

## FOCUS ON ETHICS

Jeffrey E. Barnett, Editor

### In Pursuit of Wellness: The Self-Care Imperative

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The practice of psychology can be demanding, challenging, and emotionally taxing. Failure to adequately attend to one's own psychological wellness and self-care can place the psychologist at risk for impaired professional functioning. An ongoing focus on self-care is essential for the prevention of burnout and for maintaining one's own psychological wellness. Salient aspects of self-care are discussed, including the ethical imperative of addressing self-care throughout one's career. Three invited expert commentaries provide additional insights and recommendations on positive actions, preventive strategies, and steps to be taken by individual psychologists, by those training the next generation of psychologists, and by professional associations. Realities of the current state of psychology and a clear call for action are highlighted, with the overarching goal being the ethical and effective treatment of clients and the successful management of the challenges and stresses faced by practicing psychologists.

*Keywords:* self-care, psychologist wellness, distress, burnout, impairment

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#### Who Needs Self-Care Anyway?

Jeffrey E. Barnett

Psychologists face a number of challenges and stressors that place us at risk over time for experiencing distress, burnout, vicarious traumatization, and eventually impaired professional competence. As a result, we must engage in active attempts to

effectively manage these challenges and demands through ongoing self-care efforts. Failure to do so may result in harm to our clients, our profession, ourselves, and others in our lives.

#### Underlying Concepts

Distress is typically described as a subjective emotional state or reaction experienced by an individual in response to ongoing stressors, challenges, conflicts, and demands (Barnett, Johnston, &

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Hillard, 2006). Distress is a natural state that cannot be avoided. Impairment, or impaired professional competence, may refer to the deleterious impact of distress, left untreated over time, on the psychologist's professional competence as well as the negative effects of other personal or professional factors that adversely impact one's competence. Distress does not necessarily lead to impairment, but a lack of adequate attention to distress makes this possibility more likely. Further, distress and impairment should not be viewed dichotomously; distress and impairment are not just fully present or totally absent. They each may develop and progress if left unchecked. It is hoped that psychologists will notice signs of distress as they occur and take needed actions to prevent impaired professional competence from occurring. Short of this, however, as Haas and Hall (1991) recommended, "psychologists should have the self awareness to know when they are functioning poorly and then pursue the options to resolve this problem" (p. 7). Although this may be a challenge, integrating this focus on awareness of our own functioning and its impact on those we serve is essential for all psychologists and psychologists in training.

As a result of distress experienced over time that is not adequately addressed, psychologists may experience what Freudenberg (1975, 1990) termed *burnout*. Baker (2003) described it as "the terminal phase of therapist distress" (p. 21). It is characterized by feelings of depersonalization, emotional exhaustion, and a lack of feelings of satisfaction and accomplishment, and it may result from prolonged work with emotionally challenging clients. Similarly, clinical work with victims of violence and other traumatic events may lead to vicarious traumatization, or secondary victimization, of the psychotherapist (Figley, 1995; Pearlman & Saakvitne, 1995) wherein the professional experiences emotional distress similar to the client's, thus placing the professional at risk of impaired professional competence.

Psychologists may also experience impaired professional competence as a direct result of maladaptive coping responses to ongoing distress in their personal and professional lives. The use of alcohol or other substances, for example, as a means of coping with the stresses and challenges of one's life can easily result in a decreased ability to effectively implement and utilize one's professional knowledge and clinical skills, placing the welfare of those we serve at risk.

### An Ethical Imperative

The pursuit of psychological wellness through ongoing self-care efforts has been described as an ethical imperative (Barnett et al., 2006). Its basis may be found in Principle A, Beneficence and Nonmaleficence, of the American Psychological Association (APA) "Ethical Principles of Psychologists and Code of Conduct" (APA ethics code; APA, 2002), which states, in part, "Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work" (p. 1062). This awareness is an important first step, but clearly much more is needed.

Standard 2.06 (Personal Problems and Conflicts) of the APA ethics code states the following:

- (a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal

problems will prevent them from performing their work-related activities in a competent manner.

- (b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related activities. (APA, 2002, p. 1063)

Although the APA ethics code provides relevant and important guidance for practicing psychologists, Standard 2.06 focuses on existing personal problems and conflicts. As is emphasized later, self-care should be seen as an ongoing preventive activity for all psychologists. Following these requirements of the APA ethics code is, of course, a prudent course of action when such difficulties arise, but a major emphasis of psychological wellness is preventing such circumstances from even occurring. Thus, psychologists may find guidance from Principle A to be even more helpful if they expand their reading of it as follows: Psychologists are aware of the possible impact of their own physical and mental health on their ability to help those with whom they work, and they engage in ongoing efforts to minimize the impact of these factors on their clinical competence and professional functioning.

### On Being a Psychologist

Numerous factors impact practicing psychologists in ways that make attention to self-care and ongoing wellness efforts essential for our ethical and effective practice. These include personal qualities and factors frequently associated with individuals who enter our profession, challenges and difficulties all individuals face, the nature of the work we do, and challenges for mental health professionals in particular.

### Who Chooses to Be a Psychologist?

Numerous data exist that suggest that many psychologists have histories and vulnerabilities that place us at increased risk for distress and impairment. Pope and Feldman-Summers (1992) found that almost 70% of female psychologists and 33% of male psychologists surveyed acknowledged a history of physical or sexual abuse as children. Additionally, more than one third of those surveyed acknowledged experiencing some form of abuse as adults. Elliott and Guy (1993) found that compared with women from other professions, female mental health professionals acknowledged far greater histories of childhood abuse, parental alcoholism, and dysfunction in their family of origin, and they were more likely to have experienced the death of a family member and the psychiatric hospitalization of a parent. As highlighted by authors such as Racusin, Abramowitz, and Winter (1981), many mental health professionals have personal histories of dysfunction, and they played primary parenting or caregiver roles in earlier years. As a result, those of us who are mental health professionals may have been more likely to be attracted to this profession because it allows us to continue as caregivers and because it also possibly allows us to work to address or resolve earlier patterns of difficulty and dysfunction.

### Just Like Everyone Else?

Psychologists are no less likely than the average person to experience the effects of daily stresses or physical and mental

health concerns, including mental health and substance abuse disorders. Although some may presume that our education and training as psychologists insulate us from these forces, in reality we are at even greater risk than the general population (Sherman, 1996). Stressors may include relationship difficulties and break-ups, chronic illness, deaths of loved ones, financial difficulties, and other stressors experienced by individuals throughout our lives (Thoreson, Miller, & Krauskopf, 1989). Additionally, Sherman and Thelen (1998) found that a majority of psychologists surveyed reported experiencing such difficulties in their lives. They also highlighted that these are difficulties that interact with psychologists' personal predispositions and work-related challenges.

### *Is This Any Way to Make a Living?*

Although the work of the practicing psychologist brings with it many rewards and benefits, it also carries with it a number of challenges and stressors that may add to each psychologist's risk of distress and impairment. Challenges may include the following: (a) clients who place great emotional demands on the psychologist, such as those with Axis II psychopathology and those who engage in manipulative high-risk behaviors; (b) clients with chronic difficulties who do not improve and who may even relapse at times; (c) clients who attempt or complete suicide and those who perpetrate aggressive or violent acts against themselves or others; and (d) the requirements of insurance and managed care, which include increased paperwork demands, adverse utilization review decisions, and difficulties with receiving payment for services rendered (e.g., Baerger, 2001; Gately & Stabb, 2005; Pope, Sonne, & Greene, 2006). Additional stressors may include professional isolation, being on call during nights and weekends and having to respond to crises, and concerns about or the impact of ethics, licensure board, and malpractice complaints.

### *What, Me Worry?*

As individuals trained to attend to others' emotional states and difficulties, those of us who are psychologists are at increased risk for overlooking or ignoring our own emotional needs and reactions. By virtue of our personal predispositions and professional training to be caregivers, many of us may have a professional blind spot and fail to focus on our own needs, issues, and concerns (O'Connor, 2001). We may then miss the signs of impending burnout, and even if we are aware of them, we may be likely to minimize or deny them, needing to present the façade of the strong caregiver and not the appearance of a weak person in need of assistance (Sherman, 1996). Such a blind spot may be a major risk factor for allowing emotional distress to lead to impaired professional competence.

### *The Effects of Distress and Impairment on Psychologists*

Pope and Tabachnick (1994) found that respondents to their survey acknowledged experiencing a wide range of personal difficulties, such as depression, relationship difficulties, anxiety, and self-esteem/self-confidence problems. Of these psychologists, 60% acknowledged being significantly depressed at some time during their careers; 29% reported having felt suicidal, and nearly 4% had attempted suicide. Further, in another study, Pope and

Tabachnick (1993) found that 97% of practitioners lived with the fear of a client committing suicide, and more than 50% reported that their concerns about clients negatively impacted their personal functioning, including sleep, diet, concentration, and focus.

Gilroy, Carroll, and Murra (2002) found that psychologists acknowledged depression as one of their primary symptoms of distress. These psychologists reported that depression caused low motivation, poor concentration, fatigue, sadness, and lack of enjoyment. Guy, Poelstra, and Stark (1989) found that a large percentage of the psychologists they surveyed reported experiencing distress in the preceding 3 years. It is important to note that over one third of these psychologists acknowledged that their distress adversely impacted the quality of service provided to clients, with 5% reporting that the care they provided was inadequate. Similarly, Pope, Tabachnick, and Keith-Spiegel (1987) reported that almost 60% of the practicing psychologists they surveyed acknowledged working when too distressed to be effective.

### *Are We Missing Something?*

The data I have reviewed from several researchers highlight the fact that many psychologists continue practicing without seeking assistance or taking corrective action even though they know about the adverse impact of their distress on client care (e.g., Guy et al., 1989; Pope et al., 1987; Sherman, 1996). It is also known that many psychologists who become aware of signs of distress and possible impairment in a colleague tend not to confront or offer assistance to the colleague (Floyd, Myszka, & Orr, 1998) but may be more likely to ignore the situation and take no action (Good, Thoreson, & Shaughnessy, 1995). Further, despite the availability of colleague assistance committees through many state, provincial, and territorial psychological associations (SPTPAs), psychologists overall tend not to seek out the services they provide. Barnett and Hillard (2001) surveyed all SPTPAs about psychologists' use of their colleague assistance programs and found that 13% reported no psychologists seeking their services, 60% reported between 1 and 5 psychologists seeking their services, and 27% reported between 6 and 25 psychologists seeking their services. Additionally, as a direct result of lack of use of these programs despite a wide range of outreach efforts, 10 SPTPAs have discontinued their colleague assistance programs (Advisory Committee on Colleague Assistance, 2003; Barnett & Hillard, 2001). Although it is possible that psychologists have sought assistance elsewhere, data cited earlier suggest that psychologists are not doing so. Unfortunately, despite the ethical mandate to be sensitive to distress and burnout and to take steps to prevent and, if necessary, to resolve impairment that results from distress and burnout, many psychologists may at times not be taking needed preventive and corrective actions. Is this an individual issue each psychologist must address? Must the profession of psychology take action on a more global level? Just what actions are needed to remedy this situation?

### *What Psychologists and the Profession Need to Do Now*

In light of the data and trends presented, it is essential that all psychologists see themselves as vulnerable to the pernicious effects of the many personal and professional stressors and challenges they each face. Accordingly, all psychologists should be

sensitive to these issues and should conduct regular self-appraisals as well as engaging in an ongoing preventive self-care program.

Self-assessments should include awareness of and attention to personal risk factors and warning signs. Personal risk factors may include factors such as work with certain types of clients, the presence of increased challenges or stresses in one's personal life, and health or mental health difficulties. Warning signs may include increased feelings of frustration, impatience, or anger toward clients, increased boredom or lack of focus, hoping that certain clients will cancel their appointments, increased fatigue, decreased motivation, and decreased fulfillment and enjoyment from one's work (Barnett et al., 2006).

Psychologists must also look out for and avoid the use of negative coping strategies that are likely to further compound their difficulties. Examples include self-medicating with various substances, such as alcohol, drugs, and food, seeking emotional support or gratification from clients, and engaging in minimization, denial, or rationalization. Instead, psychologists should engage in what Kramen-Kahn and Hansen (1998) termed *positive career sustaining behaviors*. These include actions such as striking a balance between personal and professional demands and activities, seeking diversity in professional activities and caseloads, taking regular breaks from work, getting adequate rest and exercise, having a balanced and healthy diet, and attending to emotional, physical, relationship, and spiritual needs outside of the work setting. Such activities should not be seen as a luxury, and attention to self-care should not be seen as selfishness. Rather, they should be seen as essential aspects of the professional role that will hopefully result in what Coster and Schwebel (1997) described as *well functioning*.

It is also hoped that psychologists will eschew professional isolation and see it as one of the significant risk factors for burnout and impaired competence. The use of peer support and supervision groups, personal psychotherapy, individual supervision, professional associations, and colleague assistance programs all may help psychologists with self-care efforts and, if needed, may effectively respond to signs of developing impairment. Numerous authors report these activities to result in great benefit to those psychologists who utilize them (e.g., Barnett & Hillard, 2001; Mahoney, 1997; Norcross, 2005).

Unfortunately, a sizeable proportion of psychologists experiencing distress and signs of impairment may not seek needed assistance (let alone engage in adequate ongoing prevention efforts; Barnett & Hillard, 2001; Sherman, 1996; Welch, 1999), an issue that needs to be better understood before it may adequately be addressed. This is essential for the profession's efforts to promote and enhance the ethical practice of psychologists. It is also important for our profession to reduce the stigma of help-seeking behavior, to create an expectation for ongoing self-care that establishes this as part of the professional identity of practicing psychologists, and as O'Connor (2001) recommended, to establish a professional environment of openness, sharing, peer support, and consultation. In this way, we each may function as professional role models to colleagues and those in training, creating a professional climate supportive of self-care and help-seeking behaviors. This is something clearly of value and benefit to individual psychologists, those in training, the profession of psychology, and those we serve. Yet, one might reasonably ask if these lofty goals are realistic.

Challenges that face our profession include developing a better understanding of the nature, causes, and remediation of distress and impairment, understanding why psychologists at times do not take needed preventive and corrective steps, and implementing the systemic changes needed in our education and training systems, licensure boards and ethics committees, and colleague assistance programs to better address these issues. The invited commentaries that follow address these and related issues that directly impact the ethical and clinically effective practice of psychologists, making specific recommendations for individual psychologists, for those who educate and train them, and for our profession overall.

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the field would agree that self-care needs to be addressed by *both* the individual psychologist and the profession of psychology (Baker, 2003). Well-functioning psychologists make for heartier, more vibrant professional associations—and the reverse is likely true as well (Baker, 2002).

## The Individual Psychologist and Self-Care

### *The Ethical Imperative of Self-Care*

As practitioners, we know that there is a fine line between our personal and professional selves (Pipes, Holstein, & Aguirre, 2005). Thus, self-denial or self-abnegation is neglectful not only of our real self-needs, but ultimately of the well-being of our clients. Appropriate psychotherapist self-care is, in fact, a critical element in the prevention of harm to clients caused by the psychotherapist or the psychotherapy (i.e., iatrogenic effects).

As articulated in Principle A, Beneficence and Nonmaleficence, of the APA ethics code, "Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work" (APA, 2002, p. 1062). As therapists, we have the responsibility to forthrightly consider the value, right, responsibility, needs, and challenges of self-care, personally and professionally, at different stages across the course of our personal and professional life span.

### *Self-Awareness: Correction for Blind Spots*

Surveys indicate that most therapists come from families of origin wherein they felt a responsibility to care in some way physically or emotionally for family members (see O'Connor, 2001). Many of us have lifelong practice in reflexively attuning to others' needs. The risk subsequently is of an overlearned, compulsive versus a conscious, caretaking response.

*Masked narcissism* (Grosch & Olsen, 1994) has been used to describe caretaking that is, in fact, a reflexive, conditioned reaction, driven by caregivers' own, albeit unacknowledged, need to be taken care of themselves. By definition, masked narcissism, tends to manifest in subtle but often eventually costly ways. Conscious self-care is an antidote.

### *Practicing Self-Acceptance and Self-Compassion*

Psychotherapists, like everyone else, are human beings. Each of us has our own unique constellation of strengths and vulnerabilities. Learning to offer empathy, tolerance, acceptance, compassion, and realistic (not rationalizing, but rational) appreciation of our own humanness is truly a gift to ourselves and is indirectly a gift to others. Research, in fact, empirically demonstrates a positive relationship between self-compassion and adaptive psychological functioning (Neff, Kirkpatrick, & Rude, 2007). Nonetheless, for some of us, learning to be self-compassionate may involve relating to ourselves, in our attitudes and behavior, in ways different from those modeled to us in our family of origin. As psychotherapists, our work involves helping clients identify and proactively tend to their needs. Ideally, we can grant that counsel and possibility to ourselves.

In reflecting on this matter, some thoughts for consideration might include the following: (a) How would I describe and how do I feel about my own unique constellation of qualities as an indi-

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## Commentaries

### Therapist Self-Care: Challenges Within Ourselves and Within the Profession

Ellen K. Baker

Jeffrey E. Barnett's latest contribution to the gradually emerging body of literature on psychotherapist self-care is grounded in state-of-the-art empirical data and makes a significant contribution to the profession's discourse on this important issue. Many of us in

vidual being? (b) What are my limits, and how do I feel about them? (c) How do I see myself in terms of practicing self-compassion? (d) How would I like to further grow and develop in my capacity to be self-empathic and self-compassionate?

### Psychologists' Dynamics Regarding Assistance: Personally and/or Professionally

#### Psychotherapy

Reasons for psychotherapists to seek psychotherapy parallel those experienced by our clients. Many psychotherapists acknowledge their doubts about and even reluctance to seek psychological assistance (Welch, 1999). Exposing ourselves to another psychotherapist can be threatening. Given that psychotherapeutic circles can be overlapping, in settings of all sizes, confidentiality and the possibility of dual relationships are not minor issues and clearly need to be addressed. The potential benefits of being able to be real and accepted in our rawness and realness is powerfully therapeutic for us as well as for our clients.

Questions for ourselves, as psychotherapists, regarding this matter might include the following: (a) Have I wished to enter psychotherapy but had concerns about the process of finding a psychotherapist or of undergoing treatment? (b) If so, what are those concerns? (c) What might I offer myself in terms of options regarding personal psychotherapy?

#### Supervision

Whatever our level of experience, conferring with colleagues or a supervisor can be useful, sometimes invaluable, in helping us resolve particular clinical matters of concern. Surveys indicate that experienced clinicians acknowledge the benefits throughout their careers of consultation, supervision, and peer support (Coster & Schwebel, 1997; Norcross & Guy, 2005). At the same time, reaching out—especially when the issue is particularly sensitive—is not always easy to do. It takes time to develop trust within collegial and supervisory relationships, and even then it can be terribly difficult and painful to risk exposing one's vulnerabilities.

Questions regarding this issue apropos to each of us as clinicians include the following: (a) What kinds of peer and other forms of supervision are available to me? (b) How safe do I feel in making use of such resources? (c) What would I need to develop a consultation or supervisory relationship in which I felt able to openly express genuine concerns potentially or actually affecting my work as a psychotherapist?

### Global, Systemic Action by the Profession of Psychology

#### Graduate Training and Continuing Education

Training modules, focusing on both personal and professional aspects of self-care across the life span, should be developed for use in graduate programs and continuing education programs that are applicable across the professional life span. Psychology may benefit from looking at professional well-being models evolving in other health care professions (Spickard & Steinman, 2002). Another resource is the Center for Professional Well-Being, a nonprofit organization in North Carolina that provides assessment, educational, consulting, and advisory programs and services to

professionals across the various disciplines of professional health care (John Pffifferling, personal communication, August 31, 2007).

### Professional Association Support of Psychotherapist Self-Care

Recognition of the importance of and support for professional self-care are needed on a system and cultural level. Although individuals make up organizations, the leadership and imprimatur of major professional organizations like the APA are crucial in the allocation of financial and infrastructural support necessary for the promulgation of professional well-being.

Given the multitude of competing presses on the profession, as well as on individual psychologists, ultimately it may be the relatively measurable realities of the legal, financial, and/or professional repercussions of professional distress and impairment that will have the greatest impact in influencing systemic change. For ourselves as psychologists and for the profession of psychology to thrive, we have little choice but to come to terms with the profound relationship between professional well-functioning and the imperative of self-care.

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## Who Needs Self-Care Anyway? We All Do!

Nancy S. Elman

Jeffrey E. Barnett's question and essay on self-care are impressive in calling direct attention to a thorny but too often dismissed

ethical question for psychologists. The decision to explore self-care as one of the first topics in this journal's "Focus on Ethics" series grants it further distinct importance. It is not simple to state that psychologists need self-care, that they are prone to avoiding or deferring recognition of their own distress or burnout, and that a lack of serious attention to the first principle of the APA code of ethics (Principle A: Beneficence and Nonmaleficence) is challenging (APA, 2002). Self-care derives special importance from the fact that the person of the psychologist is, in large part, the tool of our work: The personal is the professional. Armed with knowledge, science, and professional skills, the psychologist's own relatedness, capacity for reflection, and clinical decision making are the most important common factors that determine clinical wisdom and successful practice.

Barnett pointed to individual challenges in self-awareness and the importance of recognizing and acting on the need for self-care, but he suggested that there is a systemic challenge as well: The profession needs to reduce the stigma of self-care and of psychologists' seeking help for themselves and needs to improve how we intervene with colleagues. For that to be accomplished, we need a change in the culture of self-care in our field and an acculturation process or model for accomplishing it (Handelsman, Gottlieb, & Knapp, 2005). This is an exceptionally good time for such a change as the field moves toward a focus on competence (Nelson, 2007). Similarly, the field is moving from the concept of impairment and toward assessment of challenges to professional competence (Elman & Forrest, 2007), which in turn can help to lessen the stigma attached to self-assessment and self-care as well as to differentiate challenges of competence from disabilities protected under the Americans With Disabilities Act (1990).

A culture change needs to be initiated at the level of graduate training. Identification of and intervention with trainees who are having problems developing professional competence or whose behavior indicates a lack of self-reflectiveness, self-awareness, and self-care is the first step. Faculty and supervisors often have no paradigm for addressing these challenges in training (save for mention in the appropriate discussion of the APA ethics code in a seminar on ethics), nor do they often model such behaviors, indicating to trainees the value of self-care for themselves or conveying that self-care is respected as much as hard work and scholarly or practice productivity. When a trainee is in difficulty and requires, at minimum, remediation to enhance self-reflection and self-care, it is often the trainee's peers who have the most knowledge of the trainee's challenges. Yet the culture of silence in most training programs does not tend to foster conversations with faculty or supervisors or with the trainee himself or herself. Shapiro, Brown, and Biegel (2007) have provided one example of training in self-care for psychotherapists in training. Health psychology master's candidates in counseling psychology who received an eight-session mindfulness-based stress reduction intervention reported significant declines in stress, rumination, and anxiety and increases in positive affect, self-compassion, and mindfulness when compared with students in a control class. This type of applied research could serve as a model for further development in this largely ignored area.

In addition to Standard 2.06 of the APA ethics code, addressing psychologists' own problems and conflicts, the ethics code includes a mandate to address the ethical behavior of peers. Standard 1.04, Informal Resolution of Ethical Violations, states, "When

psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual" (APA, 2002, p. 1064). If we are to create a culture of good self-care and teach psychologists to address their own self-care and intervene appropriately with peers, it needs to begin in our training programs; success in mastering these skills may be the *prevention* effort for the profession. Thus, training programs are encouraged to create attitudes (by modeling and actual behavior), knowledge (by teaching about the ethical standards as well as the literature related to self-care and the problems of practicing while distressed), and skills (by using learning activities such as role plays, vignettes, and practice opportunities that give trainees confidence that they respect and know how to address issues in themselves and others). Our culture of protecting confidentiality and privacy, appropriate for practice with clients, may have been overutilized in models of training and professionalism (Elman, Illfelder-Kaye, & Robiner, 2005; Forrest & Elman, 2005). The field of psychology has yet to demonstrate empirically a relationship between problematic behavior in training and later difficulties in practice. However, a study in medicine (Papadakis et al., 2005) found that physicians disciplined by state licensing boards were significantly more likely than nondisciplined physicians to have had documented problems of professionalism during medical school. Research to determine if this is so in psychology would contribute greatly to a culture of attending to self-awareness and self-care.

At the professional level, as Barnett described, colleague assistance programs have often failed to deliver assistance with self-care or intervention with peers, and many states either never have had or have discontinued such programs. Confidentiality, fear of litigation, or licensing board interventions are typically cited as reasons. The Advisory Committee on Colleague Assistance of APA's Board of Professional Affairs has made a concerted effort to address systemic challenges to self-care and colleague assistance in recent years. A document, *Advancing Colleague Assistance in Professional Psychology* (APA Board of Professional Affairs Advisory Committee on Colleague Assistance, 2005), was developed in collaboration with representatives of SPTPAs, the Association of State and Provincial Psychology Boards, and the American Psychological Association of Graduate Students. Its guiding principle is that collaboration between professional associations and licensing boards and shared understanding of problematic functioning among psychologists is necessary to promote self-care across the professional life span. The document also provides specific models and strategies for prevention and intervention efforts that assist psychologists across the career life span with self-care and the outcome of self-care—the prevention of unethical practice. Sample forms and materials for assessment and level-appropriate intervention are available and, if used, could help professional psychology move this important agenda forward.

So, who needs self-care? We *all* do, and we need a systemic effort to create a professional culture that puts genuine value on self-care and takes action to promote self-care more centrally into ethical competence.

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## Do as I Say, Not as I Do

Gary R. Schoener

As Jeffrey E. Barnett pointed out, much has been written concerning distress, impairment, and self-care in the psychological literature. Although the number is currently dwindling, many states have colleague assistance committees. However, they are not necessarily finding many psychologists coming in for assistance (Barnett & Hillard, 2001).

In addition to the data that Barnett cited, during the past 20 years there have been local studies of distress or impairment done under the auspices of state psychological associations. These have often been done as part of an effort to determine if there is a rationale for developing a state colleague assistance program.

In a survey of members of the Minnesota Psychological Association (Brodie & Robinson, 1991), the 156 respondents (19% response rate) produced data consistent with the general literature in that a substantial percentage of psychologists reported that they and their colleagues have experienced significant problems. For example,

- Depression: 47% acknowledged that they had experienced depression, and 84% had observed depression in colleagues;
- Burnt out/overworked: 60% acknowledged that they had been burnt out or overworked, and 81% had observed this in colleagues;
- Relationship problems: 49% had experienced relationship problems, and 78% had observed such problems in colleagues;

- Anxiety disorder: 44% acknowledged that they had experienced an anxiety disorder, and 67% had seen it in colleagues.

Some things were observed in others, but most respondents denied that they had such problems themselves (Brodie & Robinson, 1991):

- Suicidal attempts or ideation: Only 10% acknowledged suicidal attempts or ideation, but 29% had seen this problem in their colleagues;
- Physical health/disabilities (hearing loss, cancer, memory loss): 7% acknowledged this had impacted them, but 39% had seen it in colleagues;
- Alcohol/chemical use: 7% acknowledged this as a problem, but 52% reported seeing it in colleagues;
- Personality disorder: Only one psychologist (1%) acknowledged this, but 54% reported it in colleagues.

It is possible that respondents were a biased sample and among the healthier practitioners, and that they were, in fact, accurately perceiving others as having problems that they did not have.

In 1986, the New Jersey Psychological Association Task Force on Impaired Psychologists surveyed the association's membership regarding self-reported impairment. The study found that although most respondents indicated that they had resolved the source of their impairment either by themselves or with outside help, 7.5% reported having a continuing problem and still needing assistance. This was part of the rationale for starting a colleague assistance program. (New Jersey Psychological Association Task Force on Impaired Psychologists, 1991). Thus, both at the national level, as noted by Barnett, and at a state level, our field has examined the incidence and prevalence of impairment and concluded that it is significant.

The literature examines the need to confront colleagues who are impaired (Keith-Spiegel, 2005; Schoener, 2005a; VandenBos & Duthie, 1986) and special issues involved in the treatment of impaired psychotherapists and wounded healers (Gabbard, 1995; Irons & Schneider, 1999; Schoener, 2005a, 2005b). Over time, ethics textbooks have added sections on self-care for the practitioner (cf., e.g., Pope & Vasquez, 1991, 2007). Books designed to aid practitioners now typically have large sections on self-care (cf. Pope & Vasquez, 2005). Texts have focused on special challenges and problems in small communities (Schank & Skovholt, 2006). Skovholt (2001) is an entire text devoted to resiliency in practitioners, and White (1997) has examined the issues of stress and distress in certain therapeutic workplaces.

What is missing from this picture? Psychologists are writing about self-care and talking about it and there would certainly seem to be support for the notion that the pursuit of wellness and self-care is an important imperative.

## Institutional Psychology's Response

Despite all of the foregoing information and all of what Barnett wrote about, the reality is that in the early 1980s, the APA studied the needs of psychologists with regard to dealing with distress, and a very useful book was produced: *Professionals in Distress* (Kilburg, Nathan, & Thoreson, 1986). On the basis of this self-study, it was determined that a major national effort was needed, including such things as a *warm line* (a variant on the *hotline* concept), but none of these things were actually done. Instead, a three-person

Advisory Committee on the Distressed Psychologist was created (Schwebel, Skorina, & Schoener, 1991).

The original resolution creating this committee was approved by the Council of Representatives of the APA in February 1988 and began with the following premises:

For almost half a century, psychology has been guided by its own self-developed principles of ethical behavior which are intended to protect users of psychological knowledge and services. Impairments in the performance of psychologists, induced by mental health problems, substance addiction, and other disturbances, lead to violations of APA's purposes and ethical principles. Prevention programs and early interventions may reduce the incidence and intensity of impairment. Such actions may best be introduced on the state level. (Schwebel, Skorina, & Schoener, 1994, p. viii)

The resolution listed a number of activities that were focused on provision of information and on encouraging awareness and the development of knowledge about impairment. It did not discuss any thrust regarding the education and training of psychologists.

Within 2 years, the committee changed its name to the Advisory Committee on the Impaired Psychologist (Schwebel et al., 1994), and eventually it was renamed the Advisory Committee on Colleague Assistance. This committee had very limited staffing and budget. Although it focused on encouraging states to develop programs, in fact virtually no resources were put to this task, and the major interaction with state association programs was at the annual convention of the APA, which for a time had a breakfast meeting of programs. In short, despite the evolving literature and recommendations by a task force, little was done, largely because of the limited resources that were at the committee's disposal.

Gradually, liaisons with other committees strengthened the Advisory Committee on Colleague Assistance and improved communications, and joint work with the Association of State and Provincial Psychology Boards produced some helpful collaboration. By the time the monograph *Advancing Colleague Assistance in Professional Psychology* was published by the American Psychological Association Board of Professional Affairs Advisory Committee on Colleague Assistance (2005), the committee had six members (double the original committee size) and had liaison members representing APA's Board of Professional Affairs, the American Psychological Association of Graduate Students, and the Association of State and Provincial Psychology Boards. Despite creative work over a 20-year period, the statewide effort, however, still had a limited number of programs, as noted by Barnett. However, over the past 5 years, greater resources appear to have been made available, although the resources are still well below the level recommended in the mid-1980s.

Not that the other psychotherapy professions were doing any better. The American Psychiatric Association has also had an advisory committee, but it had even less visibility and had no ability to generate a national effort. Marriage and family therapy had no committee or program. Social work had no committee but did commission the development of a manual to aid state chapters should they seek to develop a program (Negreen, 1995). Nursing, medicine, law, and a number of other professional fields did have programs of various types, and the APA's Advisory Committee utilized them as models (Schwebel et al., 1991, 1994).

The American Psychological Society also lacks any sort of group to examine this issue, and organizations in professional

psychology in other parts of the world have also typically devoted little or no attention to this problem. The International Council of Psychologists has not addressed this issue in any significant manner.

### Education and Training: What About the Students?

*Advancing Colleague Assistance in Professional Psychology* (APA Board of Professional Affairs Advisory Committee on Colleague Assistance, 2005) includes a section on graduate school issues and training needs that examines the literature on graduate school stress and challenges faced by students and their training programs; this section expresses the hope that "models of professional colleague assistance that effectively address psychologists' self-care as well as prevention and early intervention will be helpful to training programs and trainees as well" (p. 12). During the past 15 years, there has been growth in the research literature relating to impairment in students and trainees, including studies related to how trainees deal with impaired peers (Mearns & Allen, 1991; Oliver, Bernstein, Anderson, Blashfield, & Roberts, 2004; Rosenberg, Getzelman, Arcinue, & Oren, 2005).

What is conspicuously absent from the literature are models for teaching about impairment to students and trainees. For example, role playing confrontation of a peer who appears impaired or methods of intervention with troubled colleagues.

Although not a systematic survey, in workshops on professional issues such as boundaries and ethics throughout many sites in North America, when audiences are asked if any of those in attendance have had a class in which they learned to confront or give feedback to impaired colleagues, normally not a single hand goes up. The same is true when audience members are asked if they had any significant discussion of practitioner wellness or self-care in graduate training, although typically a few participants note that their course work has included some mention of burnout or of vicarious traumatization. Few if any can name key authors or key works on any of these topics.

In a major contribution on the subject of trainee impairment, Forrest, Elman, Gizara, & Vacha-Hasse (1999) noted the lack of clear standards for the identification and remediation of cases in which a psychology student was impaired. Although there is widespread agreement about the importance of good self-care for students, training programs have not created structures to support this goal. Lamb (1999) noted the need to address student impairment and its relationship to professional boundaries, and Schoener (1999) was critical of academic institutions and training programs for not practicing what they preach.

If self-care is important in psychology and if it is an ethical duty, it is incumbent on the field of psychology to do a good job of modeling this in graduate school training. If there is an ethical duty to maintain one's level of functioning to avoid impairment, is there not an ethical duty to factor this into training at all levels? I see little evidence of this occurring except for the evolving discussion of the handling of impairment in students by graduate programs.

To conclude, few would question that self-care is of essential importance for any psychologist. Indeed, there is no real controversy over the importance of maintaining one's health and mental health if one is to be an ethical practitioner. The only real question is when our field will devote significant resources and adequate

attention to this issue, beginning with adequate coverage of the topic and related skills in graduate education.

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