight
Seeking emotional support (e.g., family, friends, therapists)	4.50	.648	4	6	2	12	26
Engaging in professional supervision	4.50	.707	6	2	2	10	24
Engaging in peer supervision	4.48	.714	2	5	2	9	18
Being mindful of physical health and well-being (e.g., healthy lifestyle)	4.42	.703	3	1	4	8	15
Respecting own limits	4.27	.667	3	1	1	5	12
Balancing institutional commitments and expectations (workload)	4.19	.634	0	2	3	5	7
Developing knowledge of self-care resources	4.12	.909	0	0	1	1	1
Attending professional development seminars	3.92	.977	1	2	3	6	10
Reading literature on psychotherapy	3.88	.816	1	0	3	4	6
Performing relaxation exercises	3.19	.981	0	0	1	1	1

Note. Mean response: 1 = *unimportant*, 3 = *moderately important*, 5 = *very important*.
[a]A first rank was given a weight of three points, a second rank vote two points, and a third rank vote one point.

As in question 1, participants were given the opportunity to add (and rank the importance of) three additional items if they felt we had missed any significant coping mechanisms. Of the 26 participants, 10 utilized one or more of the optional write-in categories and provided the following strategies for coping with the stresses of therapeutic work: personal therapy; cultivating non-work-related passions, interests, and relationships; peer support and consultation; mentor support; having a holistic view of well-being; limiting scope of practice if impacted by personal life events; self-management and self-talk; maintaining good work and personal life boundaries; and taking measures to lead a rewarding and satisfying life with meaningful relationships.

The participants were then asked in question 6 to select the three coping items that, in their opinion, are the most useful for counsellors facing daily challenges related to self-care or feelings of incompetence and to rank them in order of importance from most important (*1*) to least (*3*) (see Table 3). These rankings turned out to be very similar to the mean scores.

Qualitative Results

Questions 7 to 10 were open-ended, qualitative questions that invited experts to produce original responses to queries. These responses were then analyzed using a structured and systematic thematic analysis procedure (Braun & Clarke, 2006).

Question 7 asked the experts to describe in concrete terms how they would address the difficulties earlier identified as critical (prevalent difficulties as identified in question 2). When queried as to how they would recommend addressing self-care topics in educational and supervisory settings, our respondents provided an array of responses for the following topics: isolation, compassion fatigue, secondary trauma, professional identity, feelings of incompetence and self-doubts, emotional depletion, disrupted personal relationships, role ambiguity/diffusion, stress, concerns about caseload, administrative interference in practice, disillusionment about work, competence, lack of mentor, and maintaining ethical standards (see Table 4). A myriad of exercises and activities were proposed to introduce, coach, expose, and guide students through self-care material. The methods of delivery proposed included didactic approaches, experiential approaches, exploration and discussion in class and in supervision, peer support/supervision, assignments, reflecting teams, informal discussions, and formal seminars. Most respondents recommended a multimodal approach: the use of several activities that broaches the self-care topic from different angles or lenses. Generally, the experts converged on the need to broach self-care topics through the use of theoretical literature, empirical literature, formal and informal exchanges, and self-exploration. The timing and duration suggested for self-care-related activities varied across and within self-care themes. Many advised that issues should be embedded throughout the training program while others proposed a very specific timeframe. For example, one expert thought that the topic of emotional depletion should be addressed for one hour during the ethics course specifically. In terms of specific activities recommended, some were proposed frequently while others were creative and unique. The more com-

mon recommendations included professor self-disclosure, review of the literature, case presentations, assigned readings and tasks, guided group exploration and facilitated discussions, and brainstorming and self-reflection exercises. Examples of unique activities were collaborative learning projects, making concrete preventative and remedial self-care plans with individual students, and making a checklist of common concerns in class. The tone of responses seemed to indicate that the experts expected educators and supervisors to be cognizant of self-care issues and deliberate in broaching the topic with students and supervisees. The terms guide, initiate, introduce, model, mentor, and facilitate were used throughout the responses provided to underscore the leadership role to be assumed by the educator or supervisor regarding self-care.

Question 8 was an open question that asked the experts to underscore what privileged knowledge they believed should be shared with forthcoming therapists. The structured thematic analysis yielded six themes that synthesized our experts' hypothetical advice to novices: (a) professional development throughout career,

Table 4

Categorized Responses Describing Most Useful Things New Therapists Need to Be Made Aware of as They Become Therapists (Question 8)

Category	Subcategory
Continue to attend to professional development throughout career	1. Continue to develop competency/Continuing education 2. Lifelong supervision/lifelong learning 3. Accurate self-assessment 4. Peer consultation/supervision 5. Learn from elders
Self-care	1. Time management 2. Boundaries—dual role 3. Avoid isolation 4. Realistic expectations: set boundary for who is responsible for change
Therapist know thyself	1. Self-awareness 2. Strengths & weaknesses 3. Be mindful of your motives—unsatisfied personal needs 4. Values and talents 5. Counter-transference
Count on necessary & core conditions for client growth	1. Genuineness 2. Warmth 3. Empathy 4. Respect 5. Curiosity 6. Compassion
Normalization of FOI	1. FOI ≠ actual incompetence 2. All therapists have self-doubts 3. You are taught a breadth of material—can't know it all 4. FOI are normal and healthy. It means you are paying attention.
Good theory	

(b) attend to self-care, (c) therapist know thyself, (d) necessary and core conditions for client growth, (e) normalization of FOI, and (f) basing one's practice on good theory (see codes in Table 4).

Professional development throughout career. Respondents strongly endorsed the notion of actively pursuing opportunities for continued professional growth. Examples that were offered included lifelong supervision, continuing education, learning from elders, and peer consultation.

Attend to self-care. This category gathers recommendations regarding what new therapists can do to protect and maintain their well-being such as having realistic expectations, avoiding isolation, maintaining healthy boundaries with clients, and time management. Included in the expert comments was speculation regarding the consequences of ignoring self-care such as the following:

> That they are human beings with all the same vulnerabilities, issues, needs, and difficulties as the clients they treat. That they must practice ongoing self-care actively or else they are likely to develop difficulties that will result in impaired professional competence over time.

Therapist know thyself. This category speaks to self-knowledge regarding personal characteristics as well as self-awareness and countertransference. Several experts underscored the desirability for therapists to be mindful of their motives for being therapists. They warned about the potential interference of unsatisfied personal needs and dangers inherent in a misguided quest for a "self-cure." One expert wrote:

> If therapists are not aware of their own issues, these issues can drive interventions with clients, which is unethical. Therapists cannot practice therapy for their own healing. Therapists need to be in the mental health profession for the right reasons—more and more people seem to be entering the field to fulfill unhealthy needs they have.

Necessary and core conditions for client growth. Experts located the essential elements of therapy as residing in the therapists' way of being: genuineness, warmth, empathy, respect, compassion, and curiosity. In terms of power to effectuate change and growth, this fundamental precept was highlighted as critical and primordial over and above technique and theory. Experts encouraged novices to remind themselves of the centrality of these conditions when self-doubts threatened to overcome them. One expert stated, "Genuineness, warmth, and empathy are the core of effective care." Another expert shared, "There is no one true path, and one can't usually go too wrong if they orient with respect, curiosity, and compassion."

Normalization of feeling of self-doubt and incompetence. Experts proffered reassurance to would-be novices to make it acceptable for them to not "know it all." A distinction was made between feeling of self-doubts or of incompetence and actual incompetence. One expert shared, "Everyone is scared and overwhelmed when they start out, but you know more than you realize you know, and the panic will pass."

The value of good theory. This is a stand-alone category (no subcategories) because it was selected for its meaning, value, and insight. It refers to grounding one's practice in a solid theoretical framework. Though endorsed by few participants, it resonated with the researchers and was retained.

Question 9 asked for recommended teaching or supervisory techniques to address profession-related stress and self-doubts. A number of techniques and ways of addressing stressful aspects of counselling and psychotherapy in learning and supervisory environments were proposed by participant experts (see Table 5). These techniques, methods, procedures, and exercises were analyzed for themes along learning their objective. Four main learning objectives emerged from the dozens of examples provided: (a) exposure and normalization, (b) informing, (c) raising awareness, and (d) processing.

Exposure and normalization. The techniques under this rubric allowed students to witness others struggle and deal with work-related stresses either directly, as in hearing a panel of experienced therapists examine their struggles publicly, or indirectly, as in relevant case studies. The techniques introduced students to role-related struggles, their own and others, and allowed them to explore and ostensibly accept this aspect of the profession. As one expert shared,

Table 5

Recommended Techniques to Address Professional Stresses (Question 9)

Category	Subcategory
Exposure & normalization	1. Modeling / role modeling 2. Case studies/histories 3. Supervisor interpersonal process recall 4. Panel of experienced therapists disclose/discuss in presence of novices 5. Supervisor self-disclosure of FOI & other struggles 6. Small group, student led exploration
Inform	1. Name it for the student 2. Present students with a map for gaining feelings of competency – direct teaching and coaching 3. Refer to the literature / assign readings 4. Professor initiated discussion in class 5. Direct preparation – expect ambiguity & FOI
Raise awareness	1. Kagan's IPR to access inner world of supervisee 2. Thought listing exercise to track identity development over time 3. Reflecting team 4. Compassion fatigue test 5. Counter-transference work: locate unconscious motivations for type of work to help manage counter-transferential reactions to lack of therapeutic success
Process	1. Scripted role playing 2. Therapeutic writing 3. Ask students to address in practicum 4. Name it and discuss

I recommend that professors and supervisors self-disclose how frightened and overwhelmed they felt when they first started out. I also self-disclose my ongoing struggles so that they know that some occasional need for guidance and/or lack of confidence is normal, even once you are highly experienced.

Informing. The gist of this theme was the need for the professor or supervisor to assume leadership in demystifying the issue of work-related stresses. Experts converged on the opinion that the responsibility of broaching the topic of struggles and feelings of self-doubt lay with the professor and/or supervisor. Direct methods of imparting knowledge regarding these struggles were preferred, such as naming, assigning readings, and preparing students for pitfalls by telling them about the more difficult aspects of the work (e.g., ambiguity and FOI).

Raising awareness. This category gathered techniques where the objective was to promote introspection, insight, and a deeper awareness of the internal experience of self in the role of therapist. For example, one expert suggested the use of Kagan's Interpersonal Process Recall technique in supervision. The use of tape-assisted recall and prompts to explore the inner world of supervisees as they conduct their session would presumably allow them to access their internal process in a meaningful way; by witnessing an actual behaviour sample, the supervisees' description of their inner processes would thus be enhanced, accurate, and grounded.

Processing. These recommended exercises had in common the objective of giving students tools and providing them with opportunities to work through their struggles and self-doubts. Offering students the opportunity to encounter, acknowledge, name, feel, discuss, share, and accept their struggles and difficulties was seen by our experts as both corrective and preventative of further hardships. One expert recommended, "Using case studies of actual therapists struggling with professional competence as [a] prevention tool. For example, what if you found yourself in this situation, what would you do?"

In question 10, we asked our experts whether we had omitted important elements of self-care in our queries. Seventeen of the 26 respondents provided a range of answers. Most responses were congratulatory and expressed curiosity about the results. Several raised concerns regarding the potential overlap between feeling incompetent and incompetent behaviour. There was some admonition to avoid disqualifying the potential need to refer or to seek professional development for one's professional shortcomings. As one participant stated, there may be times when "we have to be careful not to just boost confidence but rather boost competence."

DISCUSSION

Clever, creative, and sound work is being conducted in the field of self-care. There were numerous examples of innovative knowledge mobilization in the responses to our questionnaire. The 26 participants generally concurred with the proffered stresses and hazards of the psychotherapeutic profession that had been drawn from the literature and proposed more items for the list. For example, the

experts agreed that feelings of incompetence and self-doubt were prominent, as suggested by Thériault and Gazzola (2006, 2008a). They also recognized that isolation (Laidig, 2007) and stress (Shapiro et al., 2005) were common.

The experts also strongly endorsed therapist-initiated coping mechanisms and self-care activities such as seeking emotional support from friends and family, engaging in professional and peer supervision, being mindful of physical health and well-being, and respecting one's own limits. They offered nuggets of wisdom to incite beginning counsellors to attend to professional development throughout their careers, to know themselves well, and to actively attend to self-care. Furthermore, the participants offered a plethora of recommendations and examples regarding self-care activities that could be conducted in a graduate course and during supervision. The techniques recommended to supervisors and educators support exposure and normalization of stresses, promote the direct provision of information regarding the hazards of the profession and self-care manoeuvres, and provide mechanisms to raise self-awareness and tools to assist in processing self-care issues in educational and supervisory environments. Popular recommendations were professor self-disclosure, review of the literature, case presentations, assigned readings and tasks, guided group exploration and facilitated discussions, and brainstorming and self-reflection exercises. In sum, experts were prolific and unified in the recommended self-care teaching and supervision related content and process. Opinions appear more ambivalent about the necessity for self-care training to be assumed by institutions.

Williams, Richardson, Moore, Eubanks Gambrel, & Keeling (2010) state that the "importance of practicing conscious and purposeful self-care is our ethical duty if we are to remain capable of providing the best treatment possible to our clients" (p. 322). Self-care is an ethical imperative for counsellors (Bradley, Whisenhunt, Adamson, & Kress, 2013). Increasingly, counsellor education programs have been called upon to incorporate self-care practices into their curricula. For instance, since 2009 the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) has made it mandatory for accredited programs to integrate self-care education into their counselling curriculum (see CACREP, 2009). However, our group of experts were somewhat lukewarm in their endorsement of self-care within educational systems, suggesting that perhaps the responsibility for ensuring self-care remains with the individual counsellor. Although it is difficult to account for this suggestion given the growing accreditation demands on programs, we speculate that it may be due to the fact that these calls for infusing self-care in the counselling curriculum are relatively recent. This counterintuitive result is discussed in the section summarizing member check feedback below. Other perplexing and perhaps confounding events are given voice through the participants' invaluable feedback.

The five participants that responded to the member check query provided some thought-provoking comments and some valuable insights that help elucidate our results. One participant remarked on the relative preference for "self-help" type of self-care activities endorsed by our participants (questions 5 and 6). This favouring

of student-led self-care made the participant wonder if "students are on their own" when learning to navigate the difficulties of the psychotherapy profession. These results may indicate that our experts believe self-care is an individual therapist's responsibility and does not fall under the purview of counsellor/psychotherapist education. This interpretation would explain the lukewarm endorsement of items pertaining to the role of education and supervision in self-care. For example, in response to the query, "In view of the theoretical coursework and internship experience that students will have, I believe self-care is among the most important topics to cover (in educational program)," participants collectively rated the importance as 3.15. Other items that tapped into the role of education in self-care yielded similar results. The calls for programmatic reform to include self-care as standard fare in academia did not resound with our panel (Barnett et al., 2007; Brady et al., 1996; Elman, 2007; Farber & Heifetz, 1982; Mahoney, 1991; Schwebel & Coster, 1998).

Two participants underscored that the therapist difficulties identified in question 1 may not be independent of each other. That is, there may be a sequential process where, for example, one experiences stress, then feelings of incompetence followed by isolation. Alternatively, it is possible that several of these difficulties are interrelated and could be subsumed under a higher order factor (ostensibly as a result of factor analysis). That would explain the low variability across difficulties. As such, rank ordering may not provide the most illuminating information, and future studies that focus on the interrelationships and overlap between difficulties would be helpful.

Implications for Practice

At this point we can clearly speak to the hazards and difficulties that experts propose as priorities. We have confirmed a set of coping mechanisms that the experts identify as effective self-care strategies. We also recognize that experts concur as to the learning objectives when teaching self-care. These results provide a cogent and empirical base for counsellor educators and supervisors who want to initiate an exploration into self-care with their students and supervisees. Our experts have provided recommendations on content (which hazards and difficulties to address, the coping mechanisms to privilege) and on process (what the objectives could be as well as how to broach these topics).

What remains ambivalent is the issue of ownership, who owns the responsibility of imparting self-care knowledge and practices. While we had expected our experts to clamour for systematic, programmatic coverage of this topic, that fervour was not manifested. Perhaps this is due to the perception of self-care as a personal rather than a professional issue. Because of the relatively mediocre level of enthusiasm for locating self-care within graduate programs, implementing standard self-care programs is not likely in the near future. That aspect of professional development may continue to be broached at the professor's or supervisor's discretion. Alternately, it may be incumbent on professional associations and colleges to assume leadership in providing self-care training activities and incentives for therapists.

Implications for Future Research

The issue of ownership stands out as an area that warrants additional probing. Further clarification regarding which is the best venue and who ought to assume the lead in imparting self-care practices to counsellors is undetermined at this time. A focal interview-based study with key stakeholders could provide insight into how to mobilize the self-care knowledge gained through the study. Another intriguing area of future research directions underscored in this study is the relative role/responsibility of professional associations in providing guidance in the area of therapist self-care. An inquiry into the potential contribution of professional associations from the perspective of their representatives could outline an alternative route beyond education and supervision for the imparting of self-care knowledge and practices to therapists.

<div align="center">LIMITATIONS</div>

Our study suffers from three main limitations. The first limitation was in the time lapse between the first and second exchange with the participant experts. More than a year had elapsed between the first round and the member check, and this may have led to experts' loss of interest in the study. This leads us directly to the second weakness, which is the rate of response to the member checking strategy used to enhance credibility and trustworthiness. We obtained 5 responses from the 26 participants approached. These responses brought nuance to our interpretations and offered novel explanations for some key findings (see discussion). However, when responses to a member check are sparse, it is impossible to know "what valuable data for achieving credibility is missed" (Goldblatt, Karnieli-Miller, & Neumann, 2011, p. 392). Third, although the construction of the instrument was guided by the literature, the items contained on the measure in no way exhaust the population of self-care themes and perspectives. While we conducted a thorough literature review and requested input from knowledgeable collaborators during the construction of the questionnaire (Expert Group 1), we may have overlooked some materials. In order to temper this limitation, we provided ample opportunity for participants to add items for consideration (i.e., fill-in blank spaces in questionnaire). Those elicited responses were indeed varied.

Despite these limitations, our study stands as a positive endorsement for the importance of self-care while underscoring the dilemma of ownership. Although experts collectively recognize the nature and importance of the hazards of being a therapist, there is still a measure of ambivalence regarding the role of educators in adopting self-care teaching functions on a practical level.

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