3

Recognizing the Hazards

> Don't let anyone tell you different: Psychotherapy is one of the most taxing endeavors known to mankind . . . there's nothing that compares to confronting human misery, hour after hour, and bearing the responsibility for easing that misery using only one's mind and mouth.
>
> —Jonathan Kellerman (1985, p. 15)

Let us begin by saying it aloud: practicing psychotherapy is often a demanding and grueling enterprise. In *Analysis Terminable and Interminable,* Freud (1937/1964b) correctly characterized it as an "impossible" profession (along with education and government). The lack and uncertainty of therapeutic success is typically cited as the single most stressful feature of conducting therapy. Almost 75% of practitioners highlight it as a significant hazard (Farber & Heifetz, 1982).

Mental health professionals are regularly engulfed by their clients' pain and disability, are routinely confronted by conscious and unconscious hostility, and are ethically bound to secrecy about the most troubling confessions and occasionally the most heinous of crimes. All of this is accomplished under unremitting pressure in frequently less-than-humane working conditions with interpersonally disturbed (and disturbing) patients. Emotional depletion, physical isolation, and psychic withdrawal seem natural responses. Throw in the inescapable disruptions to our personal lives and one is tempted to accept the dramatic assertion that "If we ever really considered the possible risks in getting involved with a client, we would not do so for any price. Never mind that we will catch their colds and flus, what about their pessimism, negativity, and psychopathology?" (Kottler, 1986, p. 8).

Psychotherapist self-care begins with recognizing and preparing for the inevitable hazards of the undertaking. Understanding its various liabilities demystifies the process and enables us to effectively cope with its downside. Those who understand the etiology and impact of these liabilities are most effective in minimizing their negative consequences, and thus more successfully "leave it at the office" at the end of a long workday.

In the past two decades, a large amount of research has been published on the stressors and strains of the helping professions. This chapter could have easily deteriorated, if we were not vigilant, into an entire book of its own. The research is less likely now to assess generic hazards of all psychotherapists, as that has been done many times, so as the literature matures, the studies concentrate on risks associated with particular employment settings (e.g., correctional facilities, substance abuse centers), specific clinical populations (e.g., trauma survivors, political refugees), and practitioner characteristics (e.g., bilingual Latina/o, early career professionals).

Incidentally, the lower levels of burnout among Latino bilingual therapists compared to most therapists may be explained by the deep pride in, and connection to, their ethnic and cultural identities in providing treatment in Spanish (Teran et al., 2017). Our larger point is to encourage you to search the web for research studies on practice hazards that address your distinctive professional and personal identities.

Table 3.1 offers a summary of the most prominent hazards associated with clinical work. This nonexhaustive list of stressors is culled from the vast literature on the topic, which interestingly enough is at least twice the size of the literature on the benefits of clinical work. Please minimize your exposure to this frightening list, lest you stare at it for hours and put in for early retirement! In truth, we believe a little stress inoculation proves effective, and, in any case, we will not get to all of the items in the listing.

In this chapter we have set for ourselves the ambitious task of summarizing the vast literature on psychotherapist stress and extracting its recurrent themes. Our integration begins by reviewing six overlapping burdens rooted in practice itself—physical isolation, emotional isolation, patient behaviors, working conditions, therapeutic relationships, and the industrialization of mental health—and then a series of interactive hazards centered on the person of the psychotherapist—motivations for becoming a therapist, the fusion of work stress and therapist personality, and intercurrent life events. We conclude with multiple methods to anticipate, minimize, and, when necessary, accept these hazards.

PHYSICAL ISOLATION

Few rookies are prepared for the gnawing effects of physical isolation on their inner world. The need for complete privacy with no interruptions is simply

TABLE 3.1. Prominent Hazards Encountered in Conducting Psychotherapy

Patient behaviors

Hostile transference
Suicidal statements and attempts
Anger toward therapist
Severe depression
Apathy, lack of motivation
Premature termination
Passive–aggressive behavior
Being sued for malpractice
Ethics or licensing complaint
Patient violence (threats, assaults, attacks)
Terminally ill patients
Intense resistance
Severe psychopathology

Working conditions

Organizational politics
Managed care
Onerous paperwork
Excessive workload
Scheduling constraints
Work overinvolvement
High expectations with low control
Compliance with excessive rules and regulations
Exclusion from administrative decisions
Low salary
Paucity of clerical/administrative support
Time pressures and deadlines
Colleague misbehavior
Resistance to new ideas in agencies

Emotional depletion

Boredom and monotony of work
Physical exhaustion/fatigue
Difficulty leaving "psychodynamics" at the office
Inevitable need to relinquish patients
Identifying with the patient's pathology
Compassion fatigue/secondary traumatization
Repeated emotional strain
Paucity of therapeutic success
Doubts about career choice
Activation of preexisting psychopathology

Psychic isolation

Professional competition
Maintaining confidentiality
Withholding personal information
Setting aside personal concerns
One-way intimacy
Controlling emotions
Idealization and omnipotence
Devaluation and attack
Public perceptions
Physical isolation from the world and colleagues
Bodily inactivity and fatigue

Therapeutic relationships

Responsibility for patients
Difficulty in working with disturbed patients
Lack of gratitude from patients
Countertransferential feelings
Developing a pathological orientation
Loss of authenticity in relating with clients
Constraints of the "50-minute hour"

Personal disruptions

Financial concerns
Illness and disability
Aging and retirement
Death of loved one or family member
Divorce
Marriage
Pregnancy
Parenthood
Relocation
Departure of children
Terminal illness

Miscellaneous stressors

Idealistic criteria for client treatment outcome
Difficulty in evaluating progress
Doubts about the efficacy of psychotherapy
Public stigma against mental disorders

accepted as a requirement for conducting psychotherapy's private journey and in-depth exploration. But, necessary as it may be, isolation comes at a price. The paradox of being so alone in the midst of this most intimate of interpersonal encounters is perhaps one of the least understood hazards of psychotherapy (Guy & Liaboe, 1986; Hellman et al., 1986).

In contrast to the camaraderie characteristic of clinical training, the practice of psychotherapy over the course of a career is a solitary task. While some participate in treatment teams and cotherapy, most clinicians are forced by the economics of time and money to go it alone. Treatment is typically provided by a single therapist who works throughout the day in consecutive sessions with minimal contact with nonpatients and interspersed with only occasional breaks. For those working in hospital or clinic environments, group meetings, grand rounds, and in-service workshops provide interruptions and movement. For those in private practice, even when associated with a larger group, there are few breaks in the physical isolation of the typical workday. It comes as no surprise that isolation is a leading complaint of experienced independent practitioners (Tryon, 1983).

It logically follows that physical isolation from friends and family also characterizes the practice of psychotherapy. We all know that practitioners cannot be reached during a therapy session. Some have joked that even God cannot reach the dedicated clinician without an appointment! Although access may be gained in an emergency, the more serendipitous, casual contacts by friends and family during a workday prove limited. Visitors cannot stop by for an unscheduled greeting or lunch. Friends cannot call during sessions to share a few minutes of contact.

Even more unusual is the deficient access to news of daily local, national, and international events. Since our primary or exclusive interpersonal contact is limited to patients, it is possible to remain uninformed of recent events. Unless a client announces an assassination, military initiative, or natural catastrophe, it may be hours before we learn of a major event. One of our master therapists related the following illustrative story:

> "I had a full schedule of consecutive clients on the day that the United Nations forces attacked Iraq. I had no idea what had happened until several hours later, when a client mentioned it as she walked in for her session with a television in hand for us both to watch. Needless to say, I was surprised at her news, and I had to smile at the irony that my three previous clients had not thought it was appropriate, or a good use of their time, to inform me that U.S. military forces had attacked another country!"

Other therapists report similar experiences related to 9/11.

Such occurrences are the rule: what happens in the world outside of the office is oddly separate from the world inside the therapy session.

The isolation of the consulting room and the paucity of physical movement can lead to environmental deprivation. Therapists report struggling with sleepiness or recurrent daydreams while trying to concentrate on clinical material. Even the content of the sessions themselves can develop a numbing similarity, causing a mental dullness to creep in during a long day. Therapists may begin to treat all clients in parallel ways using similar techniques and similar words. Eventually, the authenticity and creativity of the therapist become circumscribed (Freudenberger & Robbins, 1979). The result is a clinician who fulfills her role mechanically, producing a sense of boredom and monotony.

Conducting a therapy session involves relatively little physical activity. Most therapists sit for 6 or more hours a day in the same chair and room, rendering them physically exhausted from immobilization (Will, 1979). We rarely walk, stretch, or exercise. The research indicates that those who do not take time out from their busy schedules to exercise and participate in outside activities are more likely to suffer from physical fatigue and emotional exhaustion (e.g., Hoeksema et al., 1993).

The isolation of the consulting room can lead to environmental deprivation.

EMOTIONAL ISOLATION

Unfortunately, therapist isolation is not limited to the physical realm. The isolation pervades our psyches. Despite the intense relational contact of psychotherapy, many practitioners feel alone emotionally. One representative study (Thoreson et al., 1989) revealed that 8% of the psychologists reported significant distress due to recurrent feelings of loneliness.

The exclusive focus on our patients' psychological world leaves little room for the expression of the clinician's feelings and needs, particularly as they relate to her life. The role of the psychotherapist requires a self-imposed limitation on self-disclosure. The criterion becomes "what's in the best interests of the client." Even in the most active treatments, clinicians exercise considerable restraint in keeping their feelings hidden. We, as clinicians, set aside the personal concerns of the day, such as disputes with loved ones, financial problems, or even an upset stomach, in order to focus on the client—even when our own worries seem more serious than the patient's.

We need to mute or restrain feelings in the name of competent treatment. And mental health professionals do experience strong emotions in their work: in one study, approximately 80% of therapists experienced fear, anger, and sexual feelings in the context of their work (Pope & Tabachnick, 1993). The constant emotional regulation segregates the therapist from others and possibly from her own feelings.

Patients' reactions to the clinician compound the psychic isolation (Freudenberger, 1990a). For example, clients who overly idealize the therapist leave us feeling burdened with unrealistic expectations. Even worse, some of us accept this client idealization as warranted, leading to a sense of grandiosity that removes us further from our authentic true feelings. In other cases, devaluing and attacking the therapist can result in us feeling discouraged, humiliated, or rejected. In fact, competent treatment may require that we absorb these projections rather than defend against them.

The ethical and legal requirements of confidentiality result in a tendency for psychotherapists to split off the emotional impact of their work from the rest of life (Spiegel, 1990). The confidentiality requirement impedes us from sharing clinical details with family and friends and fully using their support except in limited instances (Tamura et al., 1994). To avoid inadvertent domestic violations of confidentiality, practitioners must closely monitor venting of frustration or sharing of a therapeutic success (Spiegel, 1990).

Such secrecy conflicts with the need for open communication among family members (Kaslow & Schulman, 1987). The family may perceive confidentiality as a rule that shuts them out from the therapist's world, engendering jealousy and resentment from those who might otherwise help ease the isolation. Is there a psychotherapist alive who has not experienced the disheartening duplicity of one moment being the attentive, empathic psychotherapist and the next moment the tired, preoccupied family member (Brady, Norcross, & Guy, 1995)?

All these factors contribute to the "one-way" intimacy of conducting psychotherapy. The client is asked to share him- or herself in great detail, while the clinician responds with little disclosure; true mutuality is lacking. Often the seasoned veteran has no one with whom to share meaningful moments from the private journey of a psychotherapy client. Therapists wind up habitually suppressing intense feelings, leaving them unprocessed and unresolved.

Since the treatment contract requires that the relationship eventually end, psychotherapists say repeated good-byes to individuals they have come to value. The cumulative effects of these terminations on psychotherapists are a cascade of emotional losses and partial mournings (e.g., Guy et al., 1993; Norcross, Zimmerman, et al., 2017). Letting go of these meaningful relationships can prove challenging, particularly when they have been the source of considerable satisfaction (Brady et al., 1996). The hurt is often a private loss unvoiced and unshared with friends. Over time, unless the therapist is careful, these repeated losses can beget reluctance to attach, to a disinclination to care deeply.

Even relationships with colleagues can have an isolating component in them. Therapists have a strong desire to appear emotionally stable and clinically expert to peers (Guy et al., 1989a, 1989b). The increased competition for patients and referrals associated with managed care adds fuel to the perceived

need to be at the top of your game. "Top Gun" rivalries—therapists competing with one another in a hostile manner—can become common (Persi, 1992). It is difficult for clinicians to share concerns openly if they perceive that doing so might place their livelihood and professional reputation at risk.

Peer rivalry and the resultant isolation often follow from ideological schisms. Raised and socialized in a "dogma eat dogma" environment that pits one theoretical orientation against another (Norcross & Goldfried, 2018), therapists tend to avoid colleagues of differing persuasions and professions. Divisions between, say, psychoanalysts and behaviorists, master's-level and doctoral-level professionals, or psychopharmacologists and psychotherapists, generate the ironic feeling of being alone among mental health colleagues.

Male psychotherapists typically experience even more difficulty cultivating relationships with peers, since many men are socialized to inhibit expression of positive emotions and to interact competitively with other men, thereby avoiding emotional closeness with male colleagues (Brooks, 1990). At least three studies have found that women experience less emotional exhaustion than men in independent practices (Rupert & Kent, 2007), and we suspect that men's disinclination toward emotional support and affective communication may account in part for this robust difference. Secrecy and competition inhibit sharing among colleagues and breeds loneliness.

Finally, as regards emotional isolation, some psychotherapists find it difficult to set aside the interpretive observer role when leaving the office (Zur, 1993). While at home they may find that the practiced restraint and reflective treatment posture make it difficult for them to be themselves. Such detached expertise hinders genuine, spontaneous responses, leading to artificial interactions (Freudenberger & Robbins, 1979). Emotional isolation is more frequently reported by inexperienced clinicians who have not yet mastered the skill of removing the "therapeutic mask." In short, it is difficult to leave the psychodynamics at the office and turn off the therapeutic role while at home.

PATIENT BEHAVIORS

Our colleague Gerry Koocher (1999), who works with children and families confronting life-threatening illnesses, has written movingly of his work-related nightmares. One recurrent dream is that Gerry is in line for a roller-coaster theme park.

> As the line winds down slowly toward the start of the ride, I notice that I'm standing among friends, relatives, and dozens of bald-headed or bewigged children, several of whom I recognize as patients I treated before they died from cancer. Suddenly we are on the leading platform, and I notice a sign with large red letters: "WARNING! Up to 40 percent

> of riders fall to their deaths. Check your safety bar." I find myself seated in the last seat of the back car. I pull the safety bar toward me and hear a reassuring "click" as it snaps into place. As I look up the car begins to roll down the chute, and I notice that many of the riders in front of me have not secured their belts. I feel a desperate urge to reach out and help, but am locked in my seat and cannot help. We plunge into darkness that is broken by the flash of a strobe light. With each flash I see more empty seats in front of me. There is nothing I can do. (Koocher, 1999, p. 25)

This disturbing dream encapsulates what many psychotherapists feel when unable to reach a patient or when a patient disappears, dies, or commits suicide. One need not be an expert on dream interpretation to see that our rational desires to help and comfort are trumped in sleep by the magical wish to cure everyone and to stave off death. The dream powerfully reminds us of the stressful contacts and despairing lives that some patients share with us. We try to insulate ourselves from such disappointments, but some losses are like sandpaper on the soul.

Psychotherapists work with emotionally distressed and conflict-ridden patients. The natural consequence is that we rarely see people "at their best" (Guy, 1987). Dealing exclusively with pathological populations begins to color our perceptions of society and humanity; beware the "haunting" hazard as it has been called. For instance, a clinician who works with sexual abuse victims day after day can easily form a skewed perspective of the world (Pearlman & Saakvitne, 1995).

We rarely see people "at their best."

Not only are we susceptible to clients' contagious emotions, but we also possess certain vulnerabilities unique to the profession (Schwartz, 2004)—a double whammy of sorts. We are supposed to be perfect—empathic, mature, kind, hopeful, and wise—no matter how the client is. Despite intense provocations on the client's part, we are supposed to avoid pejorative remarks, wisecracks, or bitter complaints to the person/patient precipitating our distress. An impossible profession, indeed!

Most empirical research on the stressors of psychotherapy practice has been conducted on specific client behaviors. In general (e.g., Deutsch, 1984; Farber, 1983a; Kramen-Kahn & Hansen, 1998), specific patient presentations found to be the most distressing are suicidal statements and acts, aggression toward the therapist, severely depressed patients, premature termination, profound apathy, and the loss of a patient. Let us briefly consider these and other patient behaviors in turn.

Of all the patients who test our patience, the suicidal top the list (e.g., Chemtob et al., 1989). A patient suicide is *the* professional event most feared by psychotherapists (Pope & Tabachnik, 1993). Jeff Kottler (1986) describes

the challenge of treating suicidal patients on four levels. First, therapists may feel terrified at the knowledge of being so close to someone so desperate that nothingness seems like a viable option. Second, therapists feel immense responsibility to help a suicidal patient. The moral and professional obligations are extraordinary, and any mistake may prove lethal. Third, once a patient is assessed as suicidal, the entire therapeutic process is altered. Extra precautions on the part of the staff must be made, and everything must be done "by the book." The margin for error is small, and the pressure on the therapist profound (Kottler, 1986). Fourth, it is particularly difficult to leave the problems of dealing with a suicidal patient "at the office."

The probabilities of mental health trainees and professionals having a patient commit suicide are fairly high, sad to say. More than 20% of counselors, more than 30% of psychologists, and more than 60% of psychiatrists will experience a patient's suicide (Chemtob et al., 1989; Gill, 2012; McAdams & Foster, 2000). More than one in four interns/trainees will encounter a patient suicide attempt, and at least one in nine will experience a completed patient suicide (Brown, 1987; Kleespies et al., 1993).

In the event of a patient suicide, the psychotherapists involved will probably experience substantial disruptions in their personal and professional lives. One-third of psychotherapists who experienced a patient's suicide subsequently suffer from severe mental distress (Hendin et al., 2004). Several factors contribute to the severe distress: failure to hospitalize an imminently suicidal patient who then died; a treatment decision the therapist felt contributed to the suicide; negative reactions from the therapist's institution; and/or fear of a lawsuit by the patient's relatives (Hendin et al., 2004). Trainees who experienced a patient suicide, as compared to trainees who had patients only express suicidal ideation, felt greater shock, disbelief, failure, sadness, self-blame, guilt, shame, and depression (Kleespies et al., 1993; Knox et al., 2006). Patient suicide may represent the ultimate failure for a psychotherapist, who is left to deal with sadness, anger, self-doubt, confusion, and the fear of its happening again. (The American Association of Suicidology has a Clinician Survivor Task Force to help practitioners who lose a patient to suicide; go to *mypage.iu.edu/~jmcintos/therapists_mainpg.htm*.)

Also high atop the lists of stressful patient behaviors is aggression. An early psychiatrist (Freeman, 1968, p. 286) declared dramatically that "the major occupational hazard of psychiatrists is being shot by former patients." No one agreed with him literally then or now, but his forceful statement underscored the wide prevalence of threats, stalking, and physical attacks directed at therapists.

Reviews of the literature reveal that nearly half of all psychotherapists are threatened, harassed, or physically attacked by a patient at some point in their careers (Guy et al., 1992; Haller & Deluty, 1988; Pope & Tabachnick, 1993). The prevalence of physical attack, thankfully, is lower, about 20% (Pope & Vasquez, 2016); it is higher in hospitals and clinics than in private practices (Tyron, 1983).

The most frequent negative effects of actual physical attacks are an increase in personal vulnerability, escalation of fearfulness, decrease in emotional well-being, increase in a loved one's concern for the clinician's personal safety, and diminution of perceived competence (Guy et al., 1990a, 1990b, 1991). Intense anxiety, fatigue, headaches, hyperactivity, nightmares, flashbacks, and intermittent anger are also common consequences of patient violence (Wykes & Whittington, 1991). Those clinicians expressing the most worry are those who had been previously attacked and those working in hospitals.

Patient aggression manifests itself even beyond overt physical attacks, of course. Unwanted phone calls to the home or office, verbal threats against one's personal safety and that of one's family, and threats of destruction to the office contents or home all represent violence (Guy et al., 1992). Between 6 and 15% of us will be stalked sometime during our career (e.g., Carr et al., 2014; Gentile et al., 2002; Kivisto et al., 2015; Purcell et al., 2005; Romans et al., 1996), largely motivated by anger or infatuation. An illustrative example: A female psychologist in private practice was forced to obtain two restraining orders against a former female patient. The patient followed the therapist's car on numerous occasions, tried to stop her in the middle of the street, kept her home under surveillance, made telephone calls to other professionals defaming the psychologist, and made written threats.

Severely apathetic and depressed clients are bound to evoke anxiety in a psychotherapist. A continuous string of "uh," "um," "yes," or "no" can generate frustration in the best of us. A patient who is withdrawn and nearly silent can make a single hour seem endless; time seems to stand still. Eventually, therapists may begin to suspect that they must be doing something wrong (Corey & Corey, 1989).

Extensive work with trauma survivors, which involves listening to a litany of detailed atrocities and constantly empathizing with clients, also takes a high toll on clinicians. Many experts believe that the most effective therapists ironically are also the most vulnerable to this hazard, as those who have the greatest capacity for empathy are at greatest risk for compassion fatigue (Miller, 1998). In this condition, described variously as vicarious traumatization, compassion fatigue, or secondary traumatic stress (Figley, 1995, 2015), therapists repeatedly exposed to graphic trauma material develop mild PTSD-like symptoms and experience changes in their frame of reference. Such distressing responses tend to be even more stressful to practitioners who (1) conduct a lot of treatment with survivors, (2) have a personal trauma history, and (3) endure higher levels of exposure to graphic details regarding sexual abuse (Brady et al., 1999; Little & Hamby, 1996). By one estimate, as many as half of the psychotherapists routinely treating trauma patients have symptoms of secondary or acquired trauma (Reuben, 2015). Trauma work produces a contagious soul weariness at the cost of caring.

Virtually all patients experiencing interpersonal difficulties will bring those problematic patterns into the consulting room with them. Perhaps the

patients most difficult to manage are those suffering from personality disorders. "Borderline" behaviors, for example, contribute disproportionately to therapists' restless sleep; the only stability is instability and drama. The affective lability of borderline patients, their behavioral impulsivity, self-destructive patterns, suicidal threats, comorbid disorders, and intense anger directed toward the therapist require therapeutic patience and consistency that passes all human understanding. The therapist may be so busy extinguishing weekly brushfires attributable to "acting-out" behavior that attending to the underlying forest fire in the patient's identity may go undone.

Helping professionals working with patients suffering from psychotic disorders will hear many tales of suffering at the hands of others, as well as frightening delusional beliefs. Their explanations of why things happen will involve graphic images and horrific descriptions. How can a therapist not react emotionally to another's feeling that the body is being ripped apart or consumed by others? How can a therapist not respond viscerally to client impulses to attack and destroy? But, for reasons of confidentiality, the therapist is left alone with her reactions.

Passive–aggressive and covertly resistant behaviors, for another example, pose special challenges. The most notorious signs of passive–aggressiveness include late arrival, minimal disclosure, and a hollow assurance that all is well. Accentuating the distress is that these behaviors are so hard to deal with directly—they evince an "elusive" quality, not always amenable to firm evidence or confident interpretation.

A common passive–aggressive manifestation in psychotherapy is premature termination, which frequently results in relatively high levels of psychotherapist stress (Farber, 1983b). A meta-analysis of 669 studies, representing 83,834 clients, found an average dropout rate of 20% (Swift & Greenberg, 2012). Although premature discontinuation is occurring at a lower rate than it was 20 years ago (Wierzbicki & Pekarik, 1993), it is still a significant problem, with about one in every five clients dropping out of therapy. Most of our clients terminate before meeting their therapeutic goals, leaving us all feeling confused, abandoned, and disappointed with treatment outcome. It can threaten our self-worth and professional competence; client dropout constitutes a narcissistic injury of sorts.

The threat of malpractice or ethical complaint is omnipresent in health care professions, and psychotherapy is no exception. Approximately 10–15% of mental health practitioners will need to respond to a licensing complaint during their careers, all the more so if they are male, a psychiatrist, involved in custody evaluations, or routinely providing services to high-risk clients. But only about 2 to 3% of practitioners over the full course of their career end up being a defendant in a malpractice suit (e.g., Dorken, 1990; Kirkland & Kirkland, 2001; Montgomery et al., 1999; Pope & Vasquez, 2005; Schoenfeld et al., 2001; Thomas, 2005). The prevalence is rising, but it is important to remember that it is still relatively low.

We suffer not only from an actual lawsuit, but also from the potential risk of such a suit. The threat of malpractice can paralyze us and cause us to practice too defensively. Lawyers and risk managers repeatedly warn us to consider every patient who walks through the door as a potential adversary. It is a chilling and disconcerting quandary for all of us—being advised to behave like adversaries in the nonadversarial, collaborative enterprise of psychotherapy (Kaslow & Schulman, 1987).

Studies of psychotherapists (e.g., Knapp et al., 1993; Thomas, 2005; Wilbert & Fulero, 1988) consistently find them actively worrying about malpractice—both their committing it and patients suing them for it. Between 8 and 23% of clinicians worry about it often—although, again, only 2–3% will actually be charged with malpractice in their careers. In extreme cases, practitioners may develop *litigaphobia,* the excessive, unreasonable fear of litigation by a patient. However, receipt of a malpractice suit or a licensing board complaint is only the beginning of a protracted hellish story. The majority of complaints to a licensing board are ultimately determined to be unfounded, but the investigation process is rough on the psychotherapist nonetheless (Thomas, 2005). A year-long investigation may eventually bring out the truth, but not before the therapist has had to fight for her reputation, defend herself to peers, and survive the mental anguish involved (Kottler, 1986). Most mental health professionals are patently unprepared for the painful consequences and expenses of defending themselves against a complaint (Lewis, 2004). A few therapists even decide to surrender their license and retire rather than face the agony of the investigation.

Coming full circle, we return to Gerry Koocher's nightmarish dream that began this section. The range of stressful patient behaviors seems infinite at times. Our core being is touched again and again—working with terminally ill patients and facing with them their fears of death, or counseling patients with chronic pain caught in a web of hopelessness. Working with physically disabled patients can activate nightmares of our own old age as well as terrors of being confined to a wheelchair. And those conducting family therapy will invariably confront physical violence and emotional abuse in families as well as residual pain from their own family of origin. Independent of the demographics and disorders of the particular client, the therapist as a person is indeed compromised again and again.

WORKING CONDITIONS

Ideally, a practitioner's workplace is a holding environment or a safe haven when perpetually confronted with this laundry list of conflict-ridden patient behaviors. But in reality, the workplace often represents an additional source of stress.

Organizational politics, managed care, excessive paperwork, demanding

workloads, and professional conflicts lead the list of complaints of experienced practitioners (e.g., Farber & Heifetz, 1981; Nash et al., 1984; Norcross et al., 1997). The excruciating slowness of the system, persistent resistance to new ideas, and unrealistic expectations are the key stressors of students entering the helping professions (Corey & Corey, 1989). The cozy setting of psychotherapy—the comfortable armchairs, the warm relationship, intimate engagement—often obscures its hazardous working conditions (Yalom, 2002).

Virtually all healing contexts are dominated by a sense of damage, despair, and disease. And that's only with the patients! Once you add in the bureaucratic nonsense, colleague misbehavior, inadequate resources, onerous paperwork, and assorted organizational and peer problems, one begins to recognize the potential damage of "working conditions" in the helping professions.

To be sure, different contexts make for different patterns of stress. Virtually every study (e.g., Farber & Heifetz, 1982; Hellman & Morrison, 1987; Orlinsky & Rønnestad, 2005; Raquepaw & Miller, 1989; Rupert & Kent, 2007; Rupert & Morgan, 2005; Smith & Moss, 2009; Snibbe et al., 1989) finds that psychotherapists employed in institutional and HMO settings experience more distress and burnout symptoms than those employed in private practice. Psychotherapists in private practice, on the other hand, find patient behaviors and financial concerns comparatively more stressful.

The major stresses attending independent practice tend to be, in descending order, managed care, time pressures, economic uncertainty, caseload uncertainty, business-related duties, and excessive workload (Nash et al., 1984; Norcross et al., 1997). Recurrent themes distinctive to independent practitioners include frustrations with insurance companies and third-party reimbursers and unrealistic demands for superhuman feats from clients, insurers, and the court system. The financial instability and risk associated with full or part-time private practice is a huge source of difficulty. And, in the absence of firm criteria for client success, therapists are left to define their own terms for success, which often prove to be unrealistic or overly idealistic (Raider, 1989).

In institutional settings, *moral stress* seems to be on the rise or, at least, more frequently addressed in the literature. Such stress occurs when organizational or legal rules prevent practitioners from doing what they believe is right or most beneficial for a patient (Fried, 2015). Professionals experience ethical and emotional impasses: best care conflicts with organizational policies, insurance constraints, or inadequate resources. "Some care is better than none" and "We do what we can with what we have" prove the common practitioner refrains, but repeated encounters leave the healer feeling like a moral obligation has been ignored. Although all practitioners experience moral stress at times, our sense is that those in organizational settings, such as nurses and social workers, bear the disproportional brunt (Lutzen et al., 2003).

Even mental health professionals in administrative positions encounter their own varieties of stress from working conditions. Residency directors

experience unique pressures and difficulties—having to select residents, struggling to assure that the faculty provide adequate care, contending with bureaucratic hassles, being overloaded with tasks, and warily monitoring residents released to function independently, to name but a few (Yager & Borus, 1990). Clinical supervisors, similarly, must attend to multiple and occasionally conflicting constituencies: student learning, client welfare, program requirements, and so forth (Norcross & Popple, 2017).

We extract three evidence-based conclusions from the research on therapist working conditions. One conclusion is that each work setting comes equipped with generic stressors as well as its own unique pressures. A second conclusion is that we must guard against overgeneralizing group differences in work settings to individual practitioners; for example, there are many contented practitioners in agencies and many dissatisfied practitioners in private practice. A third conclusion is that we must adopt a more nuanced perspective on the person–environment interaction. It is not the general work setting or environment per se, but the particular characteristics of that setting, such as low autonomy and low support in some agencies, that pose the greatest hazards. We will return to this latter point repeatedly in Chapter 10, "Creating a Flourishing Environment."

THERAPEUTIC RELATIONSHIPS

The therapeutic relationship constitutes both the agony and the ecstasy of our work. It is, at once, the most significant source of pleasure and displeasure in psychotherapy. We alternate between sleepless nights fraught with recollections of hostility and anxiety incurred from characterologically impaired patients and fleeting moments of realization that we have genuinely assisted a fellow human being.

Among the most widely reported stressors associated with the therapeutic relationship are the responsibility for the patients' lives, the difficulty in working with disturbed patients, and the lack of gratitude from patients (Farber & Heifetz, 1981). The very process of working intimately with human suffering presents the practitioner with psychic discomfort (Goldberg, 1986). If we are not careful, we wind up carrying around the weight and pain of every single patient, as though we were a mama kangaroo.

An empathic relationship with patients will necessarily activate the pain of countertransference. Ever since Freud identified the phenomenon, overidentification and overinvolvement with the patient, manifested through countertransference, have plagued psychotherapists. Countertransference is often invoked when the practitioner recognizes within herself the client's experience and is caught in the dilemma of trying to empathize with the client's feelings while, at the same time, avoid being adversely affected by them (Goldberg,

1986). Countertransference reactions include the arousal of guilt from unresolved personal struggles, inaccurate interpretations of the client's feelings due to therapist projection, feeling blocked and frustrated with a client, and boredom or impatience during treatment.

Which of us has not been repulsed by the actions and attitudes of a child molester, rapist, thief, or murderer? Of course, not all patients stimulate these feelings; only certain clients evoke such stressful reactions. As psychotherapists, we still struggle with distortions, unconscious reactions, unresolved conflicts, misperceptions, and antagonism in relation to particular clients (Kottler, 1986). Each client rubs the therapist a different way, bringing about different reactions.

Clinical interactions are typically characterized by constant emotional arousal (Raider, 1989). This arousal is simultaneously a curative agent for the client and a damaging one for the therapist. Here lies a recurring irony of clinical work: empathy with the client's distress deepens the therapist's pain. The proper therapeutic relationship demands a delicate balance, namely, remaining open to anguished feelings while retaining a modicum of self-preserving distance. It is the successful achievement of this balance that many master therapists cite for not feeling overwhelmed and being sucked into the misery of their patients' lives.

Lastly, fear of psychopathology as a result of intense contact with disordered individuals may cause a psychotherapist, and particularly a trainee, to experience continual fear and intermittent symptoms (Greenfeld, 1985). Constant exposure to conflict is traumatic, even when it is not your own conflict. Constant exposure reactivates our own personal conflicts, or at least poses the fear of reactivating those conflicts. Examining the psychological disorders of others fosters a great deal of morbid self-examination and symptom overidentification. Identifying with the patient's psychopathology while simultaneously striving to maintain the necessary psychological-mindedness can pose significant challenges to our own mental health (Doyle, 1987).

INDUSTRIALIZATION OF MENTAL HEALTH

Had we written this chapter in the 1990s, we would have apprised you of the *classic* stressors (demanding patients, organizational politics, emotional exhaustion, and professional isolation) confronting the mental health practitioner and been done. But since then, stressors have evolved and new ones arisen, namely, increased demands for speed, numbers, and paperwork. It's what biologists call the "Red Queen Principle": it takes all the running you can do to keep in the same place (from the Queen's observation to Alice in *Alice through the Looking-Glass*).

The typical practitioner is now threatened with being overwhelmed by the

escalating number of patients per day, the 30- to 40-minute sessions, the average of three to 10 sessions, and the mounting paperwork for diagnoses, treatment plans, and accountability. Unrealistic "productivity standards" now rule the clinical roost. There is no longer a threat of professional isolation; on the contrary, the real threat is frenetic overinvolvement with patients, colleagues, insurance carriers, and administrators. All this represents a sea change not only in mental health treatment but also in the stressors endured by the terribly human clinician.

The angst and disillusionment practitioners feel toward managed care are palpable. Many speak of the "catastrophe that overshadows our profession" and, after careers dedicated to the profession of psychotherapy, find themselves "reduced to numbers in corporate computers" (Graham, 1995, p. 4). Except for those relatively rare practitioners who never accept insurance, health care industrialization is upon us: many practitioners are losing money, patients, and, perhaps most urgently, autonomy.

Health care has manifested the two cardinal characteristics of any industrial revolution (Cummings, 1986, 1988). First, the producer—in our case, the psychotherapist—is losing control over the services as this control shifts to business interests. Control of mental health services is shifting to the payer, with associated shifts in goals and toward limits in reimbursable treatments. Second, practitioners' incomes are decreasing because industrialization minimizes labor costs. Income surveys consistently demonstrate that, as a group, psychotherapists are indeed losing income, when adjusted for inflation. Depending on the survey and the methodology, beginning around 1995 psychotherapists averaged 1–5% less net income per year adjusted for inflation (e.g., *Psychotherapy Finances,* 2006; Rothbaum et al., 1998).

The strain on psychotherapists is immediately linked to managed care—or managed costs and mangled care, if you prefer—but the overarching stress lies in the industrialization of mental health care. Some form of managed care plans now cover at least 90% of the Americans who receive their health benefits through their employer. Managed care is not a monolithic entity, but most of us know the symptoms of "managing" psychotherapy (Norcross & Knight, 2000):

- Restricting access to treatment (e.g., only "medically necessary" services for severe disorders)
- Limiting the amount of psychotherapy (e.g., to four–10 sessions)
- Using lower-cost providers (e.g., baccalaureate-level therapists)
- Implementing utilization review (e.g., after eight sessions)
- Approving primarily short-term, symptom-focused psychotherapies
- Referrals only via the primary care physician gatekeepers

- Restricting patients' freedom of choice to approved panels
- Charging outlandish deductibles for mental health and substance abuse services (despite parity laws)
- Requiring detailed and frequent paperwork directly from the psychotherapist

The restrictions of managed care impact all mental health professionals, but especially independent practitioners. The external constraints, additional paperwork, and lower reimbursement rates are the most highly rated stressors (Rupert & Baird, 2004). In contrast to colleagues with low managed care involvement, practitioners with high managed care involvement worked longer hours, received less supervision, saw more clients, experienced more stress, reported more negative client behaviors, and scored higher on emotional exhaustion (Rupert & Baird, 2004). 'Tis a recipe for burnout and diminished self-care.

Fully 80% of 15,918 psychologists responding to a survey (Phelps et al., 1998) reported managed care as having a negative impact (26% high negative, 37% medium negative, and 17% low negative impact). When asked to endorse the top practice concerns from a list of 18, the psychologists most frequently nominated concerns related to managed care: managed care changing clinical practice; income decreased due to managed care fee structure; excess precertification and utilization review requirements of managed care panels; and ethical conflicts raised by managed care.

Seasoned therapists have grieved the gradual loss of autonomy and income to these "third parties" to the therapeutic relationship, but early career practitioners have not known anything else during their training and career. We used to say that the elephant of managed care was entering the house, friends; however, now we say that the elephant has taken permanent possession of the house.

HAZARDS INHERENT IN THE PERSON OF THE PSYCHOTHERAPIST

Most of the aforementioned hazards "come with the territory." They are part of the world of the psychotherapist. We find ways to minimize their impact, but few of us can avoid them altogether.

Some practitioners create additional hazards that undermine their satisfaction and well-being over the course of a career. These are rooted in the therapist's personal history and earlier life experiences, factors that may have led to the vocational choice of psychotherapy and that interact with ongoing life events (Freudenberger, 1990b; Keinan et al., 1989).

Motivations for Becoming a Psychotherapist

Several of the characteristics that attract individuals to a mental health career—altruism, idealism, and thirst for self-knowledge, for instance—lay the foundation for later disappointments. The source of our success can also be the root of our problems.

It is widely joked that some of the strangest individuals select psychotherapy as a career. Behind this humorous stereotype lies some truth. Many entering the profession are understandably motivated by curiosity about their own personalities. They hope to find solutions to personal problems or resolution of underlying conflicts (Elliot & Guy, 1993; Goldberg, 1986). If the personal distress motivating this career choice is serious enough, the pressures inherent in conducting psychotherapy will exacerbate emotional problems (Overholser & Fine, 1990).

A related characteristic is a tendency to be drawn to the intimate encounters of psychotherapy out of a desire to combat loneliness. As a group, psychotherapists had relatively few friends before adulthood and tend to be loners (Henry et al., 1973). The reality of practitioner isolation and artificial intimacy found in the work does little to satisfy interpersonal longings and attachment needs. If anything, the intense encounters with clients may heighten rather than lessen the desire for love and understanding in a person who has yet to find satisfying relationships in her personal life.

Some psychotherapists are motivated to enter the profession in part because it provides the chance to exercise influence on or to live vicariously through patients. Clinical practice offers the temptation to vicariously act out personal fantasies, conflicts, and desires by encouraging clients toward a particular perspective (Bugental, 1964). Psychotherapists indeed want to "make a difference," but this motive can deteriorate into a god-like position of control (Guggenbuhl-Craig, 1971). The psychotherapist's power can be considerable, and the resultant sense of self-importance can be intoxicating for those who secretly worry about their own competence as a professional and effectiveness as a person. Arrogance and grandiosity are occupational hazards that can also transfer to the home setting.

Some individuals are drawn to this career due to the unspoken belief that their caring has special curative powers. In a near messianic fashion, they feel compelled to pour out their love on others with the expectation that it will serve as an emotional salve or balm. Such uber-altruism leads them to ignore their own needs—caring for others but not for themselves. This motivator can lead to a false sense of omnipotence or, on the contrary, an enormous sense of disillusionment when the truth becomes known to them.

Some clinicians were born into or assigned the role of caretaker at an early age in their families of origin. The resultant career motives can prove less than ideal (Dryden & Spurling, 1989; Guy, 1987). Whether assigned or naturally

predisposed to the role of "helper," such therapists tend to burn out quickly when frustrated by slow patient progress or when their helping needs are fulfilled elsewhere. Some look to a career in psychotherapy in order to resolve personal needs related to family dysfunction. Systemic changes are likely to be modest, if they occur at all, and the need to rescue or repair these relationships diminishes as the therapist resolves her conflicts regarding her family of origin.

Intercurrent Life Events

Life has an uncanny knack of interfering with our plans to create the ideal clinical encounter that reflects only the client's need. In truth, psychotherapy reflects the combined reality of both the client and the therapist.

Life events can cause considerable distress in the therapist's inner world. In several of our early studies (e.g., Guy et al., 1989a, 1989b; Norcross & Prochaska, 1986a; Prochaska & Norcross, 1983), between 75 and 82% of psychotherapists reported experiencing a distressing episode within the past 3 years, and more than one-third indicated that these personal problems diminished the quality of their patient care. In another study (Pope et al., 1987), 62% of psychotherapists admitted to working when too distressed to be effective. The most common precipitating events of distressed psychotherapists are disruptions in their own lives—dysfunctional marriages, serious illnesses, and other interpersonal losses—as opposed to client problems (Norcross & Aboyoun, 1994).

Our emotionally taxing profession frequently places stress on the marital or partner relationship (Freudenberger, 1990b). In one survey of therapists' personal problems (Deutsch, 1985), over three-fourths of the respondents reported having experienced relationship difficulties. Another study (Thoreson et al., 1989) found that over 10% of psychologists experienced high levels of distress due to marital or relational dissatisfaction. And several studies (e.g., Rupert et al., 2009; Wahl et al., 1993) have found correlations between psychotherapist stress and marital/family dissatisfaction, suggesting that increased work stress relates to decreased marital satisfaction.

Pregnancy is another significant life event that has ramifications for both male and female therapists. The first pregnancy brings profound changes in roles and lifestyles as well as the therapist–patient relationship (Guy et al., 1986). For female therapists, pregnancy is a nonverbal communication to patients, destroying any anonymity (Paluszny & Pozanski, 1971) in that it becomes obvious that the therapist has a personal life that involves sexual activity and family ties (Ashway, 1984). Many pregnant therapists fear being less attentive to patients and becoming increasingly self-absorbed about the baby (Bienen, 1990; Fenster et al., 1986). Some therapists may feel guilty for giving birth and abandoning their patients to care for the newborn. The growing sense of physical vulnerability, hormonal changes, and fatigue also impact the female therapist's effectiveness (Guy et al., 1986).

Male therapists with pregnant partners may experience many of the same role changes, conflicts, and emotions as the female therapist (Guy et al., 1986). The male practitioner may become increasingly preoccupied with concerns for the mother, baby, and his own ability to be an adequate father. Increased financial concerns may heighten his sensitivity to premature terminations and canceled sessions. He may also find himself more reactive to patient disclosures involving pregnancy, parenting, or abortion.

Parenthood supplies an assortment of disruptions in the therapist's relationships with clients. Children become ill, break limbs, and need their parents in emergencies. These realities of parenting increase the complexity of our professional role and necessitate a precarious balancing act to meet the fluid needs of both children and patients (Freudenberger & Robbins, 1979). Common patterns are allowing the therapeutic role to impinge upon family life by overanalyzing and overinterpreting children's behavior (Freudenberger & Kurtz, 1990), pressuring children to appear emotionally healthy at all times (Japenga, 1989), allowing patients to intrude into the home life, and being too tired and emotionally drained to engage in family relationships (Golden & Farber, 1998; Kaslow & Schulman, 1987). In fact, 75% of psychotherapists complain that work issues spill over into their family life (e.g., Farber & Heifetz, 1981; Piercy & Wetchler, 1987). The therapist's family may come to resent the energy and caring that seems more available to patients. Exhorting clients to devote more time and energy to nurturing their own family may take on an empty, even hypocritical, ring to many therapists neglecting their own.

Personal disruptions frequently take the form of loss—divorce and the empty nest being two of dozens of examples. Divorce may precipitate therapists' anxiety over its possible discovery by patients or cause doubts concerning competency since their marriage has failed (Guy, 1987). Children "moving out" may precipitate feelings of abandonment, despair, and depletion. Therapists who experience these losses may find terminations with their patients especially difficult (Kaslow & Schulman, 1987). In a study of terminations, we found that therapists significantly affected by the recent departure of children from their home reported a desire for more gradual terminations with their clients (Guy et al., 1993). Similarly, the study found that those therapists substantially affected by divorce were more likely to maintain social contact with clients after termination. Therapeutic relationships may thus be (mis)used to compensate for the losses in clinicians' personal lives.

Dissatisfaction with their personal life is the leading precipitant of psychotherapists' engaging in sexual misconduct with a patient. Feeling lonely, moving through a divorce, enduring a parent's death, suffering through relationship crises, personal illnesses, and financial concerns lead the list (Lamb et al., 2003; Norris et al., 2003). These sexual boundary violations are tied directly to both intercurrent life events and past personal vulnerabilities. Of course, a therapist's personal problems do not release her from responsibility for setting

and maintaining therapeutic boundaries, but awareness of the risk factors can mitigate the lapses.

As a psychotherapist ages into late adulthood, it becomes increasingly difficult to keep personal concerns from influencing professional practice. The death of loved ones, the physical decline, the mental effects of aging, and personal illnesses all exacerbate the depletion of the therapist's abilities (King, 1983). Aging or ailing psychotherapists often experience anxiety as they confront, perhaps for the first time, the reality of their own mortality (Guy & Souder, 1986a, 1986b). Some therapists feel guilty about becoming ill and having to temporarily "abandon" their patients (Schwartz, 1987); others experiencing vulnerability and helplessness increase their desire to be cared for by their clients. This sense of weakness can be quite disturbing to the therapist who typically perceives herself to be strong and competent (Dewald, 1982).

BURNOUT

In the opening chapter, we argued that striving to prevent burnout is a more pathological and less effective strategy than cultivating self-care. Nonetheless, no chapter on the occupational hazards of psychotherapists would be complete without a few paragraphs on burnout.

Burnout has been defined in a variety of ways (e.g., Freudenberger & Richelson, 1980; Perlman & Hartman, 1982; Maslach, 2003), but it always links directly to emotional depletion. We endorse the definition of burnout as "physical and emotional exhaustion, involving the development of negative self-concept, negative job attitudes, and loss of concern and feelings for clients" (Pines & Maslach, 1978, p. 233). Across occupational groups and nations, burnout is generally characterized by exhaustion, cynicism, and decreased professional efficacy (Schutte et al., 2000). Thus, when the emotional drain from work-related factors is so great that it hinders professional confidence and functioning, the therapist is likely suffering from burnout.

Solid research indicates that approximately 2–6% of psychotherapists are experiencing full-blown burnout at any one time (Farber, 1990; Farber & Norcross, 2005), but 25–35% of therapists experience symptoms of burnout and depression to a degree serious enough to interfere with their work (Rupert & Morgan, 2005; Wood et al., 1985). (Parenthetically, that's still below the typical rates of burnout symptoms in the 50% range reported for physicians; Phillips, 2015). Thus, while the vast majority of psychotherapists are emotionally "good enough" at any given time, periodic "brownouts" and instances of clinical burnout are prevalent indeed.

There is no need here for an extensive summary of the mounting literature on psychotherapist burnout; however, we would like to punctuate three critical

points. First, one should fully appreciate the interactive effects of occupational stress and psychotherapist personality. It is not simply the stressful environment nor solely the vulnerable person, but truly the interaction between the environment and the person. The upshot: each psychotherapist must sort through the unique array of environmental work stressors that confront her and then address the iterative, idiosyncratic impacts on her own world. For example, the two of us experience physical isolation differently. It troubles one of us not an iota, the other quite a bit. Surely this says something important about our personalities and predispositions. Surely, too, this says we must individually tailor our self-care to these personality predispositions.

A second critical point: burnout is not a unitary or global disorder. There are distinct subtypes of burnout with attendant different self-care strategies. Several subtypes have been empirically delineated (Farber, 1998): wearout or brownout, in which a practitioner essentially gives up or performs in a perfunctory manner when confronted with too much stress and too little gratification; classic or frenetic burnout, in which the practitioner works increasingly hard to the point of exhaustion in pursuit of sufficient gratification to match the extent of stress experienced; and underchallenged burnout, in which a practitioner is not faced with work overload but rather with monotonous and unstimulating work that fails to provide sufficient rewards. Each type requires a different self-care solution; what works for one subtype is likely to backfire for another.

Our third and final point is that burnout does not necessarily lead to outright professional impairment. A large proportion of burnt professionals manage to deliver competent care; not exceptional or optimal, but "good-enough" care. Please do not equate burnout with impairment.

In fact, several professional organizations have promulgated formal models for self-assessment and collegial intervention. The American Psychological Association's Advisory Committee on Colleague Assistance, for instance, posits a continuum:

Stress → Distress → Impairment → Improper Behavior

Therapist distress or burnout can be stopped and can be reversed; better yet, proactive self-care can prevent burnout in the first place.

RESPONDING TO THE HAZARDS

What a staggering list of hazards and burdens! Are we trying to drive you out of the profession and into law or real estate? Not hardly. So, here are the tradeoffs, and here are the ultimate purposes of this chapter.

Recognition

Our selves are our therapeutic tools. To put our problem in a nutshell (Lasky, 2005): Is there any kind of work in this world where the tools never get dull, chipped, or broken?

We began this chapter by saying it out loud and will do so again: Psychotherapy is often a grueling and demanding calling. Be aware of the occupational hazards inherent in the work and those unique to your work setting and personal vulnerabilities. Establish realistic expectations. Expect to feel overwhelmed and drained at times. Beware of what pushes your button, rings your bell, and activates your neuroses.

When recognizing the stresses you encounter as a psychotherapist, keep in mind that similar kinds of pressure are experienced by virtually all of your colleagues. Confidentiality, isolation, shame, and a host of additional considerations lead us to overpersonalize our own sources of stress, when in reality they are part and parcel of the "common world" of psychotherapy. Disconfirming our individual feelings of unique wretchedness and affirming the universality of stresses are in and of themselves therapeutic.

Although we psychotherapists face the same trials and tribulations, we are hesitant to admit it publicly. The autobiographical accounts of experienced psychotherapists (e.g., Burton, 1972; Dryden & Spurling, 1989; Goldfried, 2001) make it painfully clear that they have experienced many of the same personal tragedies, failures, and stressors as the rest of us. Despite our secret fantasy that prominent therapists may have discovered a way to inoculate themselves against the ravages of distress, experience proves otherwise. In the words of Freud (1905/1933, p. 100): "No one who, like me, conjures up the most evil of those half-tamed demons that inhabit the human breast, and seeks to wrestle with them, can expect to come through the struggle unscathed."

Acceptance

Appreciating the universality of these hazards and accepting some of their inevitable distress contribute to the creation of corrective actions. A colleague opined after a self-care workshop that "I will always remember your honesty about the difficulties in our profession. So many conference presenters tout their techniques and their successes, leaving me with a feeling of unreality and lack of support. Your honesty and humor about what we do works for me."

Speaking of corrective actions: let us accept from the outset that our positions exact considerable demands for high-quality work. Acceptance is a crucial mind-set, as our cognitive-behavioral colleagues have learned in terms of treatment methods and our psychoanalytic colleagues have informed us in terms of a tragic view of human nature. Acceptance is an active process, not a passive resignation.

At an international conference in Japan, several years ago, one of us (JCN) was grousing about the inclement weather. My host good naturedly responded, *wabi-sabi*. He explained that it was a form of acceptance, the Japanese idea of embracing the imperfect, celebrating the tattered or worn. Learning to love the chips and cracks help us become less stressed and more mindful. Actively embrace the incomplete and impermanent. (We devote all of Chapter 9 to mindfulness.)

Here's how we personally think about it: Clinicians already have two strikes against them. Freud, as you will recall, christened psychotherapy an impossible profession. But it was only one of three that he identified; the others were education and politics or governing (depending on the translation). Thus, clinicians are daily practicing two of the impossible professions—psychotherapy and politics or government—depending on your involvement in agency politics, professional organizations, and administrative responsibilities. That's our acceptance strategy, our *wabi-sabi*—we are involved in highly gratifying but impossible pursuits, and keeping our nose above the waterline is doing well under the circumstances.

Self-Empathy

Another place to begin is to *Start Where You Are,* the title of a book by the Buddhist nun Pema Chodron (1994):

> Our first step is to develop compassion for our own wounds. . . . It is unconditional compassion for us that leads naturally to unconditional compassion for others. If we are willing to stand fully in our own shoes and never give up on ourselves, then we will be able to put ourselves in the shoes of others and never give up on them. (p. x)

Exercise even half of the empathy you experience for your favorite patient on yourself!

Source of Strength, Too

The occupational hazards are just that, of course, but also more: an opportunity to learn and grow. When challenged, the resilient practitioner (Skovholt & Trotter-Mathison, 2016) responds with corrective actions that address the present concern and develop resources to reduce the probability of recurrence. We are reminded of Hemingway's observation in *Farewell to Arms* that, "The world breaks every one and afterward many are strong at the broken places." That's a message not only for our patients.

We are all broken or, as Freud wrote, we psychotherapists have a certain skill but beyond that are flawed humans too. 'Tis largely a matter of degree of

brokenness between patients and practitioners. That mind-set takes the edge off of our occasional grandiosity and increases other-empathy and self-empathy. With clients, that enables us to present authentically as fellow strugglers, albeit better functioning, with a warm fellow-feeling for the journey of change.

Team Approach

In appreciating the universality of occupational hazards and in cultivating self-empathy, you will probably discover that high-stress clinical situations require a team approach. The death of a child, severe PTSD, and suicidal borderline pathology, for instance, require multiple professionals working together (e.g., Kazak & Noll, 2004; Linehan, 1993). It is too much for a single clinician; it is inhumane for one person to go it alone. A team can better share the burden, process the pain, manage countertransference, and support one another.

Your team comes in many guises. The team may be an interdisciplinary cadre working directly with you on a particular case. The team may be supervisors, peers, consultants, and personal therapists. Your team may be researchers publishing on the disorder or dilemma you are confronting, your profession advancing your cause for equitable reimbursement for your services, or colleagues (like us) offering workshops and books on replenishing yourself. We devote several later chapters to self-care via nurturing professional and personal relationships, but did want to highlight here that you need not be alone and need not go it alone clinically.

Tailor Self-Care to the Individual

In this chapter, we have followed the conventional typology of therapist stressors in terms of sources—physical and emotional isolation, patient behaviors, working conditions, therapeutic relationships, and so on. Another scheme is to conceptualize therapists' practice difficulties in terms of three types:

1. *Transient* difficulties based on competency deficits; we literally do not know what to do or how to do something.
2. *Paradigmatic* difficulties based on therapists' enduring personality characteristics.
3. *Situational* difficulties based on features of particular patients and circumstances (Schroder & Davis, 2004).

Here's the payoff of this typology: different types of difficulties call for differential responses. Transient difficulties call for improved knowledge, training, and wider experiences; situational difficulties require tolerance, support, and

acceptance; and paradigmatic difficulties call for enhanced self-awareness and countertransference measures.

To disentangle the three types, ask yourself questions: Have you come across such a difficulty outside of the practice setting? With other patients? How are other therapists experiencing the situation? Would training and skill enhancement solve the problem? And so on (Schroder & Davis, 2004).

As you assess your own difficulties, attend to the types you experience and then develop a corresponding self-care plan. Some difficulties call for peer acceptance and colleague support ("That damn supervisor!"; "I can't understand this new form"), some call for training ("I need to learn more about treating trauma"), and still others call for supervision or personal therapy ("It's happening with another patient, just as it does in my personal life"). Different folks need different self-care strokes.

Tradeoffs and Balance

The hazards of psychotherapeutic practice must be reconciled and balanced with its privileges. Our work's frustrations are only half the story. In the lyrics of Jackson Browne's (1974) song, "Fountain of sorrow, fountain of light."

Our esteemed colleague Jim Bugental (1978, pp. 149–150) put the tradeoffs beautifully. His 40+ years of practicing psychotherapy profoundly changed him:

> My life as a psychotherapist has been . . . the source of anguish, pain, and anxiety—sometimes in the work itself, but more frequently within myself and with those important in my life. Similarly that work and those relationships have directly and indirectly brought to me and those in my life joy, excitement, and a sense of participation in truly vital experiences.

As with most meaningful endeavors, a career as a psychotherapist is a mixed bag of benefits and liabilities. Few careers offer the rewards experienced by the dedicated clinician, as we detailed in Chapter 2. Yet most psychotherapists discover that encounters with distressed individuals and repeated confrontations with the painful aspects of human existence can undermine vitality and optimism.

IN CLOSING

The therapist who denies that clinical work is grueling and demanding is, in Thorne's (1988) view, mendacious, deluded, or incompetent. Don't let anyone tell you different! We concur wholeheartedly, but would add that the therapist who claims not to have personally benefited from this grueling and demanding

work is also likely to prove mendacious, deluded, or incompetent. Without trivializing the enormous strains associated with this impossible profession, we conclude that most of us feel enriched, nourished, and privileged in conducting clinical work.

To avoid the impression that psychotherapy is solely an impossible profession, place the content of this chapter in perspective. Most psychotherapists enjoy long, successful careers during which time they experience only a relative few of the hazards we have discussed. When they do encounter these challenges, they typically overcome them. This reflects the quality of their personal awareness, support network, and resilience. It also reminds us that practically all of us use several of the self-care strategies described throughout this book.

If you—like us—have recognized ways in which you have been harmed by the practice of psychotherapy, please be concerned but not alarmed. The liabilities associated with clinical practice can be reduced by a variety of concrete and creative measures. The remainder of this book addresses skillful self-care mind-sets and methods that have emerged from the recognition of occupational hazards.

Our genuine hope is that the material contained in this chapter, although temporarily disconcerting, will assist you in summoning the conceptual and experiential tools required for a long, satisfying career as a mental health professional. In the remainder of *Leaving It at the Office,* our aim is to share what our colleagues, experience, and research have taught us about overcoming the distress of conducting psychotherapy.

SELF-CARE CHECKLIST

- ✓ Repeat the mantra "Psychotherapy is often a grueling and demanding calling" in order to establish realistic expectations.
- ✓ Search the web for research studies on practice hazards that address your distinctive professional and personal identities.
- ✓ Affirm the universality of occupational hazards by sharing your stressors and distress with trusted colleagues. Even the Garden of Eden had snakes!
- ✓ Identify the impact of clinical practice on you and your loved ones; look in particular for problematic anxiety, moderate depression, and emotional underinvolvement with family members.
- ✓ Track your amount of physical isolation each day. What steps can you take to create more opportunities for contact with other clinicians?
- ✓ Create variety in your day, such as intermingling psychotherapy sessions with supervision, consultations, study breaks, a trip to the gym, and so on.
- ✓ Invite family and friends to point out when you become too interpretive and "objective" when it would be healthier to be spontaneous and genuine.

- ✓ Know the actuarial data about the probability of a malpractice lawsuit or licensing complaint and weigh the high-risk aspects of your practice (e.g., child custody evaluations, personality disorders, violent patients, contested divorce cases).
- ✓ Calculate the possibility of patient violence in your office and take steps to enhance your personal safety accordingly.
- ✓ Take coach John Wooden's advice and refuse to believe either your most idealizing or your most demeaning client—you are neither God nor the devil.
- ✓ Beware the toxicity of chronic moral stress: being asked repeatedly to render suboptimal care erodes your soul.
- ✓ Limit your exposure to traumatic images outside the therapy room by choosing movies, literature, and other entertainment carefully.
- ✓ Reevaluate your involvement with managed care, particularly its possible contribution to your experience of depletion and burnout. How might you enhance your autonomy in your work?
- ✓ Adopt a team approach in dealing with high-stress clinical situations; distribute the burden and lighten the individual load.
- ✓ Beware of inadvertent domestic violations of patient confidentiality, and limit the amount of client material you share with your significant others.
- ✓ Consider how you balance empathic connection and self-preserving distance in your clinical work. When you find yourself on one end of the pendulum, pursue balance.
- ✓ Reflect on the number of clients that you've said good-bye to over the years. What has been the cumulative impact of those terminations?
- ✓ Address your own clinical limitations in an open manner instead of playing competitive therapist games.
- ✓ Periodically reevaluate why you became a psychotherapist and why you continue to practice. Look for ways to work through the unhealthy motivations.
- ✓ Proactively discuss your professional and parental commitments within significant relationships.
- ✓ Accept some spillover from your professional life into your personal life as an inevitable cost of being human.
- ✓ Discuss with your spouse/partner the topics covered in this chapter. How does he or she perceive their impact on your relationship?
- ✓ Learn how to handle distracting intercurrent life events. Perhaps consult with a trusted and more experienced colleague.
- ✓ Implement proactive steps to reduce the low but real possibility of burnout.
- ✓ "Start where you are": cultivate self-empathy regarding occupational hazards.

- ✓ Embrace *wabi-sabi*: accepting the imperfect, celebrating the tattered, learning to love the chips and cracks.
- ✓ Tailor your self-care to your personality and context by disentangling transient, paradigmatic, and situational difficulties; each requires a different self-care plan.
- ✓ Reconcile and balance the hazards of psychotherapeutic practice with its rewards—"fountain of sorrow, fountain of light."
- ✓ Recognize that occupational hazards are just that but also more: an opportunity to learn and grow.
- ✓ Adopt the long perspective as a healing practitioner; most psychotherapists enjoy lengthy successful careers and would elect to do it again.

Embrace the imperfect, celebrate the tattered or worn.

RECOMMENDED RESOURCES

Advisory Committee on Colleague Assistance. Retrieved from *www.apa.org/practice/leadership/colleague-assistance.aspx*.

Dryden, W. (Ed.). (1995). *The stresses of counselling in action*. London: SAGE.

Figley, C. R. (Ed.). (2015). *Treating compassion fatigue*. London: Brunner-Routledge.

Fried Social Worker Blog. Retrieved from *www.friedsocialworker.net*.

Maslach, C. (2003). *Burnout: The cost of caring*. Los Altos, CA: Malor Books.

Sussman, M. B. (Ed.). (1995). *A perilous calling: The hazards of psychotherapy practice*. New York: Wiley.

Wolf, A. W., Goldfried, M. R., & Murran, J. C. (Eds.). (2012). *Transforming negative reactions to clients: From frustration to compassion*. Washington, DC: American Psychological Association.

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